STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555659	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Diego Post-Acute Center	1201 South Orange Ave. El Cajon, CA 92020

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of four licensed nurses (LN 1 and LN 2) reviewed for medication administration training and competency were trained and deemed competent to administer medications through a facility approved and documented validation evaluation. Licensed Nurse (LN) 1 prepared eight morning medications for Resident 6 including clozapine (used for schizophrenia, a distorted perception of reality), topiramate (used to treat seizures, abnormal and disruptive electrical activity in the brain), and levetiracetam (used to treat seizures) and gave the medications to LN 2 to administer. LN 2 then administered Resident 76's medications to Resident 187. In addition, four other LNs (LN 51, LN 52, LN 3, and LN) did not verify resident identification prior to administering their medications. This failure resulted in LNs failing to follow medication administration rights, including verification of resident identity before administering medication. As a result, Resident 187 received medications ordered for Resident 76 during medication administration training, experienced a significant change in condition, and required hospital admission. Nurses failure to identify the residents identity prior to administering medication may result in residents getting the wrong medication and can result in significant harm to the residents. (cross referenced at F-760) Medication administration observations were conducted for Residents 126, 2, 181, 73, and 43. Licensed Nurses (LNs) did not verify resident identification prior to medication administration as follows: - On 5/11/26 at 12:41 P.M., LN 51 administered a medication to Resident 126 without verifying Resident 126's identity. - On 5/11/26 at 3:34 P.M., LN 52 administered an unlabeled medication in a syringe to Resident 2 without verifying his identity. Resident 2's wristband was observed to be illegible. - On 5/12/26 at 8:19 A.M., LN 3 was observed training LN 4 on preparing and administering medications for Resident 181. Both LNs 3 and 4 administered medications to Resident 181 without verifying his identity. - On 5/12/26 at 9:14 A.M., LN 5 prepared and administered six medications for Resident 73. LN 5 did not verify Resident 73's identity prior to administering Resident 73's medications. - On 5/12/26 at 9:26 A.M., LN 5 prepared and administered six medications for Resident 43. LN 5 did not verify Resident 43's identity prior to giving his medications. 2. Resident 187 was admitted to the facility on [DATE] with diagnoses of depression and bipolar (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	disorder (mental health condition that causes dramatic shifts in a person's mood), per the facility admission record. Resident 76 was admitted to the facility on [DATE] with diagnoses of epilepsy (a brain condition that causes repeated seizures), schizoaffective disorder bipolar type (a mental illness with mood swings and psychosis), and extrapyramidal and movement disorder (medication related movement issues, tremors and stiffness) per the facility admission record. A review of the change of condition note, dated 4/29/26, 1:09 P.M., indicated Resident 187, .mistakenly received medications intended for another resident. A review of the nursing progress note dated 4/29/26, 1:55 P.M., indicated Resident 187 suffered a sudden decline in function with noted altered mental status and was transferred to the hospital emergency room. A review of the facility's medication error report (MER), dated 5/1/26, indicated Resident 187 received Resident 76's scheduled 9 A.M. medications and supplements in error on 4/29/26. The MER indicated medications administered to Resident 187 that could result in altered stated of cognition included benztropine mesylate 76mg (an anticholinergic med that can affect confusion, sedation and heart rate changes), Topamax 765mg and Keppra 500mg (anticonvulsant medications associated with dizziness and confusion), and clozapine 100mg (atypical antipsychotic that can cause sedation, low blood pressure and cardiac complications. The MER indicated Resident 187's mental status became altered after the medications administered in error. The MER further indicated the medications administered in error had the potential to cause serious neurological side effects when combined with Resident 187's routine medications (see F760 for Resident 187's prescribed medications). The MER further indicated the error occurred because the LNs (1, 2) failed to confirm Resident 187's identity before medication administration according to the facility's medication administration procedure and resident identification process. During an interview on 5/13/26 at 3:33 P.M., licensed nurse (LN) 1 stated she was assigned to orient and train newly hired LN 2 during medication administration on the morning of 4/29/26. LN 1 prepared Resident 76's medications and instructed LN 2 to administer the medications to Resident 76. LN 1 stated, she observed LN 2 exiting Resident 187's room shortly afterward. LN 1 stated LN 2 reported she administered Resident 76's medications to Resident 187 because the residents had similar sounding names. LN 1 stated she and LN 2 did not follow nursing medication administration rights, including administering the medication to the right resident at the right time. LN 1 stated Resident 187 experienced a change in mental status and was sent to the hospital. LN 1 stated she had been working at the facility for a little over two months, had never trained another nurse before, and had not received training from the facility on how to precept a newly hired nurse during medication administration. LN 1 stated she had not completed a skills competency checklist upon hire or before being allowed to administer medications to residents at the facility. During an interview on 5/13/26 at 4:11 P.M., LN 2 stated she was being trained by LN 1 during medication administration on 4/29/26. LN 2 stated LN 1 had prepared the medication from the medication cart, placed it in a medication cup, and asked her to administer the medications to Resident 187. LN 2 stated she did not remove the medications from the cart herself and did not compare the medications to the physician's orders in the medication administration record (MAR) before administering the medications to Resident 187. LN 2 stated she did not verify the medications in the cup matched the physician's orders for Resident 187 before administration. LN 2 stated (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident 76 and Resident 187 had similar sounding names, and she must have heard the wrong name when LN 1 asked her to administer the medications. LN 2 stated she did not verify the medications in the cup matched the physician's orders for Resident 187 before administration. LN 2 stated Resident 76 and Resident 187 had similar sounding names, and she must have heard the wrong name when LN 1 asked her to administer the medications. LN 2 stated there were other times that day she had administered medications prepared by LN 1 without checking them against the MAR. LN 2 stated nurses were expected to verify that the MAR order matched the resident's name on their armband before administering medication. LN 2 stated she had not completed that step in the medication administration process, which resulted in a medication error. LN 2 stated LN 1 informed her she was new to the facility and had not been instructed on how to train another nurse. LN 2 also stated the facility did not provide LN 1 with guidelines for training. LN 2 stated she felt the facility's medication training procedures and new hire orientation were inadequate for new nurses. During an interview and concurrent record review on 5/14/26 at 9:36 A.M., LN 1 and LN 2's employee files were reviewed with the director of nursing (DON). The DON stated the assistant director of nursing (ADON 1) or the DON was responsible for overseeing newly hired LN competencies were completed and documented. The DON stated the facility kept documentation of licensed nurse skilled competencies, including medication administration training, in the employee personal files. Review of LN 1's employee file indicated LN 1 was hired on 3/4/26 and the file contained no record of completed medication administration competencies upon hire, or before the medication administration error on 4/29/26. Review of LN 2's employee file indicated LN 2 was hired on 4/22/26 and did not contain documentation of completed medication administration competencies before the medication administration error on 4/29/26. The DON stated the facility recognized there was a problem with their current medication administration training process. A review of the facility policy titled, Administering Medications, revised April 2019, indicated, Policy Statement Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation. 29. New personnel authorized to administer medications are not permitted to prepare or administer medications until they have been oriented to the medication administration system used by the facility. 30. The charge nurse must accompany new nursing personnel on their medication rounds for a minimum of three (3) days to ensure established procedures are followed and proper resident identification methods are learned. During an interview on 05/19/26 at 4:05 PM, The DON acknowledged LN 1 was a new nurse who was placed in a role to train other new nurses on medication cart without having completed her own medication administration competencies. The DON stated the facility acknowledged they had problems with training new hires and ensuring staff competency, both of which needed to be addressed for resident safety. The DON stated they did not have a written policy or procedure to ensure nurses designated as new hire preceptors were deemed competent to train new nurses regarding medication administration. The DON stated the facility had many issues to fix regarding orientation of new employees. The DON stated it was important to ensure nurses were competent and could pass medications correctly before training another nurse on medication administration. The DON acknowledged Resident 187 experienced a change of condition that led to a hospital admission (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	following a medication error made by LN 1 and LN 2. The DON stated not ensuring nurses were competent in medication administration places all residents at risk of serious harm if something goes wrong. The DON acknowledged the policy indicated a charge nurse must accompany new nursing personnel on their medication rounds for three days to ensure established resident identification procedures were followed. The DON stated the facility had not followed the written procedure for training new LNs outlined in the medication administration policy. A review of the facility policy title Staffing, Sufficient and Competent Nursing, revised March 2026, indicated, Policy Statement: The facility provides sufficient nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Policy Interpretation and Implementation. Competent Staff: 1. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. 2. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. 3. Licensed staff must demonstrate the skills and techniques necessary to care for resident needs including {but not limited to) the following areas. I. medication management. 5. Competency requirements and training for nursing staff are established and monitored by nursing leadership with input from the medical director to ensure: a. programming for staff training results in nursing competency; b. gaps in education are identified and addressed; c. education topics and skills needed are determined based on the resident population; d. tracking or other mechanisms are in place to evaluate effectiveness of training; and e. training includes critical thinking skills and managing care in a complex environment with multiple interruptions. The facility had no written policy regarding the training of preceptors to orient and train new nurses. On 5/14/26 at 4:41 P.M., a meeting was held with the Administrator (ADM), DON, Assistant Director of Nursing (ADON) 1, ADON 2, Minimum Data Set (MDS, a mandated assessment tool used in nursing homes) Nurse (MDSN), Nurse Consultant (NC), Regional [NAME] President (RVP) and the survey team including the nurse surveyor supervisor. The facility was notified of Immediate Jeopardy (IJ, the most serious deficiency type occurring when a facility's noncompliance places the health and safety of residents at risk for actual or potential serious injury, serious harm, serious impairment or death, which requires immediate correction to prevent further or future serious harm). The IJ was related to the facility's failure to ensure LNs were trained under a structured medication administration competency process before administering medications to residents. In addition, the facility failed to ensure LNs assigned to precept newly hired LNs during medication administration had documented medication administration competency and preceptor training. The facility also failed to ensure all LNs had completed a competency checklist and return demonstration validation of medication administration prior to administering medications to residents. The facility's failure to ensure LNs were competent in medication administration and resident identification procedures resulted in a significant medication error on 4/29/26. The failure continued during medication administration observations from 5/11/26 through 5/12/26, when LNs failed to verify resident identity before administering medications. On 5/14/26 at 6:20 P.M., the facility provided a removal plan. The removal plan was reviewed and was not acceptable. On 5/18/26 at 8:12 A.M., the facility resubmitted a removal plan. The removal plan was reviewed and (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was not acceptable. On 5/18/26 at 12:22 P.M., the facility resubmitted a removal plan. The removal plan was reviewed and was not acceptable. On 5/18/26 at 4:10 P.M., the facility resubmitted a removal plan. The removal plan was reviewed and was accepted at 4:56 P.M. The IJ Removal Plan indicated: 1. Immediate protective actions: Beginning on 5/14/26 at 7:45 P.M., Nursing leadership and LNs received immediate verbal in-service education and return demonstration competency evaluation regarding safe medication administration practices. The NC educated the DON, the DON then educated the nurse managers (NM), and the NMs educated the LNs on the floor and oncoming LNs. The removal plan indicated, .Nurses were not permitted to administer medications until they received the required in-service education and successfully completed the competency evaluation. The education and competency evaluation included the eight rights of medication administration, resident identification protocols, and the requirement the LN who dispensed the medication must administer the medication. The facility placed medication rights posters on all medication carts. 2. Corrective measures for affected LNs: The facility required LNs to complete medication administration competency validation through return demonstration and documented completion on the medication administration competency checklist. The facility required nursing staff who were on leave, registry nurses, agency nurses, and LNs who had not completed the required in-service education and return demonstration competency evaluation to complete both before receiving a nursing assignment. A daily review of LN staff assigned to residents was conducted by nursing leadership to ensure in-service education was completed and medication administration competency checklist 3. Facility-wide system changes: The removal plan indicated the facility developed criteria to evaluate and approve licensed nurses to train or orient other nursing staff on medication administration. LNs approved to train other nurses were required to meet criteria that included six months (minimum) off satisfactory medication administration performance, a completed medication administration competency evaluation, and reevaluation of medication administration competency at six months, and DON or designee approval before training or orienting other staff. The facility required the DON or designee to provide ongoing observation, feedback and coaching to trainers and trainees during the medication administration training process. The removal plan indicated continued monitoring of LN medication administration competency for those LNs approved to provide training and orientation would be conducted by the DON. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility required new hired LNs to complete facility orientation, required in-service education, medication administration competency evaluation, return demonstration, and DON approval before being permitted to independently administer medications. . The following policies were reviewed and/or updated to ensure the facility process will be followed: a. Administering Medications; b. Resident Identification System; c. Performance Evaluations; d. Staffing, Sufficient and Competent Nursing; e. Train the Trainer Competency, medication administration. On 5/19/26 at 1:27 P.M., after onsite verification of the implementation of the facility's IJ removal plan, the IJ was removed. After the IJ was removed, the surveyor verified that the facility's non-compliance remained at a scope of isolated (when one or a very limited number of residents are affected and/or a very limited number of staff are involved) and lower severity of Level 3 (Actual Harm that is Not Immediate Jeopardy). On 5/19/26 at 1:27 P.M., the ADM was notified of the removal of the IJ.