

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055356	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Pacific Grove Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Lighthouse Avenue Pacific Grove, CA 93950	
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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on interview, and record review, the facility failed to develop and implement interventions for fall care plan to prevent accidents for one of three sampled residents (Resident 1). The facility failed to initiate a fall care plan when Resident 1 was admitted with high fall risk and did not develop care plan for fall after subsequent falls at the facility. This failure resulted in Resident 1's fall with right wrist fracture (broken bone). Findings: Review of Resident 1's Admission Record, it indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including multiple fractures of ribs, right side, unspecified injury of head, wedge compression fracture of thoracic vertebra (bone at the midback), paroxysmal atrial fibrillation (an irregular and often very rapid heart rhythm that can lead to blood clots in the heart), and dementia (decline in mental capacity affecting daily function). Review of Resident 1's hospital record titled, Clinical Decision Unit [CDU] Discharge/Transfer Summary, dated 3/17/2023, indicated, Resident 1, who presented with mechanical fall resulting in right sided rib fractures .CDU Impression/Plan: 1. Closed head injury and mechanical fall . 2. Right rib fractures with pneumothorax (air in the lungs) and pulmonary contusion (bruise caused by blow) on the right fourth sixth ribs . Review of Resident 1's Fall Risk Assessment, dated 3/17/2023, indicated a score of 20 (HIGH RISK score of 16-42), it means Resident 1 was high risk of falling. The Fall Risk Assessment indicated Resident 1 had history of falls. Review of Resident 1's admission minimum data set (MDS, assessment tool) dated 3/23/2023, indicated brief interview for mental status (BIMS, cognition [includes memory, problem solving, and thinking skills] level) score was 05 (05 suggests severe impairment). Resident 1 requires extensive assistance (staff provide weight-bearing support) with two-person physical assist for bed mobility, toilet use, dressing and personal hygiene. Resident 1 was not walking yet during the assessment. Further review of the MDS, indicated Resident 1 had a fracture related to a fall prior to entry at the facility. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055356	Facility ID: 055356 If continuation sheet Page 1 of 3

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's physical therapist's note, dated 3/27/2023, indicated Resident 1 was able to take 5-6 steps forward and back from the end of bed, with the used of two wheeled walker, and required minimal one person physical assistance (only 25 % support needed). Another review of Resident 1's physical therapist's note, dated 4/11/2023, indicated Resident 1 walked 300 feet without assistive device. Both notes reviewed, indicated, Precautions: Fall risk, Confusion and HTN (hypertension-high blood pressure). Review of Resident 1's Change in Condition Evaluation, dated 3/27/2023, indicated Resident 1 had a fall in the afternoon and did not sustain an injury. Further review indicated, Patient was noted to be on the floor, sitting on her bottom . There were no fall care plan interventions develop to prevent fall for Resident 1's fall on 3/27/2023. Review of Resident 1's Nurse's note, dated 4/15/2023, indicated, resident found sitting on floor [on 4/14/2023] beside her bed. resident unable to describe what happened. denies any pain. Neuro checks started. all parties notified . There were no fall care plan interventions develop related to the fall on 4/14/2023. Review of Resident 1's Change in Condition Evaluation, dated 4/16/2023, it indicated Resident 1 had another fall in the morning. Further review indicated, resident looks weak, and unsteady, witnessed fall on the floor with right hand support fell on her back, no head injury .rt (right) hand pain. no swollen noted, right hand light red . During a concurrent interview and record review with the nurse supervisor (NS) on 7/7/2023 at 11:30 a.m., NS reviewed Resident 1's discharge summary from the hospital, fall risk assessment and care plans. NS confirmed the following: Resident 1 had a fall at home and sustained right rib fracture prior to admission to the facility, had a fall risk for fall assessment with a score of 20 and had no fall risk care plan in placed upon admission. NS stated Resident 1 should have a fall risk care plan for staff to know the interventions needed to prevent the fall. NS confirmed Resident 1 fell on [DATE] and 4/14/2023 and there was no interdisciplinary team (IDT - a group of health care professionals from diverse fields who work toward a common goal for residents) meeting initiated related to the falls. NS stated IDT meeting was important for the team to discuss the contributing factors of Resident 1's falls, and developed a plan of care to prevent further falls or injuries. NS confirmed Resident 1 fell again on 4/16/2023 and sustained a right broken wrist. During a concurrent interview and record review with the licensed vocational nurse A (LVN A) on 7/7/2023 at 12:04 p.m., LVN A reviewed Resident 1's fall risk assessment and care plans. LVN A confirmed she took care of Resident 1 when Resident 1 was still at the facility. LVN A stated Resident 1 was oriented to self only and walked along the facility without a walker. LVN A confirmed Resident 1 was a fall risk upon admission and there was no fall risk care plan developed upon admission. LVN A stated it was important to develop a risk for fall care plan and an actual fall care plan for each falls to prevent further injuries. During an interview with the minimum data set nurse (MDSN) on 7/7/2023 at 1:30 p.m., MDSN confirmed nurses should have initiated a fall risk care plan upon admission when resident was identified a fall risk. MDSN stated an actual fall care plan should have been developed or updated every time a resident fall in the facility. MDSN confirmed she was also responsible to update the fall care plan once triggered in the MDS Care Area Assessment (CAA). (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's MDS CAA about Falls dated 3/23/2023, indicated, This area was triggered because a resident noted a balance problem when moving from seated to standing position, walking, turning around, moving on and off toilet and surface to surface transfer. Factors to consider on this trigger are: effects of medications, pain, poor safety awareness, medical condition and limitation of movement. At risk for injury and potential decline in ADLs (activities of daily living - activities related to personal care such as bathing or showering, dressing, walking, using the toilet, eating, and getting in and out of chair or bed) self-performance. Will proceed to CP (care plan) to prevent risk and keep res safe. Staff are anticipating and addressing needs to help prevent falls . Review of Resident 1's IDT Note - Fall dated 4/17/2023 at 10:24 a.m., indicated, Resident reported to have witnessed fall on 4/16/2023 .Resident was sent to emergency room for evaluation and treatment of right FA (forearm) swelling per MD (medical doctor), RP (responsible party) notified . Review of Resident 1's Nurse's Note, dated 4/17/2023 at 11:23 a.m., indicated, resident right hand swollen, c/o [complained of] pain prn [pro re nata - as needed] tylenol [brand name for acetaminophen, pain medication] given, ineffective . Further review indicated, the nurse called the doctor and received an order to send out Resident 1 to the acute hospital emergency room (ER) to get an x-ray. Resident was sent out to the acute hospitalER on [DATE] at 11:00 a.m. Review of Resident 1's acute hospital record titled, ED (Emergency Department) Provider Notes, dated 4/17/2023, indicated, Post-procedure Diagnoses: 1. Wrist fracture, right, closed, initial encounter . Review of Resident 1's Nurse's Note, dated 4/17/2023 at 5:26 p.m., indicated, resident arrived at 1715 (5:15 p.m.) via wheelchair .resident had broken right wrist .do not use right arm, it should be non-weight bearing[LI10] [do not put weight or carry heavy objects to broken part of the body] . During a review of the facility's policy and procedure titled, Falls and Fall Risk, Managing, date revised March 2018, indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling .Resident-Centered Approaches to Managing Falls and Fall Risk: 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls; 2. If a systemic evaluations of resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions .; 5. If fall recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant . During a review of the facility's policy and procedure titled, Falls - Clinical Protocol, date revised March 2018, indicated, For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall .Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling .		