STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555804	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Post Acute Care	654 S. Anza 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to ensure food served to residents was plated with an appetizing presentation.This failure had the potential to lead to a negative dining experience, resulting in reduced appetite, weight loss and feelings of disappointment.Findings:On 1/26/26 at 8:29 A.M., an interview was conducted with Resident 100 in her room. Resident 100 stated the food could have a better presentation, sometimes the look on the plates don't look good, could be nicer.On 1/26/26 at 8:45 A.M., an interview was conducted with Resident 21 in her room. Resident 21 stated the food sometimes would be cold and presentation could be better. A review of the facility's menu dated 1/28/26 indicated the regular diet meal for lunch was, Fish Italiano, Creamy Risotto style Rice, Broccoli with Garlic, Cucumber Onion Salad and Cherry Tart, alternative for the fish was chicken with gravy. The Pureed Diet was served as a pureed version of regular diet.On 1/28/26 at 11:15 A.M., a concurrent observation and interview was conducted with Dietary Manager (DM) and Consultant Dietary Manager (CDM) of the tray line. The food was plated in a hapzardly fashion. Several plates lack intentional design and appeared unbalanced and messy, with sauce spilling off the edges of the plates. The CDM stated plating should have been more presentable in appearance.On 1/29/26 at 10:33 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated plating of the resident food should have been presentable and made with care for the residents. The DON stated this could have caused residents to not to want to eat. The DON stated residents look forward to the food and the food should always be presentable and appealing to the residents.A review of the facility's policy titled, Food Preparation, dated 2023, indicated Policy: Food shall be prepared by methods that conserve nutritive value, flavor, and appearance.

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the interdisciplinary team (IDT - a group of healthcare professionals collaborating residents nursing home care, services, and plan) completed documentation in the medical record to indicate it was clinically appropriate for the resident to self-administer medications for one of 10 sampled medication pass observation residents (Resident 89).This failure had the potential for the resident to experience preventable medication errors, preventable infections from accidental cross-contamination of microbes (germs), and inappropriate self-administration of drugs.Findings:During a review of Resident 89's medical record, the History and Physical (H&P - comprehensive resident assessment) note dated 1/8/26, the H&P indicated the resident was admitted to the facility on [DATE], following a fall that resulted in a fracture (partial or complete broken bone). The H&P indicated a fall occurred when the resident caught their toe on the carpeting, causing the resident to hit their face on a door jamb. The H&P indicated the resident lived alone and had to maneuver (position) themself to reach a phone to call for help.During a review of Resident 89's medical record, the physician's orders dated 1/7/26, indicated medication orders for three (3) ophthalmic solutions (eye drops) for glaucoma (eye condition that can lead to permanent vision loss or blindness): brimonidine (drug to lower pressure inside the eye) scheduled twice a day, dorzolamide hydrocholoride - timolol (brand name Cosopt - combination of two drugs to lower eye pressure) scheduled twice a day, and latanoprost (drug to treat high eye pressure) scheduled for bedtime.During a medication pass observation on 1/27/26 at 8:25 A.M., inside Resident 89's room, Licensed Nurse 4 (LN 4) was observed administering medications. No eye drops were observed administered to Resident 89 at this time.During an interview on 1/27/26 at 8:43 A.M., with LN 4, LN 4 stated no more morning medications were due for Patient 89.During a concurrent interview and record review on 1/27/26 at 10:44 A.M., with LN 4, Patient 89's medical record was reviewed with LN 4. LN 4 stated they did not administer the eye drops to Resident 89. Instead, Resident 89 self-administered their eye drops scheduled for the morning.During an interview on 1/27/26 at 10:55 A.M., with Patient 89, Patient 89 stated they self-administered their eye drops.During an interview on 1/28/26 at 3:20 P.M., with the Director of Nursing (DON), the DON stated there was no IDT documentation or physician orders in the medical record regarding Resident 89's self-administration of their eye drops.During a telephone interview on 1/29/26 at 9:17 A.M , with Resident 89's daughter (RD), the RD stated Resident 89's eye drop medications were kept at the bedside during the resident's stay at the facility.During an interview on 1/29/26 at 2:56 P.M., with the DON, the DON stated the importance of IDT is to evaluate if the resident can self-administer medications is to assess for the appropriateness for the residents.During a review of the facility's policy and procedure (P&P) titled, Self Administration of Medications, dated 5/25, the P&P indicated, PROCEDURES.1. If a resident desire to participate in self-administration, an order will be obtained by the nurse from the Attending physician 2. If the resident is a candidate for self-administration, this will be indicated in the chart.5. Appropriate notation [documentation] of these determinations will be placed in the resident's care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of eight residents (79 and 138), who were unable to carry out activities of daily living (ADL-self-care activities such as grooming, bathing, and toileting), received assistance with nail care (cleaning, trimming and/or filing of nails). This deficient practice had the potential for Resident 79 and Resident 138 for injury and infection.Findings: Resident 79 was admitted to the facility on [DATE] with diagnoses including fracture of the right pubis (front, lower portion of the hip bone) and need for assistance with personal care according to the facility's admission Record.During an observation and interview on 1/26/26 at 8:13 A.M., Resident 79 was in bed with a breakfast tray on the overbed table. Resident 79 was observed with long fingernails with black debris under the nails. Resident stated she needed assistance with trimming her nails.During a review of Resident 79's Minimum Data Set (MDS- a clinical assessment tool) dated 1/8/26, the MDS section GG0130I indicated Resident 79 required moderate assistance with personal hygiene.An interview and concurrent observation was conducted with the Director of Staff Development (DSD- a licensed nurse certified for staff training) on 1/28/26 at 8:11 A.M. The DSD stated nail care for residents were completed on Sundays. During a concurrent observation in Resident 79's room, Resident 79 showed the DSD her fingernails and told the DSD that she (Resident 79) needed assistance with cutting her long fingernails. The DSD then went to the nursing station to check Resident 79's admission date. The DSD stated Resident 79 was admitted on [DATE] and nail care should have been provided.During an interview on 1/28/26 at 8:50 A.M. with Certified Nurse Assistant (CNA) 23, CNA 23 stated nail care for residents were completed on Sundays and as needed to prevent scratching self and for infection control.Resident 138 was re-admitted to the facility on [DATE] with diagnoses including dementia (an impairment of brain function, such as memory loss and judgment) and need for assistance with personal care.During a review of Resident 138's Activities of Daily Living (ADL- bathing or showering, dressing, getting in and out of bed or a chair, walking, toileting and eating)) care plan dated 1/16/26, the care plan indicated Resident 138 was dependent with personal hygiene. During observations on 1/27/26 at 8:25 A.M. and on 1/28/26 at 8:05 A.M., Resident 138 was in bed and observed with long fingernails. During an interview on 1/28/26 at 8:05 A.M. with Resident 138, Resident 138 stated she would like her fingernails trimmed. An interview was conducted with the DSD on 1/28/26 at 8:11 A.M. The DSD stated nail care for residents were completed on Sundays. During a joint observation on 1/28/26 at 8:23 A.M. with the DSD, Resident 138 was in bed. The DSD looked at Resident 138's fingernails and stated Resident 138's fingernails were long and should have been trimmed for infection control. An interview was conducted with the Director of Nursing (DON) on 1/29/26 at 10:45 A.M. The DON stated she expected staff to trim and clean residents' fingernails every shower day if needed. The DON stated it was important to trim and clean residents' fingernails to prevent illness from dirty fingernails and prevent injury from scratching. A review of the facility's policy and procedure (P&P) titled, Activities of Daily Living, Care and Hygiene, dated 2/2025 was conducted. The P&P indicated, It is the policy of this facility to promote cleanliness, sanitation, hygiene and assist in necessary Activities of Daily Living as appropriate and necessary to promote well-being and independence.Personal hygiene, personal habits, and ADL will include but not limited to.Nail Care, Grooming and Dressing.

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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. Based on observation, interview, and record review, the facility failed to ensure safe and effective pharmaceutical services when:1. In one of two medication rooms refrigerators (North Medication Room), one opened and undated multiple-dose Aplisol (tuberculin purified protein derivative - aid to diagnose the tuberculosis infection) vial was observed stored in the medication refrigerator and available for use.This failure had the potential for the resident(s) to be exposed to ineffective Aplisol due to possible oxidation (chemical process) and degradation (reduced quality) which may affect potency (effectiveness) if the opened and undated vials were not discarded according to the drug manufacturer's instructions. 2. In one of one medication carts (Southwest Medication Cart), one discontinued medication for Resident 76 was not removed from the medication cart and available for use.This failure had the potential to expose the resident to medication errors.Findings:1. During a concurrent observation and interview on 1/26/26, at 7:59 A.M., an inspection of a medication room was conducted with the Assistant Director of Nursing (ADON). Inside the North Medication Room refrigerator, one opened and undated multiple-dose Aplisol vial was observed stored in the refrigerator. The ADON acknowledged the opened and undated Aplisol vial was stored in the North Medication Room refrigerator.During an interview on 1/29/26 at 9:40 A.M., with the Director of Nursing (DON), the DON acknowledged an Aplisol vial was stored opened and undated in the North Medication Room on the morning of 1/26/26. The DON stated when the Aplisol vial is opened, the staff should label the vial.During an interview on 1/29/26 at 1:14 P.M., with Licensed Nurse 5 (LN 5), LN 5 stated when the Aplisol vial is opened and the vial cap is discarded, the vial is dated for thirty (30 days).During a review of the Aplisol package insert (PI - document on how to safely use medications) dated 5/24, provided by the facility, the PI indicated, Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency.During a review of the facility's policy and procedure (P&P) titled, Medication Labels, dated 5/25, the P&P indicated, POLICY: It is the policy of this facility that medications are labeled in accordance with facility requirements and state and federal laws. 2. During a review of Resident 76's medical record, a physician's order dated 11/28/25 at 11:21 A.M., indicated a discontinue medication order for Advair Diskus (combination of two medications) inhaler.During a concurrent observation and interview on 1/26/26, at 10:12 A.M., an inspection of a medication cart was conducted with Licensed Nurse 1 (LN 1). When the Southwest Medication Cart was opened, an Advair Diskus inhaler for Resident 76 was stored inside the medication cart (approximately 59 days after the discontinue date of 11/28/25). Resident 76's Advair medication carton and inhaler mouthpiece were both labeled with an opened date of 11/1/25. LN 1 acknowledged Resident 76's Advair Diskus medication carton and mouthpiece inhaler were dated with an opened date of 11/1/25.During an interview on 1/29/26 at 9:40 A.M., with the DON, the DON stated the facility did not have a policy for discontinued medications but stated the staff should have pulled the medication when the medication order was discontinued.During an interview on 1/29/26 at 1:32 P.M., with Licensed Nurse 7 (LN 7), LN 7 stated the staff should confirm the discontinue order for medications before disposing it.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure safe and effective medication labeling when: 1. Two of two opened inhaler mouthpieces were not dated in accordance with the drug manufacturer's specifications (requirements).This failure had the potential to expose the residents to ineffective medications. 2. Three of three opened inhaler mouthpieces were not properly labeled with sufficient information to clearly identify the specific resident.This failure had to potential to cause medication errors and preventable infections from cross-contamination from other residents if accidently mixed up with other residents' similar or same drugs.1. During a review of the Advair Diskus (combination of two medications) inhaler package insert (PI - document on how to safely and effectively use medications) dated 2023, provided by the facility, the PI indicated, ADVAIR DISKUS should be stored inside the unopened moisture-protective foil pouch and only removed from the pouch immediately before initial use. Discard ADVAIR DISKUS 1 [one] month after opening the foil pouch or when the [inhaler] counter reads 0 (after all the blisters [doses] have been used), whichever comes first.During a review of the Trelegy Ellipta (combination of three medications) inhaler patient information guide dated 12/22, the patient information guide indicated Safely throw away TRELEGY ELLIPTA in the trash 6 weeks after you open the tray or when the counter reads 0, whichever comes first. Write the date you open the tray on the inhaler.During a concurrent observation and interview on 1/26/26, at 10:12 A.M., an inspection of a medication cart was conducted with Licensed Nurse 1 (LN 1). Inside the Southwest Medication Cart, an opened and undated Advair Diskus inhaler mouthpiece for Resident 109 and opened and undated Trelegy Ellipta inhaler tray for Resident 29 were observed stored in the medication cart. LN 1 stated the two inhaler devices for Resident 109 and Resident 29 were opened and undated.During an interview on 1/29/26 at 2:46 P.M., with the Director of Nursing (DON), the DON stated the expectation was for staff to label the inhaler devices with the open date so they know when to discard the medications.During a review of the facility's policy and procedure (P&P) titled, Medication Labels, dated 5/25, the P&P indicated, POLICY: It is the policy of this facility that medications are labeled in accordance with facility requirements and state and federal laws. 2. During a concurrent observation and interview on 1/26/26, at 10:12 A.M., an inspection of a medication cart was conducted with LN 1. Inside the Southwest Medication Cart, an opened and unlabeled Advair Diskus inhaler mouthpiece for Resident 76, an opened and unlabeled Advair Diskus inhaler mouthpiece for Resident 109, and an opened and unlabeled Trelegy Ellipta inhaler tray for Resident 29 were observed stored in the medication cart. LN 1 stated the three inhaler medication cartons were labeled with the residents' information but the three inhaler devices for Resident 29, Resident 76, and Resident 109 were opened and not labeled with resident-specific information. LN 1 stated the potential outcome of the unlabeled inhaler devices could get confused.During an interview on 1/29/26 at 1:25 P.M., with LN 6, LN 6 stated both the inhaler box and the inhaler mouthpiece had to be labeled with resident-specific information due to the potential for the medication errors and the risk of infection if the drugs get mixed up.During an interview on 1/29/26 at 1:43 P.M., with LN 22, LN 22 stated to label both the inhaler box and inhaler device with resident-specific information. LN 22 stated the staff labels the inhaler mouthpiece device if the dispensing pharmacy forgets.During an interview on 1/29/26 at 2:46 P.M., with the DON, the DON stated the importance of labeling the inhaler devices with resident-specific information was due to infection control risk and potential for medication errors.During a review of the facility's P&P titled, Medication Labels, dated 5/25, the P&P indicated, POLICY: It is the policy of this facility that medications are labeled in accordance with facility requirements and state and federal laws.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow appropriate infection prevention and control practices when expired food was left in a dedicated refrigerator for the residents.This failure had the potential to result in foodborne illness to an already vulnerable population.Findings:On 1/26/26 at 10:15 A.M., a concurrent observation and interview was conducted with Licensed Nurse (LN) 11 in the staff lounge. LN 11 observed the residents refrigerator. LN 11 stated a food item dated 1/17/26 should have been discarded. LN 11 stated food items with no names and date should have been discarded. LN 11 stated there should not be any expired foods in the residents refrigerator. LN 11 stated eating expired foods could cause food borne illnesses or create stomach upset like nausea and/or vomiting. LN stated the food items should have been discarded after 48 hours of being stored in the refrigerator.1/29/26 at 10:33 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated her expectations were for all Staff to follow the Food Brought by Family or Visitor policy. The DON stated the residents eating expired foods could have caused resident to have GI upset, and/or foodborne illness. A review of facility's policy titled, Food Brought by Family or Visitor, revised 7/21/21, indicated .4. All foods shall be labeled with the resident name, location and date.discarded after 72 hours of storage.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure to a complete medication order for one of 10 sampled medication pass observation residents (Resident 115).This failure had the potential for the resident to experience preventable medication errors and adverse clinical outcomes.Findings:During a review of Resident 115's medical record, the History and Physical (H&P - comprehensive resident assessment) note dated 12/3/25, the H&P indicated the resident was admitted to the facility on [DATE] with a medical history of alcohol abuse (risk factor for thiamine deficiency, also known as Vitamin B1 deficiency, a medical condition where the body doesn't have enough thiamine/Vitamin B1 to function properly).During a review of Resident 115's medical record, a physician's order dated 12/01/25 at 8:58 P.M., indicated a medication order for Vitamin B1 Oral Tablet (Thiamine HCl [hydrochloride salt form]) Give 1 [one] tablet by mouth one time a day. During a medication pass observation on 1/27/26 at 7:51 A.M., inside Resident 115's room, Licensed Nurse 2 (LN 2) was observed administering thiamine (Vitamin B1) to Patient 115.During an interview on 1/28/26 at 3:39 P.M., with LN 3, LN 3 stated if a medication order for thiamine is received, the dose of the medication is needed to make sure the correct dose is given and the physician order is followed.During a concurrent interview and record review on 1/29/26 at 8:13 A.M., with LN 2, Resident 115's medical record was reviewed with LN 2. LN 2 stated for Resident 115 on 1/27/26 around 8 A.M., there was no dose in the medication order for thiamine. LN 2 stated there was no milligrams [mg - unit of measurement for dose].During an interview on 1/29/26 at 2:46 P.M., with the Director of Nursing (DON), the DON stated the importance of a complete medication order was to prevent overdosing or underdosing residents.During a review of the facility's policy and procedure (P&P) titled, Physician Orders - Administration of Medications/Treatments, dated 5/25, the P&P indicated, PROCEDURES.5. Orders must include.D. Dosage.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control standards of practice for two of eight residents reviewed for infection control when: 1.Resident 104's nebulizer (a treatment with liquid medication delivered as a fine mist inhaled into the lungs through a mouthpiece or mask) mask was placed on top of the bedside table uncovered, 2. Resident 137's nasal mask for continuous positive airway pressure (CPAP- a machine that delivers mild air pressure through the nose to keep breathing airways open while asleep) was on the floor. This deficient practice had the potential to expose residents to bacteria which could lead to infections. Findings: Resident 104 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD) according to the facility's admission Record.During an observation and interview on 1/26/26 at 8:38 A.M. with Resident 104, Resident 104 was in bed with breakfast tray on the overbed table. Resident 104 stated he received breathing treatments sometimes. A nebulizer machine was observed on the bedside table with tubing and mask connected to the machine. The mask was next to the machine, on top of the bedside table uncovered.A review of the physician's orders in the electronic health record (EHR) for Resident 104 was conducted. The physician's orders indicated, Ipratropium-Albuterol Solution [medication to open air passages in the lungs].3 ml [milliliter] inhale orally every 6 hours as needed for SOB [shortness of breath] or Wheezing via nebulizer.ordered 1/15/26.An interview and joint observation on 1/27/26 at 3:04 P.M. was conducted with licensed nurse (LN) 21. LN 21 checked Resident 104's nebulizer machine with tubing and mask connected. LN 21 stated the tubing, and mask should be changed weekly and as needed. LN 21 further stated the tubing, and mask should be stored in a plastic bag to prevent contamination. 1.Resident 137 was admitted to the facility on [DATE] with diagnoses including obstructive sleep apnea (OSA- a problem in which breathing pauses during sleep due to blocked airways) according to the facility's admission Record.During an interview and observation on 1/26/26 at 8:54 A.M., Resident 137 was sitting up in bed drinking coffee. Resident stated the machine on her bedside table was a CPAP machine. A tubing and nasal mask was observed connected to the CPAP machine. The tubing was hanging down with the nasal mask on the floor. Resident 137 stated she used the CPAP machine for sleep apnea and applied the nasal mask herself.A review of the physician's orders in the EHR for Resident 137 was conducted. The physician's orders indicated, CPAP.Apply at Bed Time [sic] and Remove in AM [morning].for OSA.An interview and joint observation on 1/27/26 at 3:07 P.M. was conducted with LN 21. Upon entering Resident 137's room, a visitor was observed sitting at Resident 137's bedside. Resident 137's CPAP nasal mask was on the floor and was picked up by the visitor. LN 21 stated the CPAP's nasal mask should be stored in a plastic bag. LN 21 stated it was important to store the nasal mask properly to prevent contamination and prevent bacteria from entering the resident's mouth.An interview on 1/29/26 at 10:45 A.M. was conducted with the Director of Nursing (DON). The DON stated respiratory equipment such as oxygen tubing, mask and CPAP mask should be stored in a plastic bag when not in use for infection control.During a review of the facility's policy and procedure (P&P) titled, CPAP/BIPAP Monitoring / Management / Storage, dated 2/2025, the P&P indicated, Store tubing and mask appropriately when not in use.A review of the facility's P&P titled, Infection Prevention and Control Program, dated February 2025 was conducted. The P&P indicated, Goals.Decrease the risk of infection to residents and personnel.Recognize infection control practices while providing care.The facility personnel will conduct themselves and provide care in a way that minimizes the spread of infection.