

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Pacific Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1323 17th Street Santa Monica, CA 90404	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure nursing facility staff verify and confirmed resident's laboratory test result as reported by resident's family member (FM 1) after Resident 1 was hospitalized on [DATE] and was diagnosed with urinary tract infection (UTI - an infection in the bladder/urinary tract) and ESBL (Extended-Spectrum Beta-Lactamase - a special shield or enzyme that certain common bacteria have developed to protect themselves from common antibiotics, because the bacteria can chew up and break down the medicine, standard antibiotics don't work against them), according to facility's policy and procedure for one of four sampled residents, Resident 1. As a result, Resident 1 received the incorrect medication for UTI according to Resident 1's laboratory culture test result (bacteria culture test can determine if you have a bacterial infection and, if so, which type of bacteria is causing it) from 6/3/2026 to 6/8/2026. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including atherosclerotic heart disease (build-up of fats, cholesterol, and other substance in and on the arterial walls), UTI, and metabolic encephalopathy (a chemical imbalance in the blood affecting the brain). During a review of the Minimum Data Set (MDS - resident assessment tool) dated 6/13/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required moderate to maximal assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Progress Notes (PN) dated 6/3/2026, the PN indicated, Resident 1 was sitting in activity area was noted with pale appearance, 911 (the standard phone number you dial to reach emergency services like the police, fire department, or an ambulance) was notified at 10:30 a.m., EMT (Emergency Medical Technician) arrival and resident (1) was transferred to General Acute Hospital 1 (GACH 1). During a review of Resident 1's After Visit Summary (AVS) from General Acute Hospital 2 (GACH 2), dated 6/3/2026, the AVS indicated, a diagnoses of UTI with hematuria (blood in urine) and laboratory test in progress including culture (a two-step laboratory process used to detect infections) blood (a lab test that checks your blood for harmful germs, like bacteria or yeast), and culture, urine (a laboratory test that checks your pee for bacteria or fungi to see if you have an infection). During a review of Resident 1's Urine Culture test result from GACH 2, collected on 6/3/2026 and result dated 6/4/2026, the urine culture test result indicated, organism is an ESBL-producer, resistant clinically to most penicillins (type of antibiotic medication used to treat bacterial infections), cephalosporins (a large, widely used group of antibiotics used to treat bacterial infections like strep throat, pneumonia, and skin issue). During a review of Resident 1's Medication Administration Record (MAR) dated 6/3/2026 to 6/8/2026, the MAR indicated, Resident 1 received cephalexin (a common, first-generation prescription antibiotic used to kill the bacteria causing an infection) oral capsule 500 milligram (mg - unit of measurement) four times a day. During a review of Resident 1's PN dated 6/8/2026, the PN indicated, Resident (1) transferred to GACH 1 for further evaluation of hypotensive episode (sudden drop in blood pressure). During a review of Resident 1's Discharge Summary (DS) from GACH 1, dated 6/11/2026, (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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the DS indicated Resident 1's primary diagnosis was recurrent ESBL UTI. During an interview with Resident 1's FM 1 on 6/24/2026 at 12:15 p.m., FM 1 stated, after Resident 1's hospitalization from GACH 2, she called the facility to notify them that Resident 1's urine culture came back with ESBL and that Resident 1 should be receiving a different antibiotic (prescription medicines used exclusively to treat bacterial infections) medication because ESBL is resistant to cephalexin. FM 1 stated, she (FM 1) had called the facility multiple times to make sure that Resident 1's medication is to be changed to the appropriate medication. FM 1 stated, Resident 1 was sent out to hospital again on 6/8/2026 to GACH 1 due to low blood pressure and when she spoke with the facility staff, she was told that Resident 1 was still on cephalexin antibiotic and the medication was never changed. During an interview with Licensed Vocational Nurse 1 (LVN 1) on 6/24/2026 at 1:52 p.m., LVN 1 stated, he spoke with FM 1 and was notified that Resident 1's urine culture came back and was prescribed wrong antibiotic medication, and medication should be changed to a different antibiotic. LVN 1 stated, he notified Medical Doctor 1 (MD 1) regarding FM 1's report. During an interview with MD 1 on 6/24/2026 at 2:45 p.m., when she was notified of Resident 1's urine culture result came back and to have the medication changed. MD 1 checked the medical record from GACH 1 because she was told that Resident 1 was sent out to GACH 1 on 6/3/2026. MD 1 was unable to see the urine test result from GACH 1 so she asked the facility staff where Resident 1 was sent out on 6/3/2026. MD 1 stated, no staff from the facility knew where Resident 1 was sent out to. MD 1 stated, Resident 1 was actually sent out to GACH 2 and was on cephalexin antibiotic until 6/8/2026. During an interview with Interim Director of Nursing (IDON) on 6/25/2026 at 5:05 p.m., IDON stated, FM1 calls the facility many times. IDON stated, if FM 1 reported urine culture result came back from hospital, facility staff should advocate for residents and verify the report. IDON stated, he was not aware of Resident 1's urine culture result of ESBL because he was on vacation. IDON stated, I don't know what happened, I was on vacation. IDON stated, nurses should be advocates to residents and facility staff should follow up on resident's pending urine culture result. IDON stated, when physician asked where Resident 1 was hospitalized on [DATE], facility staff should have checked on Resident 1's emergency transportation report to find out where Resident 1 was sent out so they could verify and confirm Resident 1's urine culture test result. During a review of facility's policy and procedures (P&P) titled, Antibiotic Stewardship, reviewed date 11/19/2025, the P&P indicated, It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. Antibiotic orders obtained upon admissions, whether new admission or readmission, to the facility shall be reviewed for appropriateness. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness. During a review of facility's P&P titled, Abuse, Neglect and Exploitation, reviewed date 11/19/2025, the P&P indicated, Prevention of Abuse, Neglect and Exploitation: the facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation of that achieves: assuring assessment of the resources needed to provide care and services to all residents is included in the facility assessment; the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.		