STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capistrano Beach Care Center	35410 Del Rey Capistrano Beach, CA 92624

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41941 Based on interview, medical record review, and facility document review, the facility failed to ensure the medications were administered as ordered for one of six sampled residents (Resident 1). * Resident 1's evening medications were not administered on the admission day because they were not delivered by the pharmacy. This failure had the potential to negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Administering Medications revised 4/2019 showed the medications are to be administered in accordance with the prescriber's orders and within the required time frame. Medical record review for Resident 1 was initiated on 3/18/24. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 3/11/24, showed Resident 1 had the capacity to understand and make medical decisions. Resident 1 had active medical problems, including hypertension, hyperlipidemia, diabetes, peripheral vascular disease, and an infection in the bone of his right big toe. Review of Residents 1's MDS dated [DATE], showed the resident had moderate cognitive impairment. On 3/20/24 at 1119 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. Review of Resident 1's MAR for March 2024 showed the following medications were not given as scheduled on 3/7/24: - Atorvastatin Calcium 10 mg one tablet by mouth at bedtime for hyperlipidemia - Betimol Ophthalmic Solution 0.5% one drop in both eyes two times a day for glaucoma - Cardura 2 mg give one tablet by mouth in the evening for high blood pressure - Gabapentin 300 mg one capsule by mouth three times a day for nerve pain (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Glimepiride 4 mg one tablet by mouth two times a day for diabetes mellitus - Metformin HCL 1000 mg one tablet by mouth two times a day for diabetes mellitus - Metoprolol Succinate ER Extended Release 50 mg one tablet by mouth in the evening for high blood pressure - Senna 8.6 mg one tablet by mouth two times a day for bowel management - Xalatan Ophthalmic Solution 0.005% one drop in both eyes at bedtime for glaucoma. Further review of the MAR showed the orders for the medications were entered on 3/7/24 at 1342 hours. Review of the nursing progress notes dated 3/7/24 at 2136 hours, showed the medications had not been delivered yet. The nursing progress notes did not show the physician was notified of the medications not being given. There was no documented evidence of the follow up with the pharmacy. On 3/20/24 at 1300 hours, a telephone interview was conducted with LVN 4. LVN 4 stated the pharmacy had a four-to-six-hour window from when the resident arrived at the facility to deliver the medications. LVN 4 stated after six hours, the next step would be to call the pharmacy and notify the physician. LVN 4 confirmed he did not call the pharmacy or notify the physician. On 3/20/24 at 1340 hours, an interview was conducted with the DON. The DON stated the pharmacy was supposed to deliver the medications to the facility within four to six hours. The DON stated the physician should have been notified that Resident 1 had not received his medications. The DON confirmed Resident 1 had the potential for high blood pressure and an increase in blood sugar levels due to not receiving his medications as ordered. On 3/20/24 at 1345 hours an interview was conducted with the Administrator. The Administrator stated if the physician had been notified, he may have ordered an increase in monitoring.