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	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capistrano Beach Care Center	35410 Del Rey Dana Point, 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the responsible party of one of six sampled residents (Resident 1) was informed in advance of the care that was going to be furnished and of the type of provider who would be furnishing the care to Resident 1. This failure posed the risk of Resident 1's responsible party not being able to make the informed decisions about Resident 1's care. Findings: Review of the facility's P&P titled Informed Consent revised 3/25/24, showed the facility is to uphold the rights of the residents and their responsible party to participate in the planning and decision-making process concerning the resident's care and treatment. Review of the facility's P&P titled Change in Resident's Condition or Status revised 2/2021 showed a nurse or healthcare provider will inform the resident or responsible party of any changes to the resident's medical care or nursing treatments. Medical record review for Resident 1 was initiated on 5/5/25. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 11/29/24,showed Resident 1's diagnoses which included advanced dementia (a form of dementia that results in increased loss of cognitive and bodily functions). On 5/22/25 at 1002 hours, a telephone interview for Resident 1 was conducted with Responsible Party 1. Responsible Party1 verbalized concerns about not being informed in advance of the psychological tests, psychiatric visits, and orders prescribedby Resident 1's psychiatrist for buspar (medication to treat anxiety). Review of Resident 1's Multidisciplinary Care Conference document dated 4/11/25, signed by the SSD showed a care conference was conducted with Responsible Party 1 and the staff to discuss an incident which occurred on 4/10/25,between Resident 1 and his previous roommate. The section titled last psych date on the document was observed blank. The document showed Resident 1 was compliant with his care and medications. The section titled additional comments showed the interventions included Resident 1 was being closely monitored for behavioral changes or recurrence of aggression. The document did not mention any tests, psychiatric visits, or orders for buspar as part of the interventions for Resident 1. (continued on next page)

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	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capistrano Beach Care Center	35410 Del Rey Dana Point, 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/25 at 1043 hours, an interview and concurrent medical record review for Resident 1 was conducted with the SSD. When asked about the care conference meeting held with Responsible Party 1 for Resident 1 on 4/11/25, the SSD verbalized the care conference meeting was conducted to discuss Resident 1's resident-to-resident physical altercation incident on 4/10/25. When asked if she had notified Responsible Party 1 that the psychiatrist and psychologist would be conducting the visits to Resident 1 including the follow-up visits related to Resident 1's 4/10/25 incident, the SSD verified she did not inform Responsible Party 1 of the follow-up visit would be conducted by the psychiatrist. The SSD verified the Multidisciplinary Care Conference document dated 4/11/25, failed to show the psychiatrist would be conducting the follow-up visit. In addition, thedocument showed the interventions for Resident 1 included the resident would be monitored for behavioral changes. Review of the psychiatrist's visit notes dated 4/11/25, showed Resident 1's psychiatrist ordered buspar 150 mg twice daily for Resident 1's status post resident-to-resident physical altercation. Review of the psychiatrist's notes showed under the section titled plan, any recommendations were subject to approval of the interdisciplinary care plan team and for the facility to fax or call Resident 1's primary care physician for the physician's approval. Review of the 4/11/25 visit notes also showed Resident 1's psychiatrist conducted a neuropsychological test on Resident 1. Further review of the document failed to show documented evidence the psychiatrist had informed Responsible Party 1 in advance of the psychiatry treatment plan for Resident 1. On 5/22/25 at 1125 hours, a telephone interview was conducted with Resident 1's psychiatrist. When asked if he had informed the resident's responsible party about the psychiatry treatment plan for Resident 1 including the order for buspar for Resident 1, the psychiatrist verbalized he tried; however, he felt it was the facility's responsibility to obtain an informed consent from Responsible Party 1. The psychiatrist verbalized Responsible Party 1 did not want any medications for Resident 1. When the psychiatrist was asked why he ordered buspar for Resident 1, the psychiatrist verbalized he ordered buspar for Resident 1's behaviors, including the resident-to-resident altercation on 4/10/25.

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	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capistrano Beach Care Center	35410 Del Rey Dana Point, 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the quality care and services were provided for one of three sampled residents (Resident 4). * The facility failed to ensure Resident 4's BP was monitored for hypotension. * The facility failed to ensure the results of the CBC test were promptly reported to Resident 4's physician. * The facility failed to ensure Resident 4's urine sample was collected in a timely manner. These failures had the potential for the residents to not receive the necessary care and services to maintain their highest physical well-being. Findings: Review of the facility's P&P titledProvision of Quality Care revised 12/19/22, showed based on the comprehensive assessments, the facility will ensure the residents receive the treatment and care by qualified persons in accordance with professional standards of practice, comprehensive person-centered care plans, and resident choices. The Policy Explanation and Compliance Guidelines section showed each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. Closed medical record review for Resident 4 was initiated on 5/22/25. Resident 4 was admitted to the facility on [DATE], and discharged on 4/30/25. Review of Resident 4's MDS assessment dated [DATE], showed the resident's cognition was moderately impaired. a. Review of the facility's P&P titled Blood Pressure, Measuring revised 9/2010 showed the purpose of this procedure is to measure the pressure exerted by the circulating volume of blood on the walls of the arteries, veins and chambers of the heart. The General Guidelines section showed the following: - Hypotension is defined as blood pressure less than 100/60 mmHg. - Hypotension should be reported to the physician. Staff should record several readings throughout the day, including before and after meals. Review of Resident 4's Weights and Vitals Summary dated 5/23/35, showed the resident's BP summary: - 96/63 mmHg: 4/28/2025 at 0910 hours - 91/60 mmHg: 4/28/2025 at 1909 hours - 90/56 mmHg: 4/29/2025 at 1046 hours (continued on next page)

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	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capistrano Beach Care Center	35410 Del Rey Dana Point, 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 85/55 mmHg: 4/29/2025 at 2142 hours On 5/28/25 at 1233 hours, an interview and concurrent closed medical record review for Resident 4 was conducted with LVN 3. LVN 3 verified Resident 4's BPs were taken twice on 4/28/25, and twice on 4/29/25. LVN 3 acknowledged Resident 4 had hypotension. LVN 3 stated Resident 4 was alert and able to answer questions. LVN 3 stated the licensed nurse usually took the BPs once per shift. On 5/29/25 at 1015 hours, an interview and concurrent closed medical record review for Resident 4 was conducted with RN 3. RN 3 verified the above BP summary. RN 3 acknowledged Resident 4 had hypotension. RN 3 stated she did not know why the BPs were not checked more often. RN 3 further stated she was not there at the time the BPs were taken. RN 3 stated the Resident 4's BPs should have been checked every hour if the resident had hypotension. b. Review or the facility's P&P titled Lab and Diagnostic Test Results – Clinical Protocol revised 11/2018 showed a nurse will identify the urgency of communicating with the attending physician based on physician request, the seriousness of any abnormality, and the individual's condition. Review of Resident 4's Order Summary Report dated 5/23/25, showed a physician's order dated 4/5/25, for CBC every Monday. One time a day. Review of Resident 4's Lab Results Report dated 4/28/25, showed the results of the CBC test was reported to the facility on 4/28/25 at 1256 hours. In addition, the report showed Resident 4's WBC was 17.45 and the reference range was 4.0-11.0. Review of Resident 4's eINTERACT Change in Condition Evaluation - V 5.1 dated 4/28/25, showed the result of the CBC was reported to Resident 4's physician on 4/28/25 at 1609 hours. On 5/28/25 at 1258 hours, an interview and concurrent closed medical record review for Resident 4 was conducted with LVN 3. LVN 3 verified Resident 4's laboratory results for the CBC test were received on 4/28/25 at 1256 hours, and Resident 4's physician was notified on 4/28/25 at 1609 hours. LVN 3 stated Resident 4 had infection and the laboratory results for the WBC test should have been reported right away. On 5/29/25 at 0 hours, an interview and concurrent closed medical record review for Resident 4 was conducted with RN 3. RN 3 verified Resident 4's laboratory results for the CBC test were received on 4/28/25 at 1256 hours, and Resident 4's physician was notified on 4/28/25 at 1609 hours. RN 3 stated she was at the nursing station when Resident 4's WBC results were received. RN 3 stated Resident 4's physician should have been called right away when the results of the CBC test were received. c. According to the Fundamentals of Nursing 10th edition, Types of Orders, a stat order is also a single order, but it is carried out immediately. Review of Resident 4's Order Summary Report dated 4/29/25, showed a physician's order dated 4/28/25 at 1747 hours, for UA with C&S stat, one time only. Review of Resident 4's Progress Notes dated 4/23/25, showed a nurse's note dated 4/28/25 at 2218 hours, showing the urine sample was collected. (continued on next page)

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	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capistrano Beach Care Center	35410 Del Rey Dana Point, 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/25 at 1050 hours, an interview and concurrent closed medical record review for Resident 4 was conducted with RN 3. RN 3 verified the UA with C&S stat was ordered on 4/28/25 at 1747 hours, and Resident 4's urine sample was collected on 4/28/25 at 2218 hours. RN 3 stated the charge nurse told her to enter UA with C&S stat order in the computer and she would collect the urine sample. RN 3 further stated the charge nurse asked her to help for Resident 4's straight catheterization on 4/28/25 at around 2200 hours. RN 3 stated Resident 4's urine sample should have been collected right away. On 5/29/25 at 1637 hours, the Administrator and DON were informed and acknowledged the above findings.