

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 02/20/2025
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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>42192</p> <p>Based on interview, record reviews, and facility policy review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) Level I Screening was updated to reflect the presence of newly diagnosed serious mental disorders for 1 (Resident #67) of 3 residents reviewed for PASARR requirements.</p> <p>Findings included:</p> <p>A facility policy titled, Resident Assessment - Coordination with PASARR Program, reviewed/revised 05/2024, revealed, This facility coordinates assessments with the preadmission screening and Resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. The policy specified, 9. Any Resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II Resident review.</p> <p>Resident #67's Admission Record indicated the facility admitted the resident on 12/01/2023. According to the Admission Record, the resident had a medical history that included diagnoses of post-traumatic stress disorder (PTSD) (onset date 12/04/2023), anxiety disorder (onset date 02/20/2024), and unspecified psychosis not due to a substance or known physiological condition (onset date 05/21/2024).</p> <p>Resident #67's care plan included a focus area, initiated 02/21/2024, that indicated the resident had a mood problem related to a diagnosis of PTSD.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/09/2025, revealed Resident #67 had short- and long-term memory problems and severely impaired cognitive skills for daily decision-making per a Staff Assessment of Mental Status (SAMS). According to the MDS, at the time of the assessment, the resident had active diagnoses that included anxiety disorder, psychotic disorder, and PTSD.</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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #67's Level I PASARR Screening, dated 11/30/2023, revealed Section III- Serious Mental Illness, question 10, was answered no to indicate the resident did not have a serious diagnosed mental disorder such as depressive disorder, anxiety disorder, panic disorder, schizophrenia/schizoaffective disorder, or symptoms of psychosis, delusions and/or mood disturbance. The Level I PASARR screening indicated the screening was Negative, due to No Serious Mental Illness, and a Level II evaluation was Not Required.</p> <p>Resident #67's medical record revealed no documented evidence a new Level I PASARR Screening was completed after the addition of new mental illness diagnoses, including additions of PTSD in 12/2023, anxiety disorder in 02/2024, and psychosis in 05/2024.</p> <p>During an interview on 02/19/2025 at 10:12 AM, the Director of Resident Assessment (DRA) stated Resident #67 had diagnoses that indicated there was a need for a new Level I Screening.</p> <p>During an interview on 02/19/2025 at 1:58 PM, the DRA stated she was unable to find another PASARR for Resident #67, aside from the one completed at the time of the resident's admission to the facility.</p> <p>During an interview on 02/20/2025 at 8:12 AM, the Executive Director (ED) stated Resident #67 should have had another PASARR submitted when their condition changed and new diagnoses were added.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46133</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were securely stored for a resident deemed safe to self-administer medications for 1 (Resident #247) of 1 resident reviewed for secure storage of self-administered medications.</p> <p>Findings included:</p> <p>A facility policy titled, Resident Self-Administration of Medication, reviewed/revised 06/26/2024, specified, 7. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into other resident's [sic] rooms or to confused roommates of the resident who self-administers medications. The following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents. Lockable drawers and cabinets are required only if locked storage is ineffective. b. The medications provided to the resident for bedside storage are kept in containers dispensed by the provider pharmacy.</p> <p>An Admission Record indicated the facility admitted Resident #247 on 01/31/2025.</p> <p>An admission Minimum Data Set (MDS), with an Assessment reference Date (ARD) of 02/06/2025, revealed Resident #247 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.</p> <p>A Self-Administration of Medication assessment, dated 02/18/2025, indicated the facility determined Resident #247 was fully capable of self-administering their inhaler and storing their medication in a secure location.</p> <p>Resident #247's Order Summary Report contained an order dated 02/18/2025 for albuterol sulfate hydrofluoroalkane (HFA, a propellant used in some metered-dose inhalers) inhalation aerosol solution to be administered every four hours as needed for shortness of breath (SOB). The Order Summary Report also contained an order dated 02/18/2025 that indicated Resident #247 May self administer Albuterol inhaler.</p> <p>Resident #247's Care Plan Report included a focus area, initiated 02/18/2025, that indicated the resident had a physician's order for unsupervised self-administration of their prescribed albuterol inhaler.</p> <p>An observation on 02/19/2025 at 11:15 AM revealed Resident #247's albuterol inhaler was in an open, zippered bag on the resident's bedside table in their room. The bag had no locking mechanism. Resident #247 shared a room with two other residents, and at the time of the observation, Resident #247 was observed sitting outside their room in an outdoor courtyard.</p> <p>During a concurrent observation and interview on 02/19/2025 at 12:34 PM, Resident #247 was observed lying in bed with their inhaler in an open, zippered bag beside them. Resident #247 said the facility had not offered them a lockable container to store their inhaler in.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 02/20/2025 at 8:50 AM, Resident #247 was lying in bed with an open, zippered bag that contained their albuterol inhaler.</p> <p>During an interview on 02/19/2025 at 1:52 PM, Case Manager (CM) #3 said residents could keep a medication at their bedside and self-administer if they had a physician's order to do so. CM #3 said the medication would usually be stored in the bedside table, or the resident should have a lockbox to store the medication in.</p> <p>During an interview on 02/19/2025 at 2:01 PM, Registered Nurse (RN) #4 said if a resident requested to self-administer a medication, the resident had to be assessed and their physician had to approve self-administration. RN #4 said if a resident was approved to self-administer and store their medication at the bedside, the resident should have a lockbox in their room to use for medication storage.</p> <p>During an interview on 02/20/2025 at 10:05 AM, RN #6 stated she was assigned to care for Resident #247. RN #6 said Resident #247 had orders to keep their inhaler in their room but the inhaler should be stored in a drawer or other lockable storage area to prevent other residents from accessing it. RN #6 said they did not know where Resident #247 was storing their inhaler. RN #6 said they would check and went to Resident #247's room and noted the bedside drawers were not lockable and that the inhaler was not in a bedside drawer. RN #6 confirmed the resident's inhaler was being kept in an unzipped bag with no lock in the resident's room.</p> <p>During an interview on 02/20/2025 at 10:28 AM, the Director of Nursing (DON) said Resident #247 had their inhaler in their room, and the inhaler was being kept in a bag with a zipper. The DON said they had lockboxes to provide to residents but did not think Resident #247 had been offered one. The DON said they thought a bag with a zipper was secure. When asked about the facility policy pertaining to self-administration of medications, the DON said they read the policy when they provided it to the surveyor and noted it mentioned the use of locked storage for medications.</p> <p>During an interview on 02/20/2025 at 10:49 AM, the Executive Director (ED) stated medications kept in residents' rooms should be stored in an area that was not accessible to other residents, but accessible to the resident for whom the medication was prescribed. The ED said if a medication was kept in a resident's room, it should be stored in a lockbox to prevent other residents from accessing the medication.</p>		