STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055356	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Grove Healthcare Center	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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on observation, interview and record review, the facility failed to ensure the safety and proper monitoring of resident funds for one of three residents investigated, Resident 1, when Resident 1 lost money in his personal bank account. This failure had the potential to affect the resident's psychosocial and general well-being. Findings: During a concurrent observation and interview of Resident 1 on 8/13/24 at 4:20 p.m., Resident 1 was laying in his bed, alert and verbally responsive. He appears calm and comfortable. Resident 1 stated that the previous business office manager (PBOM), who was no longer working with the facility, had taken money from his bank account. Review of Resident 1's clinical records indicated, he was admitted to the facility on [DATE] with diagnoses including unspecified chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe), essential primary hypertension (high blood pressure), and hyperlipidemia (a condition in which there are high levels of fat particles in the blood). Resident 1's brief interview for mental status (BIMS, an assessment used in long-term care facilities to monitor cognition) score was 10, dated 7/26/24, which suggests moderately impaired cognition. Review of the facility's investigation report dated 8/15/24 indicated, that PBOM was arrested by police. The police department reported this to the administrator of the facility. During an interview with the administrator (ADM), on 8/22/24 at 4:00 p.m., ADM verified that Resident 1 reported to them that PBOM had taken money from his bank account. ADM stated that the facility received copies of the account of Resident 1 and forwarded them to law enforcement. ADM further verified that they should have initiated checks and balance system for business office practices to safeguard resident funds and prevent this incident to happen because the personal money of Resident 1 was not protected. During an interview with the director of nursing (DON), on 9/24/24 at 3:15 p.m., DON verified that resident funds should be safe and protected. DON further verified that there should be checks and balance system for business office practices to protect resident funds, including Resident 1's money. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Resident Rights, revised, December 2016 indicated, Employees shall treat all residents with kindness, respect and dignity. Federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the resident's right to be free from abuse misappropriation of property, and exploitation

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44185 Based on observation, interview and record review, the facility failed to ensure that the resident receive proper foot care and treatment for one of three residents investigated, Resident 2, when Resident 2 did not get an immediate appointment to see a podiatrist. This failure had the potential to affect the resident's foot condition, general health and well-being. Findings: During a concurrent observation and interview with Resident 2 on 8/13/24 at 4:30 p.m., Resident 2 was laying in his bed, calm, alert, oriented and verbally responsive. Resident 2 stated that he told the nurses that he wanted to see a podiatrist for his toenails, a few months ago but until now, he was never seen by a podiatrist. His toenails were long and uncut. During another concurrent observation and interview with Resident 2 on 8/22/24 at 4:20 p.m., Resident 2's toenails remained uncut and long. Resident 2 stated that no podiatrist had seen him until this time. During an interview with the minimum data set coordinator (MDSC, collects data related to residents in order to develop and evaluate a comprehensive care plan) on 8/22/24 at 4:25 p.m., MDSC verified that Resident 2 was not seen by a podiatrist yet because it was not covered by his insurance. MDSC further verified that the previous administrator had not approved, for the facility to pay Resident 2's appointment with a podiatrist. During the interview with the administrator (ADM) on 8/22/24 at 4:30 p.m., ADM verified that Resident 2 had not seen a podiatrist yet but was scheduled to see one already. Review of Resident 2' clinical records indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses including nondisplaced fracture (broken bone where the pieces remain aligned) of base of neck of right femur (the region just below the ball of the right hip joint), subsequent encounter for closed fracture (resident is receiving routine care for a condition after the active treatment phase) with routine healing, generalized muscle weakness (decrease in muscle strength that can make it harder to move the body) and unspecified obesity (a disorder that involves having too much body fat). Resident 2's brief interview for mental status (BIMS, an assessment used in long-term care facilities to monitor cognition) score was 15, taken on 8/15/24, which suggests cognitively intact. Review of Resident 2's order summary report, dated 8/22/24 indicated, that Resident 2 had an order for referral to in house podiatrist on 3/31/24. During a concurrent record review of Resident 2's clinical records and interview with the director of nursing (DON) on 9/24/24 at 2:30 p.m., DON verified that Resident 2 had a referral order to in house podiatrist on 3/31/24 but was not seen, until recently. DON further verified that Resident 2 just had an appointment with the podiatrist on 9/4/24. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the social services director (SSD) on 9/24/24 at 2:40 p.m., SSD verified that Resident 2's delayed appointment with the podiatrist was because, it was not covered by his insurance and the previous administrator did not approve, for the facility to pay for the coverage. Review of the facility's policy titled, Physician Services, revised April 2013 indicated, Physician orders and progress notes shall be maintained in accordance with current Omnibus Budget Reconciliation Act (OBRA, primary purpose was to improve the quality of care provided by long-term care facilities and to enhance the quality of life of the residents) regulations and facility policy Review of the facility's policy titled, Referrals, Social Services, revised December 2008 indicated, Social services personnel shall coordinate most resident referrals with outside agencies Referrals for medical services must be based on physician evaluation of resident need and a related physician order