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	06/04/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 interview and record review, the facility failed to ensure three of 16 Registered Nurses (RNs 1, 11, 16) were trained and competent to administer an intravenous (IV-the administration of fluids, medications, or nutrients directly into the bloodstream through a needle or tube inserted into a vein) medication administration using a Medicine Ball infusion system (balloon-like reservoir filled with medication that relies on its own elastic walls to generate steady, continuous pressure, slowly pushing fluid into a patient's vein) to residents receiving an IV treatment. In addition, one of 19 sampled Certified Nursing Assistants (CNAs) (CNA 1) connected an IV antibiotic (medicines used to treat and prevent bacterial infections) to Resident 1's Gastrointestinal Tube (GT- medical device inserted directly through the abdominal wall into the stomach, providing a direct route to deliver liquid nutrition, fluids, and medications). As a result, Resident 1 was sent out to the hospital for evaluation. These failures could cause serious harm to Resident 1 or other residents receiving IV medications, which may lead to adverse reactions, or even death. Findings: 1. A review of the admission Record for Resident 1 indicated he was admitted [DATE] and readmitted on [DATE] for diagnoses which included: Cerebral Infarction (when a blood vessel in the brain is blocked or severely narrowed, cutting off blood supply), and Sudden Cardiac Arrest (when the heart abruptly stops beating).A review of Minimum Data Set (MDS) for Resident 1 Section C, dated 3/13/26, indicated Resident 1 had a Brief Interview for Mental Status (BIMS - evaluates a patient's temporal orientation and immediate/delayed recall to track cognitive function and decline) Score of 0, which indicated severe cognitive (thinking processes) impairment. A review of Physician Orders, dated 5/20/26, indicated Piperacillin Sod-Tazobactam (Zosyn-an antibiotic) So Intravenous Solution .Use 100 ml (milliliter) intravenously every 6 hours for PNA (Pneumonia-an infection of one or both lungs that causes the lungs to become inflamed and fill with fluid or pus) .To infuse100ml over an hour.On 5/22/26 at 12:10 P.M., an interview was conducted with RN 2. RN 2 stated she RN 2 stated she worked the morning shift on Long Term Care (LTC- a dedicated section for individuals requiring extended medical supervision and custodial assistance because they can no longer live independently) Unit 2 on 5/21/26. RN 2 stated that morning, the night nurse (RN 1) was running late in administering Resident 1's 6 A.M. Zosyn IV medicine ball dose. Because RN 1 had never been trained on medicine ball infusions, she asked RN 2 to administer the dose with her. RN 2 stated the Zosyn IV medicine ball had to be taken out of the refrigerator to warm up to room temperature and could not administer the medicine until 8 A.M. RN 2 stated RN 1 did not know how to administer the Zosyn IV Medicine ball. RN 2 stated she had to show RN 1 how to prime the lines (the process of running a fluid through an empty tube or hose to completely fill it and push out all trapped air before it is put into use), clean the port of the hub, flush, and connect the IV to the Peripherally Inserted Central Catheter (PICC- line is a long, thin, flexible tube inserted into a vein in your upper arm that acts as a durable, long-term IV line). RN 2 stated during this time, RN 1 discovered an empty Zosyn IV medicine ball was connected to Resident 1's GT balloon port (used to inflate balloon that keeps GT in place). RN 2 stated that IV medication given through the GT could have caused Resident 1 harm, because it was not given by the right route. RN 2 reported to the day (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Charge Nurse (CN 1) found Zosyn IV medicine ball. RN 2 stated when they removed the found Zosyn IV medicine ball from the balloon port, RN 2 aspirated (removed) 10 ml of fluid with a syringe but could not aspirate more fluid after the 10ml. On 5/22/26 at 2:09 P.M., an interview with RN 1 was conducted by phone. RN 1 stated she worked the night shift of 5/20/26 on LTC Unit 2, into the morning of 5/21/26 and Resident 1 was her resident that night. RN 1 stated she gave the 12 A.M. dose of Zosyn IV medicine ball with the supervision of RN 3, through Resident 1's left-arm PICC line. RN 1 stated she then administered the 6 A.M., dose with RN 2 at about 8 A.M. on 5/21/26. RN 1 stated she later discovered an empty IV bag of Zosyn connected to the balloon port of Resident 1's GT, which had been covered by a blanket. RN 1 stated she did not give Resident 1 any medications through the GT that night, so she did not see the IV bag connected to the balloon port until the end of her shift. RN 1 stated she was with RN 2 at time of the discovery. RN 1 stated she reported the incident to CN 1, the charge nurse for morning shift. RN 1 stated CN 1 assessed the situation and reported the incident to the Director of Nursing (DON). RN 1 stated the facility did not provide her with training on medicine ball IV administration prior to working on the floor, and she never completed any return demonstrations for the medicine ball IV administration with a preceptor or training staff.On 5/22/26 at 3:15 P.M., an interview was conducted with charge nurse (CN) 2, the charge nurse for the Subacute Unit (a specialized, short-term wing designed for patients who no longer need hospital care but are too medically fragile to return home). CN 2 stated that IV training on the Subacute Unit was .conducted at the bedside with the orienting nurse, watch one time, then a return demonstration. CN 2 stated she trained all RNs who work to the Subacute Unit, and the DON was responsible for the other RNs on other units. RN 5 stated the medicine ball training was conducted bedside with a return demonstration with Subacute nurses; no classroom instruction was conducted with RNs. On 5/22/26 at 4:15 P.M., an interview with CNA 1 was conducted. CNA 1 stated on the evening of 5/20/26, Resident 1 was one of his assigned residents for LTC Unit 2. CNA 1 stated at about 10 P.M., he noticed Resident 1 was wet, and he changed the resident's brief and linens. CNA 1 stated when he turned Resident 1 on his back, he saw that the Zosyn IV medicine ball was in the bed next to Resident 1's stomach. CNA 1 stated Resident 1 had a towel on his stomach, and the medicine ball was lying by his left arm but not connected. I connected the IV to the port on his GT but did not screw it in. CNA 1 stated that touching the IV and GT was outside his scope of practice as a CNA.On 5/26/26 at 10:50 A.M., an interview with CN 1 was conducted. CN 1 stated she was the charge nurse for LTC Unit 2 on 5/21/26. CN 1 stated RN 1 reported that an IV was found attached to Resident 1's GT. CN 1 stated because she was a Licensed Vocational Nurse (LVN) she could not touch the IV set-up and handle IVs. CN 1 stated she reported the incident immediately to the Director of Nursing (DON) at 7:50 A.M. (on 5/21/26). CN 1 stated the DON came to the bedside to assess the resident and took over responsibility for the incident. A review of the facility document titled Job Description: Certified Nursing Assistant dated 2-2024, indicated The primary purpose of your job position is to provide each of your assigned residents with routine daily nursing care and services in accordance with resident's assessment and care plan, and as may be directed by supervisors.Report all changes in the resident's condition to Nurse Supervisor/Charge Nurse as soon as practical.Report all accidents and incidents you observe on the shift that they occur. Perform only those nursing care procedures that you have been trained to do.A review of the facility's policy titled Staffing, Sufficient and Competent Nursing dated 2001 indicated .4. Licensed nurses and nursing assistants are trained and must demonstrated competency in identifying, documenting, and reporting resident changes of condition consistent with their scope of practice and responsibilities.2. On 5/22/26 at 2:09 P.M., an interview with RN 1 was conducted by phone. RN 1 stated the facility did not provide her with IV training on the Medicine Ball Infusion system prior to being on the floor, and she did not complete any return demonstrations for Medicine Ball IV administration with a preceptor or training staff. On 5/22/26 at 3 P.M., an interview with RN 11 was conducted who stated she had not received training for the Medicine Ball IV infusion. RN 11 stated she only received a verbal in-service with no actual administration or a return (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	demonstration. On 5/22/26 at 3:13 P.M., an interview with RN 16 was conducted. RN 16 stated, I believe I wasn't trained. RN 16 was not aware of what the Medicine Ball IV infusion was. RN 16 stated she had no official in-service and had no return demonstration for Medicine Ball IV infusion. On 5/22/26 at 3:15 P.M., an interview was conducted with CN 2 who stated she was the charge nurse for the Subacute Unit. CN 2 stated IV training on Subacute Unit was .conducted at the bedside with an orienting nurse. CN 2 stated the process was to observe the procedure once, followed by a return demonstration. CN 2 stated she trained all RNs who come to Subacute unit, while DON was responsible for the other RNs on the other units. RN 5 stated the medicine ball training was conducted bedside with return demonstration by Subacute nurses, with no formal classroom training provided. A review of the facility's policy titled Intravenous Administration of Fluids and Electrolytes dated 2001 indicated that .10. When infusion is complete: a. For intermittent therapy: (1) clamp tubing and disconnect from catheter;(2) if tubing will be reused, replace sterile cap; and (3) flush catheter per protocol. Review of policy indicated it does not address how to dispose of IV bag or tubing after disconnected. On 5/22/26 at 4:51 P.M., a meeting was held with the Administrator (ADM), Assistant Director of Nursing (ADON 1 and 2), and the Minimum Data Set Nurse (MDSN). The meeting included the California Department of Public Health (CDPH) survey team and the Pharmacy Consultant, as well as a phone call with the leadership team. During this meeting, the participants were informed of an 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 RNs were competent in IV medication administration. In addition, a CNA was not competent in his role when he connected IV tubing to a GT port. On 5/23/26 at 6:15 P.M., the facility provided a removal plan. The removal plan was reviewed and was accepted. The IJ Removal Plan indicated: 1) Immediate protective actions: The CNA involved was immediately removed from resident care duties pending investigation and re-education regarding scope of practice and resident safety.2) Corrective measures for the affected residents. 1. The Nurse Consultant provided in-service education to the Director of Nursing and RN Manager regarding safe medication administration, enteral feeding safety, tubing verification, and scope of practice requirements. The RN Manager subsequently conducted in-service education and return demonstration competency validation with nursing leadership staff. All licensed nurses and certified nursing assistants currently in the facility were immediately provided with verbal in-service education and return demonstration competency regarding the following:a. Scope of practice requirementsb. IV tubing and enteral tubing safetyc. G-tube and enteral feeding safetyd. Resident identification procedurese. Safe medication administration practicesf. Requirement that only licensed nurses may administer medications, handle IV administration systems, or connect enteral feeding and medication tubing2. Licensed nurses were instructed that enteral feeding ports, medication ports, and IV tubing connections must be verified prior to administration of any medication, feeding, and/or flush.3. Any nurse or CNA returning from leave, agency assignment, or orientation who has not completed required education and competency validation will not receive a resident assignment until completion of the required training and return demonstration competency.4. The Director of Nursing and/or designee will provide ongoing observation, monitoring, feedback, recommendations, and coaching to nursing staff to ensure continued successful implementation of safe medication administration practices, enteral feeding safety, tubing verification procedures, and compliance with facility policies and procedures.3) Facility-wide changes: 1. The facility's policies were reviewed and/or updated to ensure the facility process will be followed:a. Administering Medications through an Enteral Tubeb. Intravenous Administration of Fluids and Electrolytesc. IV Administrationd. Scope of Practice Guidelinese. Tube Feeding and Enteral Safety2. Monthly monitoring of medication administration competencies, enteral feeding competencies, and orientation completion will be reviewed by the Director of Nursing or designee. Audit findings will be reviewed through the QAPI process monthly and quarterly to ensure (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ongoing compliance and sustained corrective action.On 5/26/26 at 3:33 P.M., in the presence of the ADM and two ADONs (ADON 1 and ADON 2) the IJ was removed, and the ADM was notified after verifying the IJ removal plan while on-site.On 6/4/26 at 10 A.M., a concurrent interview with (ADON) 1 and a record review of RN competencies were conducted. ADON 1 stated the DON was terminated and currently she was the DON designee. Review of the facility document titled Medication Administration Skills Competencies Checklist for RN 1, RN 11, and RN 16 indicated, IV administration skills and techniques were not on the checklist. There was no confirmation as to whether the RNs were competent in IV administration. ADON 1 stated IV administration checklists were started after 5/22/26, the day after the investigation began. ADON 1 stated no IV competencies were completed for the above nurses prior to them working on the floor and administering IVs. ADON 1 stated the expectation for IV administration was that RNs should have had training and their competency checked before working on the floor and administering IVs, because administering IVs without demonstrated competency could cause medication errors that could lead to resident harm. ADON 1 further stated CNAs need to work within their scope of practice, which included ADLs (activities of daily living), showering, and feeding. ADON 1 stated CNAs should not touch any lines or tubes that are not within their scope of practice, as they could cause harm to residents if done incorrectly.Review of facility policy titled Staffing, Sufficient and Competent Nursing dated 2001 indicated .3. Licensed staff must demonstrate the skills and techniques necessary to care for resident needs including (but not limited to) the following areas .I. Nursing skills consistent with scope of practice.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication was administered according to the professional standards of practice for one of four sampled residents, (Resident 25), when the manufacturer's instructions and directions on the pharmacy label for Budesonide inhalation suspension (a medication to control symptoms of lung disease) were not followed during administration. This deficient practice had the potential for Resident 25 to not receive the full efficacy of the medication and to develop side-effects such as an oral thrush (a yeast infection on the mouth and throat with primary symptoms of white patches on tongue, cheeks, gums or tonsils with bleeding and pain).Findings:A review of Resident 25's admission Record, indicated the resident was admitted on [DATE] with diagnoses to include chronic obstructive pulmonary disease (an inflammatory lung disease that restricts airflow) with exacerbation, unspecified emphysema (lung disease that restricts air flow) and chronic respiratory failure with hypoxia (lack of oxygen). A review of Resident 25's PACS-Medication Administration Record for the month of May 2026 indicated, Budesonide Inhalation Suspension 0.5 milligram (mg)/2 milliliter (ml). 2 ml, Inhale orally in the morning for sob [shortness of breath]/wheezing [high pitched sound when breathing] with start date of 3/15/26 at 9:00 A.M. A review of Resident 25's Budesonide inhalation's pharmacy label included the following instructions, Shake gently.Rinse mouth after each use. On 5/23/26 at 8:50 A.M, a concurrent observation and interview was conducted with licensed staff (LN) 20 while inside Resident 25's room. Resident 25 was observed sitting up in bed, alert and talking to LN 20. LN 20 was observed to be grabbing and squirting Budesonide inhalation suspension into the nebulizer (device that turns liquid medication into a fine mist). LN 20 then started administering the medication without shaking the medication inside the nebulizer. LN 20 stated it would take about eight to ten minutes for the nebulization (inhaling the fine medication mist). LN 20 stated all he had to do after administering the medication was check Resident 20's lung sounds. On 5/23/26 at 9:36 A.M, another interview was conducted with LN 20. LN 20 stated Resident 25 completed the Budesonide inhalation administration. LN 20 stated Resident 25 did not rinse his mouth after the Budesonide administration. LN 20 stated he had no knowledge of the need for the resident to rinse mouth and spit out the water. LN 20 stated he did not check the administration instructions label affixed to the Budesonide packaging. LN 20 stated not following the instructions for rinsing and spitting could increase the possibility of Resident 25 developing oral thrush. On 5/23/26 at 4:10 P.M., an interview was conducted with LN 27. LN 27 stated she was currently taking care of Resident 25 and had previously administered Resident 25's Budesonide inhalation. LN 27 stated she did not know Resident 25 needed to rinse his mouth and spit after Budesonide administration. LN 27 pulled out Resident 25's Budesonide medication from the medication cart and viewed the packaging label and instructions. LN 27 stated she had not read the instructions prior to administering the medication to the resident. LN 27 stated the instructions on the medication label included shaking the medication gently prior to administering and rinsing the mouth with water and spitting after the administration of Budesonide. LN 27 stated she did not know the purpose of swishing and spitting was to lessen the risk of side effects like oral thrush. On 5/23/26 at 3:54 P.M., an interview was conducted with the director of staff development (DSD). The DSD stated licensed nurses should read all administration instructions prior to administering each medication. The DSD stated inhalation medications, especially ones containing steroids (medication for inflammation) like Budesonide should be followed by rinsing the mouth with water and spitting it out. The DSD stated all LNs administering the medication should be aware of this. The DSD stated Resident 25 could develop an oral thrush, which would be uncomfortable for the resident. A review of the Budesonide Patient Information Leaflet provided by the facility, last revised February 2026, indicated, BUDESONIDE 0.25 MG/2ML [NAME].BUDESONIDE SUSPENSION FOR (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NEBULIZER-INHALATION.COMMON BRAND NAME(S): Pulmicort.USES: Budesonide is used to control and prevent symptoms (wheezing and shortness of breath).HOW TO USE: .Shake the container gently before use.To prevent dry mouth, hoarseness, and oral yeast infections, gargle, rinse your mouth with water and spit out after each use.SIDE EFFECTS:.Tell your doctor right away if you have any serious sideeffects [sic], including: white patches in your mouth or on yourtongue [sic].A review of the facility's policy titled, Administering Medications through a Small Volume (Handheld) Nebulizer dated 2001, indicated, .Purpose.The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway.General Guidelines.1. Follow the medication administration guidelines. The policy did not provide guidance specific to medications like Budesonide.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interviews and document review, the facility failed to ensure that their Facility Assessment included and addressed the nurse competencies related to administration of medication via intravenous (IV - into a vein) route, including the use of an IV bulb infusion system (a disposable, portable, and non-electric device used to deliver intravenous medication safely over a preset amount of time) . As a result, nurses who were not trained and whose competencies were not assessed on the IV bulb infusion system, were assigned to administer IV medication using the bulb infusion system. This may result in significant medication error and may cause harm to the resident. (cross reference F 726) A review of the facility's Facility Assessment, dated 4/1/26, indicated the facility provides IV medications and the number/average range of residents receiving IV medications was 3-4 residents. The document also indicated competencies to consider included Medication administration - injectable, oral, subcutaneous, topical. Intravenous route of medication administration was not included in the Facility Assessment. On 5/23/26 at 10:10 A.M., during an interview with the Administrator (ADM), the ADM acknowledged that the Facility Assessment should have included IV medication administration, as well as the IV bulb infusion system. A review of the facility's policy and procedure titled Facility Assessment, revised on December 2024, indicated, A facility assessment is conducted annually to determine and update the capacity to meet the needs of and competently care for residents during day-to-day operations (including nights and weekends) and emergencies.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and document review, the facility failed to ensure infection prevention practices were followed by three of five staff members when:Staff did not perform hand hygiene before putting on their personal protective equipment (PPE - wearable gear to protect users from infectious hazards).A licensed nurse (LN) used a breathing treatment unit dose container (singe dose of measured dose of liquid medication) on a resident, after the container landed on the floor.These failures had the potential to spread infection to the residents, staff, and visitors. On 5/23/26 at 8:50 A.M., a medication administration observation was conducted on licensed nurse (LN) 25. LN 25 went in a resident room with a signage indicating Enhanced Barrier Precaution (EBP - an infection control practice to prevent the spread of multi-drug-resistant organisms and requires healthcare staff to wear gloves and gowns during high-contact activities) to check a resident's vital signs. LN 25 put on his gloves and gown without performing hand hygiene. LN 25 exited the resident's room and proceeded to prepare the resident's medication. One of the medication LN 25 prepared was a breathing treatment unit dose container. As LN 25 removed the unit dose container from the box, LN 25 dropped the unit dose container on the floor, picked it up and placed the container on top of the medication cart. LN 25 used the hand sanitizer to clean his hands and then grabbed the unit dose container and used it on the resident. On 5/23/26 at 9:05 A.M., during an interview with LN 25, LN 25 stated he should not have used the unit dose container when it dropped on the floor. LN 25 stated the unit dose that dropped on the floor was dirty and should not have been used to prevent spread of infection. LN 25 also added that he should have performed hand hygiene before putting on his gown and gloves to ensure that his hands were clean. On 5/23/26 at 9:25 A.M., two certified nursing assistants were observed assisting a resident back to bed. The resident was on EBP. Both CNAs did not performed hand hygiene before putting on their gloves and gowns. On 5/23/26 at 9:30 A.M., LN 26 stated that staff should perform hand hygiene prior to putting on their personal protective equipment (PPE) to ensure their hands are clean and help avoid the spread of infection. A review of the facility's policy and procedure titled Infection Prevention and Control Program, revised on April 2025, indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. A review of the facility's policy and procedure titled Handwashing/Hand Hygiene, revised on December 2025, indicated, Hand hygiene is the primary means for preventing healthcare associated infections (HAIs) and the transmission of multidrug-resistant organisms (MDROs). 1. Perform hand hygiene before applying non-sterile gloves.