

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Capistrano Beach Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being for one of three sampled residents (Resident 2).</p> <p>* The facility failed to ensure Resident 2 was administered Tamiflu (a medication used to treat the flu or can reduce the chance of getting the flu) as ordered by the physician. This failure had the potential to negatively impact the resident's well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Acute Condition Changes - Clinical Protocol revised March 2018 showed the physician will help identify individuals with a significant risk for having acute changes of condition during their stay. The nurse and physician will discuss and evaluate the situation. The physician will help identify and authorize appropriate treatments. The staff member will monitor and document the resident/ patient's progress and responses to treatment, and the physician will adjust treatment accordingly.</p> <p>Review of the facility's P&P titled Medication Orders revised November 2014 showed the purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. Orders must be written and maintained in chronological order.</p> <p>Review of the facility's P&P titled Administering Medication Orders revised April 2019 showed medications are administered in a safe and timely manner and in accordance with prescriber orders, including any required time frames.</p> <p>Medical record was initiated on 1/24/25. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 2's H&P examination dated 7/12/24, showed Resident 2 had no capacity and was confused.</p> <p>Review of Resident 2's progress note dated 1/22/25 at 1629 hours, showed Resident 2 had a change of condition. Resident 2 was noted with a cough and the physician ordered Tamiflu 75 mg every day for seven days.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 2's Order Summary Report as of 1/24/25, failed to show the physician's order for the Tamiflu medication ordered on 1/22/25.</p> <p>Review of Resident 2's MAR as of 1/24/25, failed to show the Tamiflu medication was administered to Resident 2 after an order was received from the physician on 1/22/25.</p> <p>On 1/24/25 at 1154 hours, an interview and concurrent medical record review with LVN 1 was conducted. LVN 1 stated Resident 2 had a change of condition due to a cough couple of days ago. LVN 1 verified Resident 2's medical record failed to show the written physician's order for the Tamiflu medication and whether the Tamiflu medication was administered to the resident since 1/22/25.</p> <p>On 1/24/25 at 1154 hours, an interview and concurrent medical record review with the IP was conducted. The IP verified Resident 2 had a cough on 1/22/25, and he notified Resident 2's physician. The IP stated he received the order for the Tamiflu 75 mg every day for seven days; however, he did not transcribe the ordered medication into Resident 2's medical record. The IP further stated it was a mistake and he would inform Resident 2's physician.</p> <p>On 1/24/25 at 1349 hours, an interview was conducted with the DON. The DON stated she expected the licensed nurses to timely notify the physician and the residents' family member regarding any changes of condition for the residents and carry out the physician's orders. The DON was informed and acknowledged the above findings. The DON further stated there was a miscommunication between the charge nurse and the IP in regard to carrying out the order for the Tamiflu medication ordered by the physician.</p>