

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056048	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Pacific Coast Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1935 Wharf Road Capitola, CA 95010	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46939</p> <p>Based on interview and record review, the facility failed to protect resident's right to be free from physical abuse for two of two sampled residents (Resident 1 & Resident 2) when:</p> <ol style="list-style-type: none"> 1. Resident 1 was hit in the face by Resident 3 2. Resident 2 was kicked in the leg by Resident 3. <p>These failures resulted in Resident 1 sustaining a minor laceration to the face and Resident 2 sustaining a minor laceration to the leg, both requiring minor medical care.</p> <p>Findings:</p> <p>1. During an interview on 5/7/24, at 10:20 a.m., with Administrator (ADM), ADM stated, we got a report from Resident 4, he saw Resident 2 grab Resident 3's arm, then Resident 3 punched Resident 1 in the head. ADM stated both Resident 1 and Resident 3 have been involved in resident-to-resident altercations before.</p> <p>During a review of SBAR- Alleged Abuse Report of Incident dated 5/6/24, indicated, Resident 3 was involved in an incident of alleged: Physical abuse with redness [to] right hand 2nd and 3rd knuckle. Behavior status 1. Agitated. Staff responded to yelling from the room. [Resident 1] was holding onto his [Resident 3's] left wrist and [Resident 1] observed with blood coming from his left temple. [Resident 4] confirmed that [Resident 3] hit roommate on the face.</p> <p>During a review of Report of Suspected Dependent Adult/Elder Abuse form dated 5/6/24, form indicated Reported Types of Abuse (check all that apply). a. Physical abuse was reported by facility between Resident 1 and Resident 3.</p> <p>During a review of Interview/Investigative record dated 5/6/24, indicated, Resident 4 was interviewed by Social Services Director (SSD), Content of interview: [Resident 4] stated he saw [Resident 2] grabbing [Resident 3] and not letting go. [Resident 4] stated [Resident 3] then 'slapped [Resident 1] with his fist'. Record was signed by Resident 4 and SSD.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 3's Progress Note dated 5/6/24 at 11:28 a.m., note indicated, Was a behavior observed? YES. Pt [patient-Resident 3] appears irritated and short tempered. Using distraction and reorientation, and reassurance.</p> <p>During a review of Resident 3's Progress Note dated 5/6/24 at 11:31 a.m., note indicated, Pt [patient-Resident 3] is still agitated.using distraction methods to calm patient.</p> <p>During a review of Resident 3's Progress Note dated 5/6/24 at 1:44 p.m., indicated, staff responded to yelling from the room. [Resident 1] was holding on to [Resident 3's] left wrist and [Resident 1] observed with blood coming from his left temple. Resident 4[roommate] confirmed that [Resident 3] hit [Resident 1] on the face.</p> <p>During a review of SBAR-Alleged Abuse Report of Incident dated 5/6/24, indicated, Resident 1 was involved in an incident of alleged: a. Physical abuse.on 5/6/24. Assessment 3.Laceration or cut.</p> <p>During a review of the Summary of Investigation dated 5/6/24, Summary indicated, Residents affected:[Resident 3 and Resident 1] on 5/6/24 about 11:30am.Allegation: On 5/6/24 it was reported to supervisory of an incident between two roommates [Resident 3 & Resident 1]. [Resident 1] had a cut to his eyebrow.Roommate [Resident 4] reported seeing [Resident 1] holding [Resident 3's] arm while in a wheelchair and [Resident 3] hitting him in the face.Conclusion: Based on interviews and record reviews, the incident did happen.</p> <p>During a review of Resident 3's Brief Interview for Mental Status (BIMS-screening used to determine cognitive condition) dated 2/12/24, indicated a BIMS score of 1 (indicating severe cognitive impairment: a very hard time remembering things, making decisions, concentrating, or learning).</p> <p>During a review of Resident 1's BIMS score, dated, 3/2/24, resident is rarely/never understood.skip. Indicating resident was cognitively impaired.</p> <p>2. During a review of Summary of Investigation dated 5/8/24, Summary indicated, Residents affected: [Resident 3 and Resident 2].Allegation: it was reported of a resident to resident [incident] [Resident 2] and [Resident 3]. [Licensed Vocational Nurse (LVN) A] reported [residents] shaking fists and yelling at each other in the hallway and [Resident 3] stood up and kicked [Resident 2] in the leg.Conclusion: confirmed incident.</p> <p>During an interview on 5/7/24, at 10:02 a.m., with LVN A, LVN A stated, she was in the hallway during the incident between Resident 2 and Resident 3 on 5/6/24. LVN A stated, she saw Resident 2 in his wheelchair going towards Resident 3, and thought they were talking, then Resident 2 tried to punch Resident 3 and missed, then Resident 3 stood up and kicked Resident 2 in the leg. Resident 2 began bleeding from his shin.</p> <p>During a review of Resident 2's Order Summary Report dated 5/7/24, report indicated, Monitor right shin skin tear.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's Progress note dated 5/8/24, note indicated, [Resident 2] was in the hallway in w/c [wheelchair] when he moved his w/c forward and approached another male resident [Resident 3] in a threatening way to which the other residents stood up and kicked [Resident 2] on the right shin twice causing the skin tear. Incident observed by nurse nearby, no other physical contact, residents were separated immediately, [Resident 2's] wound attended.</p> <p>During a review of Resident 2's BIMS score, dated, 4/21/24, indicated a BIMS score of 08. Indicating moderate cognitive impairment.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Alleged or Suspected Abuse and Crime Reporting dated 2022, P&P indicated, Each resident has the right to be free from abuse. Abuse is the willful infliction of injury. Physical abuse includes, but is not limited to, hitting, slapping, pinching, and kicking. Resident-to-Resident abuse means the willful infliction of injury. willful as used in the above definition of abuse, means the individual must have acted deliberately.</p>