STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055121	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Ridge Post Acute	466 Flagship Road Newport Beach, CA 92663

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348 Based on interview, medical record review, and facility P&P review, the facility failed to protect the resident's rights to be free from the physical abuse when Resident 2 pushed a table hitting Resident 1 in the head resulting in a small movable mass with minimal redness and flaky skin located on the top right side of Resident 1's head. * The facility failed to ensure the concern was addressed when Resident 2 verbalized he was unhappy with his roommate on 3/19/25. Additionally, the facility failed to ensure Residents 1 and 2 were separated when the nurse noticed both residents were using verbal aggression towards each other and Resident 2 stated I will hurt you on 3/23/25. This failure had the potential to negatively impact the residents' well-being. Findings: Review of the facility's P&P titled Prevention, Reporting, and Correction of Inappropriate Conduct Including Abuse, Neglect, and Mistreatment of Residents and Investigations of Injuries of Unknown Origin revised 10/2021, showed while the investigation is being conducted, all efforts will be made to ensure that the resident is free from harm. The resident will be immediately separated from the suspected abuser. If the abused is not employed at the facility, he/she will be denied unsupervised access to the resident. The CDPH, L&C Program received an SOC 341 from the facility on 3/24/25. The SOC 341 showed on 3/23/25 at 1500 hours, Residents 1 and 2 had a disagreement in the room regarding a loud television. The disagreement immediately escalated, Resident 1 threw a water bottle at Resident 2, and Resident 2 pushed the over-bed table at Resident 1. Closed medical record review for Resident 2 was initiated on 4/8/25. Resident 2 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 2's H&P examination dated 2/22/25, showed resident had the capacity to understand and make decisions. Review of Resident 2's MDS assessment dated [DATE], showed Resident 1 was cognitively intact with a BIMS score of 15. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further Review of Resident 2's MDS dated [DATE], showed the Section GG for Functional Limitation in Range of Motion for the upper and lower extremities was coded as 0 (no impairment). Review of Resident 2's Progress Notes dated 3/19/25 at 1000 hours, under the section for Education/Notification, the comfort concerns note showed the resident was unhappy with the roommate. Review of the facility's Census dated 3/19/25, showed Residents 1 and 2 were in the same room. Review of Resident 2's Progress Notes dated on 3/23/25, showed at 1500 hours while doing rounds the nurse noticed both the residents were using verbal aggression towards each other. The note further showed Resident 2 stated I will hurt you. Review of Resident 1's eINTERACT Change in Condition Evaluation V 5.1 form dated 3/23/25 at 1519 hours, showed the charge nurse was made aware of the resident'sverbal/physical altercation with the roommate. Resident 1stated his roommate on the left side of him allegedly pushed a bedside table into the residents' head. The document showed the charge nurse assessed the resident, and a slight redness and bump were noted on the resident's right side of the head. Further review of the document showed under the section for Skin Status Evaluation showed Resident 1 had a small movable mass with minimal redness and flaky skin located on the top right side of the head. Review of Resident 1's Order Recap Report for March 2025, showed a physician's order dated 3/23/25, to apply the ice pack to the right side of the head bump for 10 minutes every four hours as needed for three days. Review of Resident 1's acute care hospital Admission H&P examination dated 3/29/25, showed Resident 1 reported three days ago, he got involved in an altercation when he was struck in the head. The note further showed Resident 1 complained of headache ever since. Further review of Resident 2's medical record failed to show the concern about Resident 2 being unhappy with his roommate was addressed. Review of Resident 1's medical record review was initiated on 4/8/25. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's Plan of Care dated 8/9/23, showed a care plan problem to addressing Resident 1 had ADL self-care performance deficits related to the resident's impaired balance, limited mobility, and musculoskeletal impairment. Further review of Resident 1's Plan of Care dated 9/8/24, showed a care plan problem addressing Resident 1 had limited physical mobility related to disease process and weakness. Review of Resident 1's H&P examination dated 9/16/24, showed the resident had capacity to make medical decisions. Review of Resident 1's MDS assessmentdated 3/13/25, showed Resident 1 was cognitively intact with a BIMS score of 15, indicating cognitively intact. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/25 at 1233 hours, an interview was conducted with Resident 1. Resident 1 stated on 3/23/23, Resident 2 was unhappy and got upset when he was playing music. Resident 1 stated Resident 2 poured coffee all over his backpack that was on the floor which contained his laptop. Resident 1 stated as he leaned over to pick his wet backpack off the floor, Resident 2 grabbed the table, threw the table, and hit him on the head. Resident 1 stated after he was struck in the head with the table, he felt pain, felt his head swell up and could not think straight after. Resident 1 stated, it had been building up, and Resident 2 had stated why don't you just go die. Resident 1 stated he requested the room change over the past week and had informed the charge nurse and CNAs 1 and 2. Resident 1 stated the facility was aware they were having problems but did not change their rooms. Resident 1 stated he was bedridden and unable to get out of bed. Resident 1 stated a staff member was in the room and witnessed the incident. When asked if the resident felt safe in the facility, Resident 1 stated, generally, but then I didn't. On 4/8/25 at 1254 hours, an interview with Resident A was conducted. Resident A verifiedhe was in the room on 3/23/25, when the incidentoccurred between Residents 1 and 2. Resident A stated he did not see the incident occur since his curtain was closed; however, he stated he heard the altercation occurred. Resident A stated there was a bunch of commotion; Resident 2 was yelling at Resident 1 who stated what did I do? Resident A further stated he heard the table hit Resident 1. On 4/8/25 at 1334 hours, an interview was conducted with CNA 2. CNA 2 stated prior to the abuse allegation, she had observed Residents 1 and 2 arguing when Resident 2 was transferred into the room. CNA 2 stated Resident 1 was normally quiet, kept to himself, and wanted privacy. CNA 2 stated she had heard Resident 2 yell and scream, and the resident had a very hard temper. CNA 2 stated Resident 2 would get mad and upset when he did not get what he wanted. CNA 2 stated she had informed LVNs 1 and 2 about the behavior of Residents 1 and 2. When asked if Resident 1 and 2's room was changed upon reporting to the supervisors, CNA 2 stated no. On 4/8/25 at 1612 hours, a telephone interview was conducted with LVN 1. LVN 1 stated on 3/23/25 at 1500 hours, he observed Resident 1 lying in bed, and Resident 2 was sitting at the edge of the bed facing Resident 1 while they were yelling at each other. He was informed by a CNA that Residents 1 and 2 were going back and forth saying mean things to each other. LVN 1 stated Resident 2 asked to speak to a supervisor, and LVN 1 left the room to notify RN 1. On 4/9/25 at 0929 hours, a telephone interview was conducted with RN 1. When asked regarding the incident between Residents 1 and 2, RN 1 stated she was informed by LVN 1 that Residents 1 and 2 were yelling each other in which she could also hear from the hallway. RN 1 stated when she entered the room was already cluttered, with a lot of things on the floor. RN 1 stated when she walked into the room, she saw Resident 1 threwsomething at Resident 2, and as Resident 1 was reaching for his backpack on the floor, Resident 2 pushed the table towards Resident 1 with force. RN 1 stated Resident 1 began to cry and stated, oh my God,he hurt me. RN 1 stated she told the two residents to stop, removed the table, called for assistance, and Resident 2 was moved to another room within the facility. RN 1 stated when she assessed Resident 1, he had a small bump on his forehead, and an ice pack was provided. On 4/9/25 at 1410 hours, an interview was conducted with LVN 2. When asked about his documentation on 3/19/25, when Resident 2 was unhappy with his roommate, LVN 2 stated Resident 2 wanted a different room and was unhappy with his neighbor. LVN 2 stated he notified the RN Supervisor and social services. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/25 at 1432 hours, a follow up interview was conducted with LVN 1. LVN 1 stated if he had known Resident 2 stated he was unhappy with his roommate on 3/19/25, he would have requested for a room change. When asked what the process was if two residents were verbally aggressive, LVN 1 stated to get them separated, before something like that happens, especially when Resident 2 can stand up on his own. When asked when the two residents were separated, LVN 1 stated after RN 1 came into the room. On 4/11/25 at 1008 hours, an interview and concurrent medical record review was conducted with the SSD. When asked about the nurse's documentation on 3/19/25, when Resident 2 stated he was unhappy with his roommate, the SSD stated she was not informed Resident 2 was unhappy with his roommate. The SSD further stated if she was made aware, she would have moved the residents. On 4/11/25 at 1146 hours, an interview was conducted with the Administrator. The Administrator stated he was not aware Resident 2 stated he was unhappy with his roommate on 3/19/25. On 4/11/25 at 1412 hours, a follow up interview was conducted with RN 1. When asked what it meant if someone said, I will hurt you. RN 1 stated, intention, threat. When asked if she was aware Resident 2 stated I will hurt you, RN 1 stated no. When asked when the argument started as a verbal argument and escalated to physical, when should the two residents have been separated, RN 1 stated from the start of the verbal argument. When asked during the verbal argument if the residents were separated, RN 1 stated not until she separated them. On 4/11/25 at 1607 hours, an interview and concurrent medical record review was conducted with the DON. When asked when Residents 1 and 2 should have been separated, the DON stated once the argument had started. On 4/18/25 at 1639 hours, the Administrator and DON was made aware and acknowledged the above findings.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 49348 Based on interview, facility document review, and facility P&P review, the facility failed to thoroughly investigate the allegation of abuse for Residents1 and 2. * The facility failed to interview Residents 1 and 2's roommate after Residents 1 and 2 had had the verbal and physical altercation in their room. This failure had the potential for the abuse allegation to not be thoroughly investigated. Findings: Review of the facility's P&P titled Prevention, Reporting, and Correction of Inappropriate Conduct Including Abuse, Neglect, and Mistreatment of Residents and Investigations of Injuries of Unknown Origin revised 10/2021 showed every report of inappropriate conduct or an injury of an unknown source will be investigated thoroughly under the coordinated supervision of the Administrator. Based on the evaluation of the facts of the allegation and all related circumstances by the Administrator and/or Compliance Officer, the investigation may include interviewing some or all of the following steps as deemed appropriate based on a case-by-case analysis: - Any individual who reported the alleged inappropriate conduct and/or the injury of unknown source; - any resident who is alleged to have been subject to inappropriate conduct; - any alleged perpetrator(s) of the inappropriate conduct; - all persons who are known to have or claim to have knowledge of alleged inappropriate conduct and/or injury of unknown source; and - other individuals who were in the vicinity at the time the inappropriate conduct and/or injury of unknown source are alleged to have occurred, or individuals who may otherwise have encountered relevant information and who are able to express their observations, as well as employees who cared for the resident during applicable time periods (whether or not these employees are thought to have actual knowledge of the inappropriate conduct and/or injury of unknown source. The CDPH, L&C Program received an SOC 341 from the facility on 3/24/25. The SOC 341 showed on 3/23/25 at 1500 hours, Residents 1 and 2 had a disagreement in the room regarding a loud television. The disagreement immediately escalated, Resident 1 threw a water bottle at Resident 2, and Resident 2 pushed the over-bed table at Resident 1. Review of the facility's investigation file for the alleged abuse allegation between Residents 1 and 2 showed the facility interviewed the facility staff, and Residents 1 and 2. However, the filedid not show other residents were interviewed, including Resident A who was in the room at the time the allegation occurred, and other affected residents within the facility as Resident 2 was ambulatory within the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/25 at 1254 hours, an interview with Resident A was conducted. Resident A verified he was in the room on 3/23/25, when the incident occurred between Residents 1 and 2. Resident A stated he did not see the incident occur since his curtain was closed; however, he stated he heard the altercation occur. Resident A stated there was a bunch of commotion, Resident 2 was yelling at Resident 1, and Resident 1 stated, what did I do? Resident A further stated he heard the table hit Resident 1. On 4/11/25 at 1008 hours, an interview was conducted with the SSD. When asked if the SSD interview Residents 1 and 2's roommate, the SSD stated she did not. The SSD further stated she usually interview only the residents involved. On 4/18/24 at 1145 hours, an interview was conducted with the Administrator. When asked if Residents 1 and 2's roommate was interviewed, the Administrator stated, I don't think we need to interview the roommate. Cross reference to F600.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the systematic approach to ensure the effective monitoring of the acceptable parameters of nutrition status for two sampled residents (Residents3 and 4). * The facility failed to ensure Resident 3 was assessed and monitored by the IDT when Resident 3 had a severe weight loss of 51 lbs. (-23.29%) in the last six months, 14 lbs. (6.39%) in one month from 9/12 - 10/16/24, and 30 lbs. (14%) from 1/3 - 2/16/25. In addition, the facility failed to initiate a COC for Resident 3 when there was a severe weight loss, including notifying the physician, and legal representative. * The facility failed to ensure Resident 4 was assessed and monitored by the IDT when Resident 4 had a severe weight loss of 17 lbs. (12.14%) in one month. In addition, the facility failed to initiate a COC for Resident 4 when there was a severe weight loss, including notifying the physician and legal representative, ensure the resident centered plan of care reflected the goals or interventions regarding the risk for weight loss, and monitor the weekly weights as ordered by the physician. These failures posed the risk of nutritional interventions not being implemented in a timely manner and cause the residents to have further weight loss. Findings: 1. Closed medical record review for Resident 3 was initiated on 4/17/25. Resident 3 was admitted to the facility on [DATE], and transferred to the acute care facility on 4/16/25. Resident 3 had diagnoses including enterocolitis due to clostridium difficile, anemia, and gastro-esophageal reflux disease. Review of Resident 3's Order Summary Report showed the following physician'sorder: - dated 3/7/25, to add snacks at 1400 and 200 hours to supplement meal intake; - dated 3/29/25, for oral nutrition supplement two times a day for supplement; and - dated 3/13/25, to obtain weights for 3 weeks one time a day every seven days for 21 days. Review of Resident 3's Care Plan Report dated 2/17/25, showed a care plan problem addressing the resident is at risk for weight loss, nutrition, hydration, skin integrity complication related to his current health, therapeutic diet and history of c-diff episodes. The interventions included the IDT will assist resident during meals, will encourage the resident to consume adequate and appropriate nutrition as recommended, will monitor the resident for nutrition intake and weights per protocol. Review of Resident 3's Weights and Vitals Summary showed the following resident's weights: - dated 9/12/24, 219 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 10/16/24, 205 lbs., a weight loss of 14 lbs. (6.39%) - dated 1/3/25, 206 lbs. - dated 2/16/25, 173 lbs., a weight loss of-3 lbs. (16.02%) Review of Resident 3's eINTERACT Change in Condition Evaluation V5.1 dated 11/14/24, showed Resident 3 had a 9.1% weight loss in the past month. The provider notification and feedback indicated for an RD consult. However, further review of Resident 3's medical record showed the RD nutritional assessment was not done until 12/3/24. Review of Resident 3's Interdisciplinary Care Conference V5 dated 3/12/25, showed a weight variance of -32 lbs., 24 days after Resident 3 had lost 33 lbs. from 1/3/25 to 2/16/25. Further review of Resident 3's medical record did not show a COC was initiated when Resident 3 had severe weight loss of 14 lbs. from 9/12 -10/16/24, and 33 lbs. from 1/3-2/16/25, including the notification of Resident 3's physician and legal representative. 2. Medical record review for Resident 4 was initiated on 4/17/25. Resident 4 was admitted to the facility on [DATE]. Resident 4 had a diagnosis of dysphagia oropharyngeal phase. Review of Resident 4's Care Plan Report dated 3/18/25, showed a care plan problem to address the resident's risk of weight loss. The interventions included to add multivitamin/minerals (supplement) daily, Prostat (protein supplement beverage) 30 ml daily for 30 days, and weekly weights for three weeks due to a significant weight loss. Review of Resident 4's Weights and Vital Summary showed the following resident's weights: - dated 2/3/25, 140 lbs. - dated 3/6/25, 123 lbs., a weight loss of 17 lbs. (12.14%) - dated 3/14/25, 122 lbs. - dated 4/1/25, 126 lbs. Review of Resident 4's Interdisciplinary Care Conference dated 3/12/25, showed Resident 4 had a weight variance of -17 lbs. (12.1%) weight loss in one month. The interventions included Prostat, multivitamins, and monitor weight for three weeks. Further review of the Weights and Vital Summary did not show Resident 4's weights were monitored after 3/14/24 until 4/1/25 (14 days) later. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/25 at 1320 hours, an interview was conducted with Resident 4. Resident 4 stated he was notified he was losing weight but was not aware how much weight he had lost. Resident 4 stated he used to be 140-150 lbs. In addition, Resident 4 stated there was no discussion on how much weight he hadlost, and what the facility was implementing regarding the weight loss. Resident 4 stated he would like to gain his weight back. On 4/18/25 at 1538 hours, an interview was conducted with RD 1. The RD 1 stated the significant weight loss was greater than 5% in one month, greater than 7.5% in three months, and greater than 10% in six months. RD 1 stated when there was a significant weight change, the process would include to notify the DON, and the LVN would initiate a COC. RD 1 verified she did not notify the physician for Resident 3's severe weight loss of 51 lbs. (23.29%) in the last six months. On 4/18/25 at 1606 hours, an interview was conducted with the DON. The DON verified when there was a significant weight change of five % or more, the staff should initiate a change of condition, which included for monitoring the resident, physician's notification, the legal representative notification, an RD consult, and IDT evaluation should be done. The DON stated once the weight was entered into the medical records, the COC should be done immediately. The DON verified the above findings. On 4/18/25 at 1639 hours, the Administrator and DON was made aware and acknowledged the above findings.