STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555371	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Care Center	1405 Teresa Drive Morro Bay, CA 93442

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 2), rights for a fair and proper discharge when the facility failed to do an accurate assessment of the resident's mental capacity to understand the meaning of leaving the facility against medical advice (AMA) and denied the resident an appropriate assessment to determine return to the facility after being cleared by the emergency department (ED) physician. This facility failure resulted in an extended hospital stay and transfer from the ED to a facility more than two hours away limiting the resident's only nearby advocate's ability to visit and provide support. Findings: During a review of the medical record (MR) for Resident 2, the Face Sheet (FS), indicated a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE]. Resident 2 had multiple diagnoses including cerebral infarction ([stroke] decreased oxygen supply causing brain damage), encephalopathy (brain dysfunction that causes confusion, memory loss, and personality changes), cytotoxic cerebral edema (brain swelling that causes confusion), anxiety (emotion that causes restlessness and difficulty concentrating), history of traumatic brain injury (brain injury that can cause memory issues, mood swings, memory problems and personality changes). During a review of Resident 2's Comprehensive Nursing Observations Upon admission (CNOUA), dated [DATE] at 4 p.m., the CNOUA indicated, Elopement Risk Evaluation . The resident has attempted to leave a residence or other place unescorted that placed him/her in danger . Yes . The resident is cognitively impaired with poor decision-making skills (i.e. intermittent confusion, cognitive deficits or disorganized all the time) and independently ambulatory . Yes . Interventions: Elopement Deterrent Device Implemented. During a review of Resident 2's Clinical Notes Report (CNR), dated [DATE] at 11:57 p.m., the CNR indicated, Resident needed constant supervision d/t [due to] poor safety awareness. The CNR dated [DATE] at 11:25 a.m., the CNR indicated, Resident noted with impulsiveness and impaired regard for safety upon admission. Resident attempted to walk up out of w/c [wheelchair] towards the exit. Wander guard [a wander management system designed to protect memory care residents] placed and working properly. Resident not easily redirected (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's CNR, dated [DATE] at 1:51 a.m., the CNR indicated, Resident needed constant supervision d/t [due to] poor safety awareness. During a review of Resident 2's CNR, dated [DATE] at 11:14 p.m., the CNR indicated, Very confused . looking for the husband. She was always followed by one CNA [Certified Nursing Assistant]. During a review of Resident 2's CNR, dated [DATE] at 12:06 p.m., the CNR indicated, Not capable of making own decisions. During a review of Resident 2's CNR, dated [DATE] at 2:36 p.m., the CNR indicated, Exhibiting impulsive behavior AMB [as manifested by] walking around room/hallways looking for her husband. She was always followed by one CNA. During a review of Resident 2's Initial Discharge Plan & Assessment (IDPA), dated [DATE] at 9:13 a.m., the IDPA indicated, BARRIERS TO discharge: Not capable of making decisions. During a review of Resident 2's CNR, dated [DATE] at 6:19 p.m., the CNR indicated, Prefers to be out wandering in halls. CNA supervision always. During a review of Resident 2's Interdisciplinary Team Care Plan Review (ITCPR), dated [DATE] at 1:17 p.m. , the ITCPR indicated, Summary of Care Plan Review . There are concerns over her safety r/t [related to] noted impulsivity . Per her friends . they express concern over her behaviors, poor decision making over the past few years . DC [discharge] plan discussed, her plan is unclear at this time . Residents cognition fluctuates at times. During a review of the police report titled, Incident Detail Report (IDR), dated [DATE], the IDR indicated, Priority: Law Code 2 [immediate risk of serious injury to a person] . Caller Name: [facility staff name] . 16:14:26 [4:14 p.m. and 26 seconds] . 16:14:49 . SUBJ [subject] ALREADY ON THE ON RAMP TO HWY 1 . STAFF MEMBER IS WITH SUBJ . 16:16:16 . SUBJ ON HWY 1 NB [northbound] . SUBJ ON FOOT . 16:17:43 . OFFICER REQ [requesting] AMBULANCE PRECAUT [as a precaution] . 16:19:05 . SUBJ WALKING ON HWY 1 . 16:19:33 . RP [reporting party] IS FOLLOWING THE RESD [resident] . 16:23:36 . MULT [multiple] VEHS [vehicles] PULLED OVER THAT ARE ALL ASSOCIATED W/ [facility name] . NOW BECOMING COMPLICATED, PT [patient] IS GETTING AGITATED . 16:25:01 . ANOTHER STAFF MEMBER SLOWING TRAFFIC ON SIDE OF PT BECAUSE PT WAS IN LANE . SILVER SUV GOING SLOWLY ALONG SIDE HER, SLOWING TRAFFIC DOWN . 16:25:15 . ALMOST TO MBB [[NAME] Bay Blvd] EXIT . 16:27:42 . PT NOW AT MBB EXIT SIGN NB 1 . 16:28:36 . PT IS NOW GETTING IN BLU TRK [truck] W/ 2 STAFF MEMBERS . 16:29:26 . ADVSING RP TO HAVE BLU TRK PULL OVER SAFELY OFF OF MBB EXIT SO DEPS [deputies] AND AMB [ambulance] CAN MEET HER . 16:29:59 . RP DOESNT BELIEVE THEY CAN GET MUCH FURTHER W/PT IN VEH . 16:30:54 . PT TRIES TO JUMP OUT OF VEH WHEN THEY MOVE . 16:32:49 . RP IS REQ [requesting] TO HAVE AMB RESPOND TO MBB BLVD EXIT SIGN / HWY 1 . 17:05:27 . TURNED OVER TO MEDICS FOR TRANSPORT TO [hospital name]. During a review of Resident 2's CNR, dated [DATE] at 5:01 p.m., the CNR indicated, Resident desired to leave the facility . Offered AMA resident refused to wait for paperwork. Resident left the facility with staff members accompanied. Staff called EMS and [police name] PD [police department]. Resident transported by ambulance to acute care center. Resident refusing to return to facility per PD. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's ED (Emergency Department) Note-Physician (EDNP), dated [DATE] at 7:45 p.m., the EDNP indicated, Patient states that she and her husband were in a cult type situation. This is why they left the facility . Delusional . I think she is experiencing intermittent delusions from her recent frontal lobe stroke. There is no medical reason to be found today for the symptoms . I was able to speak with the patient's friend [advocate's name] at the bedside . [advocate's name] has concerns about the patient being discharged back to her house where she lives alone. I do share these concerns as well. Therefore, I subsequently called [facility physician name] . She agrees that discharging from the ED tonight may not be in the patient's best interest and she recommends sending her back to [facility name] where they can work on the social issues for a better discharge plan. Patient and friend [advocate's name] are in agreement with this treatment plan . Disposition: Discharge back to [facility name]. Condition stable. During a review of Resident 2's Discharge Against Medical Advice (AMA), dated [DATE] at 8:46 p.m., the AMA indicated, discharged to Address . [Hospital name and address]. During a review of resident 2's CNR, dated [DATE] at 10:25 a.m., the CNR indicated, late entry for [DATE] approximately 1610 [4:10 p.m.]. Resident attempted to leave the facility. wander guard (wrist alarm) was activated. This writer attempted to redirect resident back to the station. Resident stated, Now you're trying to hold me prisoner, You can't hold me here against my will. I have the right to leave. Writer and Social Services attempted to explain discharge process and AMA. Resident verbalized understanding and pushed this writer aside several times. Resident accompanied by Social Services and this writer until PD [police department] and EMS [emergency medical services] arrived. During a review of Resident 2's EDNP, dated [DATE] at 11:13 p.m., the EDNP indicated, Nursing staff called [facility name] who informed us that she could not return because she had been discharged against medical advice. and no longer had a bed. I discussed with the patient who wishes to return to [facility name] and does not recall the events that led to her endorsing a desire to leave [facility name] . I called to discuss with [administrator name] . I was highly doubtful that this patient had capacity to make an AMA decision or understand the prerequisite informed consent [ensuring the patient comprehends the information provided and can make a rational choice] . I discussed with . physician on-call for [facility name] . [physician name] does not have the power to overrule the admin on this decision who are not allowing the patient to return because she had signed out AMA . I then discussed with . [Chief Operating Officer (COO) name]. She indicated to me the reason the patient cannot return to the facility is because she requires higher level of care . the patient is calm and cooperative and desires to return to [facility name] . and that it would be safe to do so . I explained my concerns that the patient was allowed to be discharged AMA when she does not likely have capacity to make that decision, and I am highly doubtful that she was adequately consented for that decision . admitted into observation today [DATE] 01:42:25 [1:42 a.m.] for continued monitoring of social situation and to ensure patient safety. During a review of Resident 2's CNR, dated [DATE] at 12:15 p.m., the CNR indicated, Writer [administrator] spoke to [hospital name] regarding resident returning to facility . Writer explained to [hospital name] that facility is no longer able to accept resident due to her erratic behavior and poor safety judgement/impulsivity. During a review of Resident 2's ED Supervision/Handoff (EDSH), dated [DATE] at 11:07 a.m., the EDSH indicated, The patient was stable for transfer . discharged from observation status. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Facility Assessment ([FA] an evaluation of the facilities resident population and the resources needed to provide the necessary care and services), dated 2025, the FA indicated, Mental Health and behavior/ Specific care and practices: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior. Identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment . In-service training includes . Cognitive impairments and how to provide care/services. Behavioral Management and how to provide care / services . Facility has a holistic protocol and plan of care to meet the care requirements for residents needing attention pertaining to their mental, behavioral, psychosocial, and cognitive well-being. Staff is trained sufficiently in the provision of dementia and behavioral management. Facility utilizes an attending psychologist and external psychiatric services to help meet the needs of residents with mood, behavioral, and psychiatric challenges . The facility staffs according to resident needs and based on acuity and census. During an interview on [DATE] at 12 p.m. in the Administrator's office with the Chief Operating Officer (COO) and the Administrator (ADM), COO stated Resident 2's discharge was, technically an AMA. During an interview on [DATE] at 10:26 a.m. with the Nursing Supervisor (NS), NS stated she did not see any behaviors from Resident 2 since her admission on [DATE]. When asked what she remembers about Resident 2 NS stated, I can't remember. When asked again, NS stated Resident 2 was restless and had confusion. Resident 2 didn't remember where she was and thought her husband was still alive. During an interview on [DATE] at 10:39 a.m. with the Medical Records Supervisor (MRS), MRS stated when Resident 2 got into the ambulance she asked the medics if they could take her home. MRS also stated Resident 2 was confused and she wanted to go home to be with her husband. During an interview on [DATE] starting at 11:04 a.m. with a Licensed Vocational Nurse (LVN), LVN stated she went to the front of the facility and explained to Resident 2 that if she went out of the building, it's an AMA. LVN also stated that Resident 2 stated, No, I'm leaving. LVN next stated, No, she did not have the AMA form with her and did not sign it until the ED doctor asked for it. During an interview on [DATE] at 11:18 a.m. with ADM, ADM stated she instructed staff to send the face sheet, medication list, and allergies. ADM further stated the AMA form was sent because the doctor at the ED wanted a copy of it. ADM further stated, Yes, it was the AMA form printed earlier that Resident 2 refused to sign. ADM was asked why Resident 2 wasn't allowed to return after the ED visit. ADM stated they never said she wanted to come back. During an interview on [DATE] at 12:05 p.m. with Resident 2's friend (Advocate), Advocate stated on [DATE] before the incident with Resident 2 Advocate was contacted by SSD. Advocate next stated SSD said Resident 2 was running out of Medicare (insurance) and SSD asked Advocate to call around and find other placement for her. Advocate additionally stated, It seems like they wanted to wash their hands of her. Advocate further stated Resident 2 was very confused when she met her at the ED and believes Resident 2 was not able to make a decision to AMA in her state. Advocate stated since 2006 Resident has become more confused. It takes some time talking to her in order for her to come back to the current time and Resident 2 can reorient for only short periods. Advocate said Resident 2 wanted to return to the facility. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 5:09 p.m. with the facility physician (PHY), PHY stated Resident 2 was probable not capable of making the AMA decision at the time of the incident. PHY next stated she did not assess Resident 2 to determine if she could return to the facility. PHY stated she spoke with the ED physician twice. The ED physician evaluated Resident 2 and thought she was OK to return to the facility. The ED physician thought Resident 2's behavior was related to her stroke. PHY additionally stated she called the ADM who said Resident 2 was not able to return because she AMA'ed to the nurse and the police. PHY was asked if there is a service Resident 2 needed that the facility was not able to provide. PHY stated she does not know of one. During an interview on [DATE] starting at 1:48 p.m. with the Ombudsman (OMB), OMB stated they did receive a call from SSD on the morning of [DATE] letting them know that SSD thought Resident 2 was going to be a difficult discharge. OMB further stated OMB has heard other families say they got a call from the SSD around day 21 of their Medicare stay with SSD telling them the Medicare is about to end and they needed to find other placement. OMB additionally stated OMB has tried to educate the facility that they cannot tell families they need to find placement for the Residents. During an interview on [DATE] at 4:45 p.m. with ADM, ADM stated Resident 2 left AMA from the facility. ADM stated her staff called 911 and followed the Resident onto the highway because they have a heart and not because they were concerned about her safety. ADM stated they did not provide the hospital with the usual transfer documents because she wasn't transferred, she was an AMA. ADM stated nobody assessed Resident 2 after she was cleared by the ED physician because there wasn't a need to assess her because we weren't accepting her back. During a review of the facility's policy and procedure (P&P) titled, Transfer and Discharge Requirements, undated, the P&P indicated, It is the policy of Compass Health facilities that residents will be allowed to remain in Compass Health facilities unless . The transfer or discharge is necessary for the welfare of the individual resident . the resident's needs cannot be met .The decision for admission is based on the availability of the facility to meet the expressed needs and expectations of the residents to the extent possible . When Compass Health facilities transfers or discharges a resident under any of the above circumstances, appropriate documentation shall be made in the resident's clinical record. All appropriate information will be communicated to the receiving health care institution or provider. During a review of the facility's P&P titled, Against Medical Advice (AMA) Procedure, undated, the P&P indicated, The purpose of this procedure is to ensure that resident is aware of their rights regarding leaving against medical advice. Review of the National Library of Medicine website, https://www.ncbi.nlm.nih.gov/books/NBK430827/, accessed on [DATE], indicated, Informed consent is a cornerstone of medicine, ensuring ethical treatment decisions and patient-centered care . screen patients for factors that may affect their ability to understand and provide informed consent, such as . cognitive impairments, or emotional distress . Informed consent can be challenging in specific situations, such as with patients who have impaired decision-making capacity due to cognitive impairments.

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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 one of three sampled residents (Resident 2) had Ativan (lorazepam -antianxiety medication): 1) administered as ordered by the physician and 2) reported to the physician when the Ativan was not effective. These failures resulted in Resident 2 receiving more Ativan than prescribed, and to a delay in notifying the physician when medication did not appear effective. Findings: Review of [NAME] and [NAME], Tenth Edition, Fundamentals of Nursing, page 607-608 in the section titled, Medication Administration, indicated, To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some ways to an inconsistency in adhering to these seven rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. During a review of Resident 2's Physician Order Sheet (Order), dated 4/2025, the Order indicated: - Ordered 4/4/25, Ativan 0.5 milligrams (mg) tablet oral (po, by mouth) as needed every six hours for anxiety manifested by frequent physical restlessness with impaired regard for safety, such as frequently attempting to stand up impulsively. - Ordered 4/5/25, Ativan 2 mg/ml (milliliter) injection solution. Give 0.5 ml (1 mg) intramuscular (IM) as needed every six hours when the resident is unable to receive po dose. For anxiety manifested by frequent physical restlessness with impaired regard for safety, such as frequently attempting to stand up impulsively. 1) During a concurrent interview and record review on 5/2/25 at 3:45 p.m. with the Director of Nursing (DON), Resident 2's Medication Administration Record (MAR), dated 4/2025 was reviewed. The MAR indicated: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Ativan 0.5 mg tablet by mouth as needed every six hours starting 4/4/25 was administered on 4/11/25 at 4:21 a.m. and 6:30 a.m., two hours and eight minutes apart. DON stated, I could not find a note, indicating the physician was notified of the error. DON further stated, Of course, the nurses should be following the physician's order. -Ativan 2 mg/ml injection solution as needed every six hours, to administer when the resident is unable to receive po dose, was administered 4/7/25 at 3:10 p.m. without the po dose being tried first. DON reviewed Resident 2's medical record for a note indicating the physician was notified of the error and stated she did not see one. DON further stated the nurse should have tried to give it po before IM. 2) During a concurrent interview and record review on 5/2/25 at 3:45 p.m. with the Director of Nursing (DON), Resident 2's Medication Administration Record (MAR), dated 4/2025 was reviewed. The MAR indicated: -Ativan 0.5 mg tablet by mouth as needed every six hours starting 4/4/25 was administered on 4/6/25 at 12 p. m. At 1 p.m. the result was, No Effect. DON reviewed the medical record and did not find any note indicating the physician was notified. DON stated she would expect the nurse to notify the physician.