STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055508	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jacob Healthcare Center	4075 54th St. San Diego, CA 92105

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 interview and record review, the facility failed to follow their policy regarding receipt and storage of controlled medications (drugs regulated by the government for its use, possession, and manufacture). This failure resulted in a medication card containing 60 tablets of Morphine (a controlled medication used for pain) to be missing and unaccounted for. Findings: On 11/1/24, the facility reported to the Department On 10/30/24, Staff reported to the DON that a medication Morphine Sulfate 15 milligrams 60 tablet card was nowhere to be found . On 11/13/24 at 8:45 AM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated the missing medication was for Resident 1. The ADON stated the medication was noted to be missing on 10/30/24 when the facility attempted to reorder it. The ADON stated the pharmacy informed them it was already delivered on 10/20/24. The ADON stated the Facility Delivery Log was retrieved which indicated the medication was delivered on 10/20/24, and was signed in by a Licensed Nurse (LN 1). The ADON stated upon receipt of controlled medications, the licensed nurse was supposed to sign the delivery record and put the medication card and accompanying count sheet in the locked controlled medication drawer. The controlled medications were then supposed to be counted and reconciled at each shift change. The ADON stated controlled medications and associated count sheets were reconciled every shift, but since there was no sheet for the missing Morphine, reconcilation can not be verified. On 11/13/24 at 9:35 A.M., a concurrent review of the Facility Delivery Log was conducted with LN 1. LN 1 stated Resident 1 ' s Morphine was running low and he had messaged pharmacy to refill the order. LN 1 stated it was later determined it was already delivered on 10/20/24. LN 1 stated when medications were delivered, he was supposed to verify delivered medications against the list and sign the delivery sheet. LN 1 stated if controlled medications were delivered, he was supposed to put them in the locked controlled medication box with the controlled sheet that came with it. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LN 1 acknowledged his signature on the Facility Delivery Log dated 10/20/24. The first line of the Log indicated, 10/20/24 .Morphine Sulf ER 15 milligram Tablet .Quantity 60 .LN 1 stated he did not remember any details about the delivery. LN 1 stated he did not know why it was missing and did not remember checking that medication in. On 11/13/24 License Nurse 2 (LN 2) was interviewed. LN 2 stated Resident 1 ' s Morphine was running low and the facility was attempting to re order it. LN 2 stated pharmacy indicated it was delivered on 10/20/24 but LN 2 stated she never saw a new medication card or sheet for Resident 1. LN 2 stated when accepting a medication delivery, the licensed nurse was supposed to sign and verifiy each medication on the list. LN 2 stated if there was a discrepancy they were supposed to document on the sheet and notify the Director of Nursing (DON) and pharmacy. LN 2 stated that on occasion the drug shipment sheet did not match what was delivered. LN 2 stated controlled medications and associated count sheets were reconciled every shift. LN 2 stated since there was no count sheet for Resident 1 ' s missing Morphine, it was not noted to be missing. On 11/14/24 at 9 A.M., the Director of nursing (DON) was interviewed. The DON stated she was notified on 10/30/24 that a Morphine 60 tablet card supposedly delivered on 10/20/24 for Resident 1 could not be located. The DON stated Resident 1 still had Morphine in stock so it was not noted the new medication card was missing until 10/30/24 when staff attempted to re order it. The DON stated the facility was searched and the mediation was not found. The DON stated this was reported to pharmacy and law enforcement. Per facility policy, Controlled Substances, dated April 2019, .Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift .Policies and procedures for monitoring controlled medications to prevent loss, diversion or accidental exposure are periodically reviewed and updated . Per facility policy, Accepting Delivery of Medications, dated February 2021, .Before signing to accept the delivery, the nurse must reconcile the medications in the package with the delivery ticket/order receipt. If an error is identified when receiving medication from the pharmacy, the nurse verifying the order shall inform the delivery agent of any discrepancies and note them on the delivery ticket . The dispensing pharmacy, consultant, pharmacist, and director of nursing services should be notified of medication order errors .