

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

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 08/14/2024
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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46552 Based on interview, and record review, the facility failed to ensure interdisciplinary team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals to their residents) quarterly care conference meeting arranged, conducted, and documented for two out of two sampled residents (Resident 1 and 2). This failure had the potential for Resident/resident responsible party (RP: healthcare or financial decision maker for resident) to participate in the development and implement of person-centered plan of care decisions for Resident 1 and 2. Findings: Review of Resident 1's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 1 was admitted on [DATE]. Resident 1's FS also indicated Resident 1 was self-responsible for daily decision making. Review of Resident 1's custom IDT care conference forms indicated there was no documented evidence for quarterly IDT care conference was arranged, conducted, and documented for 6/2023, 12/2023, and 7/2024 for 3 quarters. Review of Resident 2's FS indicated Resident 2 was admitted to facility on 10/11/2023. Resident 2's FS also indicated Resident 2's significant family member was assigned as Resident 2's RP. Review of Resident 2's clinical documentation indicated there was no documented evidence for custom IDT care conference was arranged, conducted, and documented after Resident 2 admitted to facility on 10/11/2023 for 3 quarters in a row. During an interview with facility's director of nursing (DON) on 8/14/2024 at 12:10 p.m., DON confirmed quarterly IDT care plan meeting and documentation was not completed for Resident 1 and 2 on quarterly basis. DON stated facility's social service director (SSD) was responsible to arrange, conduct, and document IDT care conferences every quarter, and as needed all residents. (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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with facility's SSD on 8/14/2024 at 12:43 p.m., SSD confirmed social service department was responsible to arrange, conduct and document for quarterly care conferences for residents. SSD also acknowledged facility was non-complainant with quarterly care conferences and documentation for residents. SSD stated she identified this concern, auditing for all residents and she will submit the audit report to quality assurance and performance improvement program (QAPI: data driven, proactive approach to improving the quality of life, care, and services for residents). SSD also stated social service staff should have arranged quarterly care plan meeting, documented every quarter, and as needed for all residents in the facility. During an interview with DON on 8/14/2024 at 12:55 p.m., DON stated SSD should have arranged quarterly IDT care conference with resident/RP and documented for all residents. Review of the facility's policy and procedure (P&P) titled, Care Planning-Interdisciplinary Team, revised September 2013, the P&P indicated, Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family. The mechanics of how the Interdisciplinary Team meets its responsibilities in the development of the interdisciplinary care plan (e.g., face-to-face, teleconference, written communication, etc.) is at the discretion of the Care Planning Committee. Review of the facility's P&P titled, Social Worker, revised October 2020, the P&P indicated, Involve the resident/family in planning individualized objectives and goals for the resident.		

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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** 46552 Based on an observation, interview and record review, the facility failed to ensure medications were administered as ordered by the medical doctor (MD) for 2 of 2 sampled Residents (Resident 1 and 2). This failure had the potential to adversely affects the health and well- being of Resident 1 and 2. Findings: A Record review of Resident 1's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's FS indicated Resident was admitted with diagnoses included dementia (loss of ability to think, remember, and reason to levels that affect daily life and activities), and anxiety (persistent and excessive worry and fear about active daily living situations). Review of Resident 1's physician's medication orders indicated quetiapine (antipsychotic medication to treat mental illness) 25 mg (mg: milligrams, unit of measurement of mass equal to a thousandth of a gram) 0.5 tablet one time a day, and before lunch for dementia ordered on 6/11/2024. Review of Resident 1's electronic medication administration record (EMAR: a legal document for medication administration record) for July 2024 indicated on 7/2, 7/3, 7/4, 7/7, 7/8, 7/9, 7/13, 7/14, 7/15, 7/18, 7/20, 7/21, 7/22, 7/25, 7/26, 7/27, 7/28, and 7/31, total 19 of 31 doses of quetiapine administration documented as 9 (EMAR chart codes for 9= Other/See Progress Notes) at 11:30 a.m., and on 7/1, 7/9, 7/13, 7/16, 7/17, 7/20, 7/23, and 7/24, total 8 doses documented as 9 for quetiapine administration at 9:00 p.m. During the record review of Resident 2's FS indicated Resident 2 was admitted to facility on 8/7/2024. Review of Resident 2's FS indicated she was admitted with diagnoses included diabetes type 2 (a condition when body unable to regulates and uses sugar as a fuel), hypertension (a condition in which the force of the blood against the blood vessels wall), and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Review of Resident 2's documentation for brief interview for mental status (BIMS) dated 8/12/2024 indicated Resident 2's BIMS score of 15 of 15 (score of 0-7: severe impaired cognition, 8-12: moderately impaired cognition, 13-15: intact cognition). Review of Resident 2's physician medication orders indicated potassium chloride (used to treat hypertension) ER 10 meq (milliequivalent: a unit of measurement used to express the amount of substance in a solution) one time a day, ordered on 8/7/2024. Medication tizapatide (to treat diabetes type 2) 2.5 mg/0.5 ml (milliliter: a unit of volume that measures the capacity of a liquid) inject subcutaneously (insertion of medication just under the skin) one time a day every 7 days ordered on 8/7/2024. Medication rosuvastatin (used to treat to lower cholesterol [fat like substance in the blood]) 10 mg one time a day, ordered on 8/8/2024. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's EMAR for August 2024 indicated medication rosuvastatin 10 mg administered on 8/8, 8/9, 8/10, 8/11, 8/12, and 8/13 at 9:00 p.m., total 6 doses administered to Resident 2. Further review of EMAR documented as 9 for tirzepatide administration on 8/8/2024 at 9:00 a.m., and potassium chloride 20 meq medication administration documented at 9:00 a.m., as 9 on 8/8, 8/9, 8/10, 8/11, 8/12, 8/13, and 8/14, total 7 doses. During an interview with Resident 2 on 8/14/2024 at 11:22 a.m., Resident 2 stated she did not receive cholesterol medication 2 nights in row. Resident 2 also stated did not receive potassium and injection for diabetes since admitted to facility. Resident 2 also stated Resident 2 was told by charge nurse that the medications were not available and waiting for pharmacy to deliver. During on observation of medication cart (storage, secure, reliable and transport of medications to residents) 1 along with license vocational nurse A (LVN A) on 8/14/2024 at 12:15 p.m., for physician ordered medications supply for Resident 2, LVN A confirmed there was no supply of potassium chloride and tirzepatide in medication cart 1 or in medication supply room (drug preparation and storage room). LVN A also confirmed medication rosuvastatin 10 mg, 4 doses were given from supply of 15 tablets received from pharmacy since Resident 2 admitted on [DATE]. During an interview with LVN A on 8/14/2024 at 12:25 p.m., the RN A reviewed EMAR for Resident 2, acknowledged EMAR documentation of 9 means medications not administered. RN A confirmed potassium chloride, and tirzepatide were not given to Resident due to medications were not available to administer. RN A also confirmed Resident 2 received rosuvastatin 4 doses only based on tablets taken to administered from supply not administered 6 does as documented in EMAR. RN A stated license staff should have called pharmacy when medications were not available to administer to Resident 2. RN A also stated Resident 2 should have received medications as ordered. RN A further stated will call pharmacy today for these two medications. During an interview with RN A on 8/14/2024 at 12:35 p.m., RN A reviewed Resident 1' EMAR for June 2024, acknowledged medication quetiapine 25 mg was not administered for above dates due to unavailability of medication. RN A stated license nurses should have followed up with pharmacy for supply of quetiapine, received medication from pharmacy and administered to Resident 1 as ordered by MD. During an interview with facility's director nursing on 8/14/2024 at 12:58 p.m. DON confirmed Residents 1 and 2 did not receive medications as ordered. DON stated license staff should have followed up with pharmacy when medications were not available, received supply of medications and administered to Resident 1 and 2 as ordered by MD without missing doses of medications. DON also stated license staff should not have documented as administered medication rosuvastatin without giving to Resident 2. Review of facility's P&P titled, Administering Medications, revised April 2019, the P&P indicated, Medications are administered in according with prescriber orders, including nay required time frame. The individual administering the medication must initial the resident's MAR (medication administration record) on the appropriate line after giving each medication and before administering the next ones.		