STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056048	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Coast Manor	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)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46552 Based on interview and record review the facility failed to ensure to follow their policy and procedure (P&P) to assess for history of psychosocial, trauma and stressors trigger an event, for two of two sample residents (Resident 1 and 2). This failure had the potential to effect health, psychosocial well-being, and person-centered trauma informed care for Resident 1 and 2. Findings: Review of Resident 1's FS (FS: a document that gives a resident's information at a quick glance) indicated Resident 1 was admitted to the facility on [DATE] and readmitted to facility on 6/14/2024. Review of Resident 1's FS indicated Resident 1's admission diagnoses included depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in daily living activities), anxiety (a mental health condition involves persistent and excessive worry that interferes with daily living activities), and insomnia (a sleep disorder that make it hard to fall asleep or stay asleep). Review of Resident 1's physician medication orders dated 6/14/2024 indicated, buspirone (used to treat anxiety) 5 mg (milligram: unit of measurement equal to a thousandth of a gram) two times a day for anxiety. Sertraline (used to treat depression) 200 mg in the morning for depression dated 6/14/2024, and trazodone (used to treat depression) 100 mg at bedtime for depression dated 6/14/2024. Review of Resident 1's minimum data set (MDS: clinical assessment tool) assessment dated [DATE] indicated Resident 1's brief interview for mental status (BIMS, an assessment to test a person's cognition level)) score of 14 of 15 meaning he had intact cognition (score of 0-7: severe impaired cognition, 8-12: moderately impaired cognition, 13-15: intact cognition). Review of Resident's MDS assessment dated [DATE] indicated Resident 1's BIMS score of 14 of 15, intact cognition. Review of Resident 1's initial admission social service assessment dated [DATE] upon Resident 1's initial admission indicated, questions for history for psychosocial, trauma and stressors trigger an event were left blank, incomplete. Review of Resident 1's initial readmission social service assessment dated [DATE] indicated, questions for history for psychosocial, trauma and stressors trigger an event were left blank, incomplete. (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

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident 1 on 7/9/2024 at 2:10 p.m., Resident 1 stated facility staff did not enquire or questioned Resident 1 for mental health history or history of trauma. Resident 1 also stated facility's documentation was not reflected with Resident 1's history of mental health and childhood trauma. Review of Resident 2's FS indicated Resident 2 admitted to facility on 1/9/2021. Review of Resident 2's FS also indicated diagnoses included depression, anxiety, insomnia, bipolar disorder (a mental disorder with episodes of mood swings ranging from lows to manic highs), parkinson's disease (a brain disorder that causes unintended or uncontrollable body movements), and adult failure to thrive (a syndrome of unexplained weight loss, deterioration in mental and functional ability and social isolation). Review of Resident 2's physician orders indicated citalopram (used to treat depression) 100 mg daily for depression, dated 9/29/2022, trazadone 200 mg at bedtime for depression, dated 2/1/2023, and melatonin (used to treat for sleep disorders) 10 mg at bedtime for promote sleep dated 11/30/2021. Review of Resident 2's MDS assessment dated [DATE] indicated Resident 2's BIMS score of 15 of 15, intact cognition. Review of Resident 2's quarterly social service assessment dated [DATE] indicated, questions for Resident 2's history for psychosocial, trauma and stressors trigger an event were left blank, incomplete. Review of Resident 2's another quarterly social service assessment dated [DATE] indicated, questions for Resident 2's history for psychosocial, trauma and stressors trigger an event were left blank, incomplete. During an interview with Resident 2 on 7/9/2024 at 2:30 p.m., Resident 2 stated facility staff did not ask for history of trauma or mental health concerns for Resident 2. During concurrent review of Resident 1's social service assessments and interview with license vocational nurse/case manager (LVN/CM) on 7/9/2024 at 3:22 p.m., LVN/CM confirmed social service assessments done by LVN/CM on 4/19/2024 and 6/17/2024. LVN/CM also confirmed psychosocial history, trauma and stressors trigger an event, were left blank and not completed for both assessments. LVN/CM stated history of psychosocial assessment questions were not reviewed with Resident 1 on both dates. LVN/CM stated she should have questioned Resident 1 for history of psychosocial assessment to meet Resident 1's mental health needs. During a concurrent interview and record review of social service assessments for Resident 2's dated 4/11/2024, and 7/4/2024 with social service director (SSD) on 7/9/2024 at 3:45 pm., SSD confirmed assessment for history of psychosocial, trauma and stressors were not verified with resident 2. SSD also confirmed questions for history for psychosocial assessment were left blank and not completed for above both assessments. SSD stated she should have asked and completed Resident 2's psychosocial history to meet Resident 2's trauma informed care, health and psychosocial well-being. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with director of nursing (DON) on 7/9/2024 at 4:04 p.m., DON stated social service staff were responsible to complete social service assessments for all residents. DON also stated social service staff should have questioned resident's psychosocial history and completed social service assessments upon the admission, readmission and every quarter to meet resident centered plan of care for Resident 1 and 2. During a review of the facility's P&P titled, Initial Assessment, December 2011, the P&P indicated, 1. The Social Service staff will complete the Initial Social Service Assessment. 2. The resident and /or family will be interviewed to obtain accurate information to complete the assessment. 5. This assessment will include: n. Psychosocial stressors During a review of facility's P&P titled, Job Description/Performance Evaluation for Social Service Director, revised 11/13/2017, the P&P indicated, Manages department to assure assessments, discharges and psychological needs of residents are met. Timely, accurate and on-going comprehensive social history assessment and care planning of identified psychosocial needs.