STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capistrano Beach Care Center	35410 Del Rey Dana Point, CA 92624

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to inform and provide the written information regarding the rights to formulate the advance directives for three of 23 final sampled residents (Residents 20, 46, and 63). * The facility failed to provide documented evidence if the written information and assistance on how to formulate an advanced directive were provided Residents 20, 46, and 63 when the residents did not have an advance directive. This failure had the potential for the residents to not receive the treatment and services based on the residents' wishes. Findings: Review of the facility's P&P titled Advance Directives revised on 9/2022 showed the following: - the residents have the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance Directives are honored in accordance with state law and facility policy; - prior to or upon admission of a resident, the SSD or designee inquires of the resident, his or her family members and/or his or her legal representatives about the existence of any written advance directives; - the resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so; - if the resident or representative indicates he or she had not established an advance directive, the facility staff will offer assistance in establishing an advance directive; and - nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance. 1. Medical record review for Resident 20 was initiated on 11/17/25. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's Advance Healthcare Directive (AHCD) Acknowledgement Form dated 7/15/25, indicated I do not have an AHCD. Review of Resident 20's POLST form dated 7/17/25, the section for Information and Signatures indicated Resident 20 had no advance directive. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 20's H&P examination dated 7/17/25, showed Resident 20 had the capacity to understand and make decisions. Review of Resident 20's MDS assessment dated [DATE], showed Resident 20's BIMS score was 10 (moderate cognitive impairment). On 11/19/25 at 1045 hours, a medical record review and concurrent interview was conducted with the SSD. Resident 20's POLST and AHCD form was reviewed and the SSD. The SSD verified there was no documented evidence the facility had provided the information on how to formulate an advance directive to Resident 20 when Resident 20 did not have an advance directive. The SSD stated she must complete a new social service review assessment after any resident was readmitted to the facility and document if the information was provided to the resident or responsible party on how to formulate an AHCD. On 11/19/25 at 1135 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Medical record review for Resident 46 was initiated on 9/30/25 Resident 46 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 46's POLST dated 8/23/25, the section for Information and Signatures showed Resident 46 had no advanced directive. Review of Resident 46's H&P examination dated 8/25/25, showed Resident 46 had the capacity to understand and make decisions. Review of Resident 46 's MDS assessment dated [DATE], showed Resident 46 had BIMS score of 11 (moderate cognitive impairment). Further review of Resident 46's medical record failed to show the documented evidence if the facility had provided the information and assistance on formulating the advance directive to Resident 46 and/or the resident's representative. 3. Medical record review for Resident 63 was initiated on 9/30/25. Resident 63 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 63's POLST dated 2/25/24, the section for Information and Signatures showed Resident 63 had no advanced directive. Review of Resident 63's H&P examination dated 2/26/25, showed Resident 63 had the capacity to understand and make decisions. Review of Resident 63's MDS assessment dated [DATE], showed Resident 63 had a BIMS score of 13 (cognitively intact). Further review of Resident 63's medical record failed to show the documented evidence if the facility had provided the information and assistance on formulating the advanced directive to Resident 63. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/25 at 0925 hours, an interview and concurrent medical record review for Residents 46 and 63 was conducted with the SSD. The SSD stated the admission nurse will fill out the advance directive acknowledge form, then the SSD would follow up if the resident had an advance directive. If the resident had an advanced directive, the SSD would ask for a copy, and if the residents did not have an advanced directive, the SSD would provide the information on how to formulate an advanced directive. The SSD further stated the information provided would be documented in the Advanced Healthcare Directive Acknowledgement form. The SSD verified there were no documentation in Resident 46 and 63's medical record to show if the facility had provided the information or discussed with the residents on how to formulate an advance directive. On 11/19/25 at 1155 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 46 and 63.

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	055585	A. Building B. Wing	11/19/2025

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the information on how to file a grievance was provided to one final sampled resident (Resident 16) and one nonsampled resident (Resident 48) who participated in the Resident Council meeting. * The facility failed to ensure Residents 16 and 48 was informed on how to file a grievance. This failure had the potential to cause the residents feeling hopeless and may negatively affect their emotional well-being.Findings: Review of the facility's P&P titled Investigating Grievances/Complaints dated 11/2010 showed the facility investigate all grievances and complaints filed with the facility. The investigation report form must be filed with the Administrator or designee and begin investigating grievances and complaints. Copies of all reports will be available to the resident or person acting on behalf of the resident. On 9/30/25 at 1029 hours, a Resident Council Meeting was conducted with the residents in the facility. When asked to whom they would report if they had concerns, the residents responded they would raise their concerns to the administration, they would take time to respond but were able to resolved their concerns. When asked if the residents were aware on how to file a grievance, Resident 16 and 48 replied no and added they did not know how to file a grievance. 1. Medical record review for Resident 16 was initiated on 9/30/25. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's MDS assessment dated [DATE], showed Resident 16's BIMS score of 11 (cognitively intact). 2. Medical record review for Resident 48 was initiated on 9/30/25. Resident 48 was admitted to the facility on [DATE]. Review of Resident 48's H&P examination dated 8/7/25, showed Resident 48 had the capacity to make decisions. Further review of Resident 16 and 48's medical records for failed to show documented evidence if the information on how to file a grievance was provided to the residents. On 9/30/25 at 1120 hours, an interview and concurrent facility document review for Residents 16 and 48 was conducted with the admission Office Manager. The admission Office Manager verified and acknowledged the grievance information was not documented on the admission packet and provided to Residents 16 and 48. On 9/30/25 at 1146 hours, an interview and concurrent facility document review for Residents 16 and 48 was conducted with the SSD. The SSD verified and acknowledged there was no documentation to show the information on how to file a grievance was explained to the Residents 16 and 48. On 10/1/25 at 0903 hours, an interview for Resident 16 and 48 was conducted with the Activity Director. The Activity Director verified and acknowledged there was no documentation if the residents were informed on how to file a grievance and no documentation on providing education regarding the filing of grievance. On 11/19/25 at 1145 hours, the DON was informed and acknowledged the above findings.

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	055585	A. Building B. Wing	11/19/2025

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of six final sampled residents (Residents 46) reviewed for the unnecessary medications were free from the unnecessary medications. * The facility failed to ensure Resident 46's was monitored for the side effects of paroxetine HCl (antidepressant medication). In addition, the facility failed to show documentation of the behavior monitoring for depression. These failures had the potential for the resident to not receive the necessary care due to the delay in the detection of adverse effects and determination of the effectiveness of the psychotropic medication.Findings: Review of the facility's P&P titled Psychotropic Medication Use dated 7/2022 showed the psychotropic medication management includes adequate monitoring for efficacy and adverse consequences; residents receiving psychotropic medications are monitored for adverse consequences. Medical record review for Resident 46 was initiated on 11/17/25. Resident 46 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 46's H&P examination dated 8/25/25, showed the resident had the capacity to understand and make decisions. Review of Resident 46's Order Summary Report showed a physician's order dated 11/6/25, for paroxetine HCl oral tablet 10 mg, give one tablet by mouth one time a day for major depression disorder manifested by verbalization of sadness. Review of Resident 46's Monitoring Record and MAR for November 2025 failed to show documented evidence if Resident 46 was monitored for the side effects of the paroxetine HCl medication use after Resident 46 started taking the medication on 11/7/25. In addition, the document failed to show if Resident 46's behavior was monitored for the verbalization of sadness. On 11/17/25 at 1508 hours, an interview and concurrent medical record review for Resident 46 was conducted with the DON. The DON acknowledged there were no documentation to show the monitoring of the side effects for the paroxetine medication use and no monitoring of the episodes of the depression, to ensure the facility was able to monitor the effectiveness of the medication and for the adverse side effects. The DON verified and acknowledged the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for the resident to attain or maintain the highest practicable well-being for one of two final sampled residents (Resident 4). * The facility failed to ensure the 72 hours monitoring following a change of condition for Resident 4 was completed. This failure posed the risk of the residents not receiving the appropriate care and potential for the delay in providing the necessary care to the residents.Findings: Review of the facility's P&P titled Change in a Resident's Condition or Status revised on 2/2021 showed the following:- our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical or mental condition and status;- prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider including information provided by the Interact SBAR Communication form; and- the nurse will record in the resident's medical record the information relative to changes in the resident's medical or mental condition or status. Medical record review for Resident 4 was initiated on 11/17/25. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 7/28/25, showed Resident 4 had no capacity to understand and make decisions. Review of Resident 4's MDS assessment dated [DATE], showed Resident 4's BIMS score was 99, indicating unable to complete the interview. Review of Resident 4's Change in Condition Evaluation dated 8/16/25 at 2347 hours, showed Resident 4 had low PO intake, consumed approximately 25% of meals, and only sips of water. Further review of Resident 4's medical records failed to show documented evidence if Resident 4's nutritional status was monitored on 8/17 to 8/19/25, after the change in condition on 8/16/25, for having a low PO intake. On 11/18/25 at 1408 hours, an interview and concurrent medical record review was conducted with RN 1. Resident 4's Change in Condition Evaluation dated 8/16/25, and progress notes on dates 8/17 to 8/19/25, was reviewed with RN 1. RN 1 verified the above findings. In addition, RN 1 stated after the completion of the change in condition evaluation, the 72 hours documentation of the monitoring every shift would be completed by the licensed nurses to show the provided care and resident's well-being. On 11/19/25 at 1135 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. Furthermore, the DON stated after the completion of the resident's change in condition evaluation, the licensed nurses would monitor the resident's condition and document in the progress notes every shift for 72 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the resident remained free from accident hazards for one of 23 final sampled resident (Resident 2). * The facility failed to ensure Resident 2 was supervised in Shower room [ROOM NUMBER]. In addition, Shower room [ROOM NUMBER] had no call system available to call the staff for assistance if needed. These failures had the potential to place the resident at risk for accidents and serious injury.Findings: Review of the facility's P&P titled Bath, Shower/Tub revised 2/2018 showed to never leave the resident unattended in the tub or shower and to use the emergency call signal for assistance, if needed. Review of the facility's P&P titled Call System, Residents dated 9/2022 showed the residents are provided with a means to call the staff for assistance from his/her bed and from toileting/bathing facilities through a communication system that directly call a staff member or a centralized workstation. On 11/17/25 at 1122 hours, an observation was conducted of Resident 2. Resident 2 was observed in Shower room [ROOM NUMBER] with the door open. Resident 2 was observed shaving his face using a razor in front of the bathroom mirror by himself. Shower room [ROOM NUMBER] was observed without a call system. On 11/17/25 at 1124 hours, an observation and concurrent interview was conducted with the DSD. The DSD verified Resident 2 was shaving by himself in Shower room [ROOM NUMBER] and there was no call system/call light in-placed in the shower room. Medical record review for Resident 2 was initiated on 11/17/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2 needed supervision or touching assistance from the staff for personal hygiene tasks. Review of Resident 2's Care Plan Report showed the following focused problems:- initiated on 8/22/25, for Resident 2's risk for unavoidable falls related to his history of falls and limited mobility. The interventions included to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, and the resident needs prompt response to all requests for assistance.- initiated on 9/6/25, for Resident 2's ADL maintenance which included personal hygiene assisted by one staff member. The interventions included to have a call light within reach and answer promptly; and to assist Resident 2 to wash face, brush teeth, comb hair, shave, apply lotion, etc. On 11/17/25 at 1140 hours, an interview was conducted with the DON. The DON stated all the residents should not be left alone, unsupervised in the shower room, even if they were independent because there was a risk for falls/injury. On 11/18/25 at 1534 hours, an interview was conducted with the Administrator and DON. The Administrator and DON was made aware and acknowledged the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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	055585	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document and P&P review, the facility failed to ensure the acceptable parameters of nutritional status were maintained for one of four final sampled residents (Resident 72)) reviewed for nutrition status. * The facility failed to ensure the nutritional assessment was completed when Resident 72 weighed 174 pounds (lbs) on 4/8/25. In addition, the facility failed to monitor Resident 72's weight and implemented interventions to address Resident 72's severe weight loss. * The facility failed to conduct a nutritional assessment in a timely manner when Resident 72 weighed 160 lbs on 8/4/25. In addition, the facility failed to closely monitor Resident 72's weight. * The facility failed to ensure the nutritional assessment was completed when Resident 72 weight 155 lbs on 10/3/25. In addition, the facility failed to monitor Resident 72's weekly weights as ordered by the physician. These failures contributed to Resident 72's severe weight loss of 45 lbs/22.50% since admission on [DATE], which could lead to increased medical complications including increased mortality.Findings: Review of the National Library of Medicine professional reference titled An approach to the management of unintentional weight loss in elderly people dated 3/15/25, showed in part, unintentional weight loss, or the involuntary decline in total body weight over time, is common among elderly people who live at home. Weight loss in elderly people can have a deleterious effect on the ability to function and on quality of life and is associated with an increase in mortality over a 12-month period .unintentional weight loss is the involuntary decline in total body weight over time. In clinical practice, it is encountered in up to 8% of all adult outpatients and 27% of frail people 65 years and older. Weight loss is an important risk factor in elderly patients. It is associated with increased mortality, which can range from 9% to as high as 38% within 1 to 2.5 years after weight loss has occurred .Weight loss of 4%-5% or more of body weight within 1 year, or 10% or more over 5-10 years or longer, is associated with increased mortality or morbidity or both. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC552892/ Review of the facility's P&P titled Nutritional Assessment revised October 2017 showed the following:- The dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission and as indicated by a change in condition that places the resident at risk for impaired nutrition; and- The nutritional assessment will be conducted by the multidisciplinary team and shall identify at least the following components under the Dietitian section: (1) an estimate of calorie, protein and fluid needs; and (2) whether the resident's current intake is adequate to meet his or her nutritional needs. Review of the facility's P&P titled Weight Assessment and Intervention revised 3/2022 showed the threshold for significant unplanned and undesirable weight loss will be based on the following criteria:a. one month - 5% weigh loss is significant, greater than 5% is severe;b. three months - 7.5% weight loss is significant, greater than 7.5% is severe; and c. six months - 10% weight loss is significant, greater than 10% is severe. The P&P section for Evaluation showed undesirable weight change is evaluated by the treatment team whether or not the criteria for significant weight change has been met. The evaluation included the resident's target weight range (including rationale if different from ideal body weight), and resident's calorie, protein and other nutrient needs compared with the resident's current intake. The section for Interventions showed the interventions for undesirable weight loss are based on careful consideration which included the resident choice and preferences, nutrition and hydration need of the resident, functional factors that may inhibit independent eating, chewing and swallowing abnormalities and the need for diet modifications and medications that may interfere with appetite , chewing, swallowing, or digestion. Medical record review for Resident 72 was initiated on 10/1/25. Resident 72 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 72's diagnoses included type two diabetes mellitus, dysphagia, and NSTEMI. Review of Resident 72's H&P examination dated 1/31/25, showed Resident 72 had no capacity to make medical decisions. The H&P further showed Resident 72 weighed 200 lbs. Review of Resident 72's Care Plan Report showed the following focused problems:- initiated on 1/31/25, addressing the resident's high risk for malnutrition related to variable PO intake, weakness and deconditioning. The interventions included to consult a dietician per order; and- initiated on 4/17/25 and revised on 7/31/25, addressing the resident's high nutritional risk and/or fluid deficit related to poor/variable meal intake, recent weight loss and at risk for further weight loss. The interventions included for the RD to assess nutritional and hydration needs PRN. Review of Resident 72's Weights and Vitals Summary showed the following weights:- dated 1/31/25 = 200 lbs;- dated 2/7/25 = 198 lbs;- dated 3/11/25 = 184 lbs; and- dated 4/8/25 = 174 lbs (a sever weight loss of 10 lbs/5.4% in one month;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capistrano Beach Care Center	35410 Del Rey Dana Point, CA 92624

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care and services for two of two final sampled residents (Residents 13 and 14) reviewed for oxygen therapy. * The facility failed to ensure Resident 13 received oxygen therapy as ordered by the physician's order. * The facility failed to ensure the oxygen tubing for Resident 14 was labeled with the date. These failures had the potential for the residents not to receive the appropriate respiratory care and may negatively impact the residents' medical conditions.Findings: Review of the facility's P&P titled Oxygen Administration revised 10/2010 showed under the preparation section, to verify there is a physician's order for this procedure and to review the physician's orders or facility protocol for oxygen administration. Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head. 1. On 9/29/25 at 0853 hours, during the initial tour of the facility, an observation was conducted in Resident 13's room. Resident 13 was observed lying in bed receiving oxygen therapy via nasal cannula at three liters per minute. The nasal cannula was observed on Resident 13's chest. On 9/29/25 at 0907 hours, an observation and concurrent interview was conducted with the MDS Coordinator in Resident 13's room. The MDS coordinator verified Resident 13 oxygen concentrator was turned on, however; the oxygen nasal cannula was not on the Resident 13 nose. Medical record review for Resident 13 was initiated on 9/29/25. Resident 13 was admitted to the facility on [DATE], and was readmitted to the facility on [DATE]. Review of Resident 13's Order Summary Report showed a physician's order dated 1/20/25, for the continuous oxygen to be administered at two liters per minute up to four liters per minute via nasal cannula to maintain an oxygen saturation above 90%. Review of Resident 13's MDS assessment dated [DATE], the section for Functional Limitation in Range of Motion showed Resident 13 had impairment on both side of the upper extremity (shoulder, elbow, wrist and hands). On 11/17/25 at 1450 hours, a follow-up observation was conducted with Resident 13. Resident 13 was observed with the oxygen concentrator turned on at a rate of five liters per minute. On 11/17/25 at 1456 hours, an observation and concurrent interview was conducted with LVN 3 in Resident 13's room. LVN 3 verified Resident 13's oxygen concentrator was on at a rate of at five liters per minute. On 11/17/25 at 1459 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified Resident 13 had a physician's order for oxygen administration at a rate of two liters per minute up to four liter per minute via nasal cannula continuously to maintain an oxygen saturation above 90% . LVN 3 stated she did not know who changed the oxygen rate to five liters per minute. On 11/19/25 at 1052 hours, an interview was conducted with DON and Administrator. The DON and Administrator verified and acknowledged above findings. 2. On 9/29/25 at 1224 hours, an observation was conducted for Resident 14. Resident 14 was observed in the dining room using the oxygen via nasal cannula. However, Resident 14's oxygen tubing was observed with no date label. Medical record review for Resident 14 was initiated on 9/29/25. Resident 14 was admitted to the facility on [DATE] and was readmitted on [DATE]. Review of Resident 14's Order Summary Report showed the following physician's order:- dated 7/11/24, to administer continuous oxygen at two liters per minute to three liters per minute via nasal cannula; and- dated 6/10/25, to change the oxygen humidifier and nasal cannula/tubing every week on Sundays and PRN (label with date). On 9/29/25 at 1230 hours, an observation and concurrent interview was conducted with the IP. The IP verified Resident 14's oxygen tubing was undated. The IP further stated the oxygen tubing were changed every Sunday, and all oxygen tubing should be labeled with the date when it was changed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the pharmaceutical services to meet the resident's needs for three of three final sampled residents (Resident 2, 20, and 69) reviewed for the unnecessary medications. * The facility failed to ensure the insulin (medication to lower the blood sugar) injection administration sites were rotated for Residents 2 and 20. * The facility failed to ensure the Zosyn (antibiotic) IV medication was administered to Resident 69. These failures had the potential for the residents to not receive the necessary medications and could negatively affect the residents' well- being. Findings: Review of the facility's P&P titled Insulin Administration revised on 9/2014 showed the following: - to provide guidelines for the safe administration of insulin to residents with diabetes; - select an injection site. Insulin may be injected into the subcutaneous tissue of the upper arm and anterior or lateral areas of the thighs and abdomen. Avoid the area approximately two inches around the navel; - injection sites should be rotated, preferably within the same general area (abdomen, thigh or upper arm); and - document the injection site for presence or absence of any bruising, pain, redness, swelling, or unusual marks on or near the injection site. 1. Medical record review for Resident 20 was initiated on 11/17/25. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's H&P examination dated 7/17/25, showed Resident 20 had the capacity to understand and make decisions. Review of Resident 20's Order Summary Report showed a physician's order dated 7/15/25, for Humalog insulin (a rapid acting insulin used to control blood glucose) injection solution 100 unit per ml, inject as per sliding scale subcutaneously before meals and at bedtime for Diabetes Mellitus. Review of Resident 20's Location of Administration Report for September 2025 showed the Humalog insulin was administered subcutaneously on Resident 20's left lower quadrant (LLQ) of the abdomen on the following date and times: - 9/24/25 at 1630 and 2100 hours; - 9/25/25 at 0630, 1630, and 2100 hours; and - 9/27/25 at 1130, 1630 and 2100 hours. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/17/25 at 0945 hours, an interview and concurrent medical record review was conducted with LVN 4. Resident 20's Location of Administration Report for September 2025 was reviewed with LVN 4, which showed the insulin injection sites were not rotated on 9/24, 9/25, and 9/27/25. LVN 4 verified the above findings. LVN 4 stated the insulin injection sites must be rotated because it would cause swelling, pain, bruising, and poor absorption of the medication. On 11/19/25 at 1135 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. Medical record review for Resident 2 was initiated on 9/17/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 8/20/25, showed Resident 2 had the capacity to make decisions. Review of Resident 2's Order Summary Report showed a physician's order dated 8/18/25, to administer Sem [NAME] Subcutaneous Solution 100 unit/ml (Insulin Glargine) 8 unit subcutaneously at bedtime for Diabetes Mellitus; and Humalog Injection Solution 100 unit/ml (Insulin Lispro) subcutaneously as per sliding scale before meals and at bedtime for Diabetes Mellitus. Review of Resident 2's Location of Administration Report for October 2025 showed the Humalog Insulin was administered on the following sites: a. left lower quadrant of the abdomen on the following date and times: - 10/1/25 at 1615 and 2043 hours, - 10/2/25 at 1642 and 2323 hours; - 10/3/25 at 0647 hours; and - 10/7/25 at 1924 and 2224 hours; b. left deltoid on the following date and times: - 10/9/25 at 1705 hours and 2050 hours; and - 10/23/25 at 1616 and 2151 hours. c. left upper quadrant of the abdomen on 10/21/25 at 1145 and 1722 hours. On 11/19/25 at 1110 hours, an interview and concurrent medical record review for Resident 2 was conducted with LVN 2. LVN 2 verified Resident 2 had an insulin injection and the insulin injection sites should be rotated to avoid the scarring of the skin that will affect the absorption of the insulin medication. LVN 2 verified and acknowledged Resident 2's insulin injection sites were not rotated. (continued on next page)

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	055585	A. Building B. Wing	11/19/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/25 at 1114 hours, an interview and concurrent medical record review for Resident 2 was conducted with RN 2. RN 2 stated she was responsible for the implementation of the care of the residents including the monitoring of the residents medication. RN 2 stated the insulin administration sites should be rotated to prevent any complications such as skin scarring that will affect the absorption of the insulin medication. RN 2 verified and acknowledged Resident 2's insulin administration injection sites were not rotated. On 11/19/25 at 1355 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. The DON was informed and verified the findings. 3. Review of facility's P&P titled Documentation of Medication Administration revised 4/2007 showed the facility shall maintain a medication administration record to document all the medications administered; a nurse shall document all medication administered to each resident on the resident's medication administration record (MAR). Medical record review for Resident 69 was initiated 11/17/25. Resident 69 was admitted to the facility on [DATE]. Review of Resident 69's MDS assessment dated [DATE], showed the resident's BIMS score was 12 (cognitively intact). Review of Resident 69's Order Summary Report showed a physician's order dated 9/10/25, to administer Zosyn (antibiotics) 3-0.375 gm/50 ml intravenously every eight hours for right foot osteomyelitis for 35 days. Review of Resident 69's MAR for September 2025 failed to show the documentation of Zosyn medication administration on 9/18/25 at 1400 hours and 9/28/25 at 2200 hours. On 11/17/25 at 1007 hours, an interview and concurrent medical record review for Resident 69 was conducted with the DON. The DON verified there were no documentation on Resident 69's MAR to show the Zosyn medication was administered to the resident on 9/18 and 9/28/25. The DON further stated the administration of any medication should be documented in the MAR. The DON was informed and acknowledged the above findings.

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	055585	A. Building B. Wing	11/19/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of three residents (nonsampled resident, Resident 40) observed for medication administration was free from the significant medication errors. * LVN 5 did not check the resident's pulse rate prior to the administration of the metoprolol (a medication to lower blood pressure) to Resident 40. This failure had the potential to negatively impact the resident's health and well-being.Findings: Review of the facility's P&P titled Administering Oral Medications revised 10/2010 showed to verify that there is a physician's medication order for this procedure and perform any pre-administration assessments. On 10/1/25 at 0828 hours, a medication administration observation for Resident 40 was conducted with LVN 5. LVN 5 was observed checking Resident 40's blood pressure prior to the medication administration, then prepared Resident 40's medications including the metoprolol 12.5 mg one tablet. The metoprolol medication bubble pack had a direction to hold the medication if the SBP (systolic blood pressure) was less than 110 mmHg or pulse rate was less than 60 beats per minute. LVN 5 checked the resident's blood pressure but did not check Resident 40's pulse rate. On 10/1/25 at 0846 hours, LVN 5 stated she was ready and proceeded to Resident 40 to administer her medications. LVN 5 had started to administer one of the medications and was asked if she would give all of the prepared medications to Resident 40. LVN 5 stated yes. LVN 5 was asked to stop administering the metoprolol medication to Resident 40. LVN 5 was informed and acknowledged she did not check Resident 40's pulse rate. LVN 5 verified there was an order to check Resident 40's pulse rate and hold the metoprolol medication if the pulse rate was less than 60 beats per minute. Medical record review for Resident 40 was initiated on 9/29/25. Resident 40 was admitted to the facility on [DATE]. Review of Resident 40's Order Summary Report showed a physician's order dated 4/16/24, to administer metoprolol tartrate give 12.5 mg one tablet by mouth two times a day for hypertension and hold if the SBP was below 110 mmHg or pulse rate was below 60 beats per minute. On 11//18/25 at 1442 hours, an interview was conducted with DON. The DON was made aware and acknowledged the above findings. The DON stated if there was a physician's order to check the blood pressure and pulse rate and hold the medication if the SBP was below 110 mmHg or pulse rate was below 60 beats per minute, the licensed nurses need to assess both the blood pressure and the pulse rate of the resident. On 11/19/25 at 1052 hours, an interview was conducted with the DON and Administrator. The DON and Administrator was made aware and acknowledged above findings.

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	055585	A. Building B. Wing	11/19/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and facility P&P review, the facility failed to ensure the medications/supplies in the medication room and medication cart were store properly. * The facility failed to ensure the expired Covid-19 Binax Now (a test to detect Covid-19) were removed from Medication Room A. In addition, the facility failed to ensure the oral medications were stored separately from the externally used medications. * The facility failed to ensure the expired bottles of the 0.9% normal saline solutions were removed from Medication Cart A. These failures had the potential for medication errors and the use of the expired medications/supplies which could negatively impact the residents' well-being.Findings: Review of the facility's P&P titled Medication Storage in the Facility (undated) showed the outdated, contaminated or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists, and orally administered medication are kept separate from externally used medication, such as suppositories, liquid, and lotions. 1. On 10/1/25 at 0956 hours, an inspection of Medication Room A and concurrent interview was conducted with RN 2. During the inspection the following were observed in Medication Room A:- 20 individual packages of Covid-19 Binax Now, with expiration date of 9/23/23; and- enema (a laxative solution given per rectum) was observed in the same cabinet with the orally administered Geri-Lanta (antacids) and calcium tablets (supplement). RN 2 verified the above findings and stated any expired supply needs to be discarded according to the facility protocol. RN 2 further stated the external and internal medications needed to be separated and not stored in the same cabinet. 2. On 10/1/25 at 1123 hours, a medication cart inspection for Medication Cart A and concurrent interview was conducted with RN 2. During the inspection, two sterile bottles of 0.9% normal saline 100 ml were observed inside Medication Cart A. One bottle was expired on 2/13/21, and the other bottle was expired on 4/1/22. RN 2 verified the findings and stated any expired supply needs to be discarded according to the facility protocol. On 11/18/25 at 1442 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated the R N supervisors need to check the medication room in a daily basis for any expired medication or supply. The DON further stated the medication cart should be checked by the licensed nurses for any expired medication and any expired medications should have been discarded. On 11/19/25 at 1052 hours, an interview was conducted with the DON and Administrator. The DON and Administrator was made aware and acknowledged above findings.

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	055585	A. Building B. Wing	11/19/2025

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview, and facility document review, the facility failed to employ a staff with the skills and abilities to effectively implement the departmental processes in accordance with standards of practice in the food services department. * The facility failed to ensure the Dietary Manager was competent in managing the day-to-day functions of the food services department. This failure had the potential to jeopardize the health and well-being of the 77 residents who received food prepared in the kitchen.Findings: Review of the facility's Matrix showed 77 residents consumed food prepared in the kitchen. Review of the facility's document titled Dietary Manager dated 6/25/24, the section for Position Summary showed the purpose of your job position is to organize, plan and supervise the dietary department functions in accordance with current applicable federal, state, and local standards that govern the facility and as directed by the Administrator and Dietitian. During the annual recertification survey from 9/29 to 10/1/25, 11/17, and 11/18/25, multiple issues were found in the kitchen including: the proper hand hygiene was not performed during meal preparation, sanitizing test strips were not available to test the sanitizing solution and the sanitizing log was not complete, resident nutritional supplements were not stored appropriately, hair restraints were not donned by the kitchen staff, food stored in the resident nourishment refrigerator was not dated or stored at the proper temperature, employee personal items were not stored appropriately, expired food was not discarded, food stored in the walk-in freezer was not covered, a kitchen employee was observed eating in the kitchen, food in the dry storage area was not stored appropriately, food preparation equipment and utensils were not clean or in good working condition, non-food contact surfaces were not in good working condition, food preparation equipment was not air dried, the appropriate food texture was not served, the menu was not followed, a meal entree substitute was not equivalent in nutrient value to the main entree served, one kitchen employee was not competent in their job duties, kitchen equipment was not in good working order, and flies were observed in the kitchen. On 10/01/2025 at 0911 hours, an interview was conducted with the Administrator. When asked how the Administrator ensured his department managers were competent in their job duties, the Administrator stated all the managers should be experts in their area of supervision. The Administrator stated he relied on the Registered Dietitian for feedback on the Dietary Manager's job performance. Cross references to F812 examples #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #13, #14, #15; F805; F803; F806; F802; F908, and F925.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure one of 14 kitchen staff members (Cook 2) had the appropriate skill set necessary to safely perform the manual dishwashing. * The facility failed to ensure [NAME] 2 was competent to describe or demonstrate the manual dishwashing process. This failure had the potential for the residents' dishes to not be washed correctly which could lead to sanitation concerns.Findings: Review of the facility's P&P titled 3-Compartment Procedure for Manual Dishwashing dated 2023 showed the following:- The first compartment is for washing. Fill the first compartment with detergent per manufacturer's instructions and hot water (110 to 120 degrees Fahrenheit);- The second compartment is for rinsing. Fill the second compartment with clean, clear hot water (110 to 120 degrees Fahrenheit); and- The third compartment is for sanitizing. Fill the third compartment with Sani Tech solution (a cleaning solution) from the dispenser. Test the concentration with the appropriate test strip, which is dipped in the sanitizer solution for ten seconds before reading. The test strip must read 200 to 400 ppm. Immerse all washed items for sixty seconds. Review of the facility's document titled Inservice Lesson Plan and Attendance Record for Sanitation Procedures for Dietary Kitchen Staff in-service dated 6/11/25, showed [NAME] 2 was in attendance of the in-service. The handout showed the in-service training purpose was to ensure all dietary staff understand and follow proper sanitizing procedures to maintain food safety and meet California Health and Safety Code requirement. On 9/30/25 at 0844 hours, an observation and concurrent interview was conducted with [NAME] 2 and Dietary Manager. [NAME] 2 was asked to describe the manual dishwashing process. [NAME] 2 stated the first compartment was used to wash items, the second compartment was used to rinse items, and the third compartment was used to sanitize items. When asked what the minimum temperature for the hot water used during the manual dishwashing, [NAME] 2 was unable to answer. When asked for how long the items needed to be sanitized for, [NAME] 2 stated the items could stay in the compartment for a long time. [NAME] 2 was asked to demonstrate how to test the sanitizing solution. [NAME] 2 used a test strip and dipped the strip in the sanitizer solution for one second, instead of 10 seconds. The RCDM verified and acknowledged the above findings.

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	055585	A. Building B. Wing	11/19/2025

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and facility document review, the facility failed to ensure the menu to meet the resident's nutritional needs was followed for one of 77 residents (Resident 23). * The facility failed to ensure Resident 23 was provided with the high caloric pudding and whole milk on her lunch tray. This failure had the potential to not meet the resident's nutritional needs.Findings: Review of the facility's Matrix showed 77 residents consumed food prepared in the kitchen. On 9/29/25 at 1238 hours, during the dining observation, Resident 23's lunch meal ticket showed Resident 23 was on a controlled carbohydrate diet with pureed texture. The meal ticket indicated for Resident 23 to have a high caloric pudding and 8 fluid ounces of nectar - mildly thick whole milk. However, Resident 23's lunch tray did not contain the high caloric pudding and whole milk. An observation, interview and concurrent meal ticket review was conducted with the MDS Coordinator in the dining room. The MDS Coordinator verified Resident 23 was not provided with the high caloric pudding and whole milk in her lunch tray. On 11/18/25 at 1534 hours, an interview was conducted with the Administrator, DON, and RCDM. The Administrator, DON, and RCDM was made aware and acknowledged the above findings.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility document review, the facility failed to ensure the food served was in accordance with the prescribed diet texture to one of 23 final sampled residents (Resident 12). * The facility failed to provide Resident 12's diet was according to the physician's order. This failure posed a risk for the resident to not tolerate the food texture and choke.Findings: Medical record review of Resident 12 was initiated on 9/29/25. Resident 12 was admitted to the facility on [DATE], with diagnoses which included COPD and dysphagia. Review of Resident 12's Order Summary Report showed a physician's order dated 9/15/25, for Regular Diet, Soft and Bite-Sized Level 6 texture, vegetarian, no salad entree and may give grilled cheese, allow regular bread and toast. Review of the facility's document titled 2023/2025 Diet Manual, the IDDSI (International Dysphagia Diet Standardization Initiative) Level 6: Soft & Bite-Sized Diet showed to avoid all raw vegetables. On 9/29/25 at 1225 hours, during the dining observation, Res 12 was observed with a small, tossed salad with croutons, fresh chopped cantaloupe melon, cooked green beans, a grilled cheese sandwich and chocolate pudding for her lunch meal. On 10/1/25 at 1510 hours, an interview and concurrent record review was conducted with the RCDM. The RCDM acknowledged raw vegetables were not allowed on a Soft and Bite-Sized texture diet. The RCDM stated Resident 12 had an order to allow fresh fruits and vegetables. When asked about the physician's order, the RCDM was not able to find a physician's order for Resident 12 to have fresh fruits and vegetables.

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	055585	A. Building B. Wing	11/19/2025

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility document review, the facility failed to ensure the resident was served a substitute meal entree that was equivalent to the nutritive value of the main meal entree for one of 23 final sampled residents (Resident 12). * The facility failed to ensure Resident 12 received a substitute meal entree equivalent to the main meal entree of three ounce baked chicken. This failure had the potential for the resident to not receive a meal to meet the resident's needs.Findings: Medical record review of Resident 12 was initiated on 9/29/25. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's Order Summary Report showed a physician's order dated 9/15/25, for Regular Diet, Soft and Bite-Sized Level 6 texture, vegetarian, no salad entree and may give grilled cheese, allow regular bread and toast. On 9/30/25 at 1227 hours, an observation of the lunch meal tray line and concurrent interview was conducted with [NAME] 1. [NAME] 1 was preparing a grilled cheese sandwich. [NAME] 1 placed three slices of the American cheese between two slices of bread, then [NAME] 1 added another slice of American cheese to the sandwich. [NAME] 1 was asked why he added another slice of American cheese and [NAME] 1 stated the RCDM told him to add another slice of American cheese. On 9/30/25 at 1300 hours, an observation was conducted for Resident 12. Resident 12 was served a grilled cheese sandwich in placed of the three ounces of the soft and bite-sized baked chicken for her entree. Review of the facility's document titled Cooks Spreadsheet dated 9/30/25, showed for the lunch meal, the Soft and Bite-Sized diet should be served with three ounces of baked chicken. Review of the nutritional analysis provided by the facility for the baked chicken served at lunch on 9/30/25, showed the 100 grams (3.5 ounces) provided 25 grams of protein; therefore, the three ounces of baked chicken would provide 21 grams of protein. Review of the nutritional analysis located on the packaging of the American cheese used to make the grilled cheese sandwich served to Resident 12 on 9/30/25, showed the one slice of American cheese would provide three grams of protein; therefore, the four slices of American cheese would provide 12 grams of protein. Therefore, when Resident 12 was served a substitute meal entree of grilled cheese sandwich on 9/30/25, Resident 12 only received 12 grams of protein instead of 21 grams of protein. On 11/18/25 at 1534 hours, an interview was conducted with the Administrator, DON, and RCDM. The Administrator, DON, and RCDM was made aware and acknowledged the above findings.

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	055585	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capistrano Beach Care Center	35410 Del Rey Dana Point, CA 92624

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure the adaptive equipment was used properly for one nonsampled resident (Resident 23). * The facility failed to ensure the plate guard was placed on Resident 23's plate during meals. This failure posed the risk for Resident 23 to not reach her maximum level of independence.Findings: On 9/29/25 at 1216 hours, during the dining observation, Resident 23 was observed having lunch in the dining room. Resident 23's plate guard was placed under the plate. Resident 23's meal ticket showed to have the plate guard as an adaptive equipment. Medical Record Review for Resident 23 was initiated on 9/29/25. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's Order Summary Report showed a physician's order dated 6/11/25, for the resident to have a plate guard for all meals to increase independence with self-feeding. On 9/30/25 at 1300 hours, an observation and concurrent interview was conducted with the Dietary Manager and RCDM. The RCDM stated the plate guard was an order from occupational therapy and was used when the resident had tremors. The RCDM verified the above findings and stated the plate guard should have been placed on the plate to guard the food.

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	055585	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capistrano Beach Care Center	35410 Del Rey Dana Point, CA 92624

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capistrano Beach Care Center	35410 Del Rey Dana Point, CA 92624

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed. 1. One of 14 kitchen employees did not perform hand hygiene during food preparation.2. The sanitizing test strips were not available to test the sanitizing solution and sanitizing solution log was incomplete.3. The residents' nutritional supplements were not stored appropriately.4. The hair restraints were not utilized by kitchen staff.5. The food stored in the nourishment refrigerator was not stored at the proper temperature.6. The employee's personal items were not stored appropriately.7. The expired food was not discarded and food was not dated.8. The food in the nourishment refrigerator was not dated.9. The food was not covered in the walk-in freezer.10. One of fourteen kitchen employees was observed eating in the kitchen.11. The food in the dry storage area was not stored appropriately.12. The ice packs intended for residents' personal use were stored with the food in the nourishment refrigerator. 13. The food preparation equipment and utensils were not clean or in good working condition.14. The non-food contact surfaces were not in good working condition.15. The food preparation equipment was not air-dried. These failures posed the risk for food borne illnesses in a highly susceptible resident population of 77 facility residents who received food prepared in the kitchen.Findings: Review of the facility matrix showed 77 of 77 residents who resided in the facility consumed food prepared in the kitchen. 1. Review of the facility's P&P titled Hand Washing Procedure dated 2023 showed hand washing is important to prevent the spread of infection. Employees must wash their hands:- before starting work in the kitchen;- after handling soiled dishes and utensils;- before and after doing housekeeping procedures;- before and after handling foods with hands (cutting peeling, mixing, etc.);- after going to the toilet, after sneezing, after using a handkerchief or tissue or after touching your hair or face;- before and after eating or smoking;- after leaving a resident's room; and- touching trash can or lid. On 9/30/25 at 1210 hours, an observation was conducted in the kitchen. [NAME] 1 was observed wearing gloves while he opened the refrigerator, touched multiple counter surfaces, and then [NAME] 1 began to cut the raw onions, lettuce, and tomato. [NAME] 1 was not observed performing hand hygiene or changing his gloves. The Dietary Manager was made aware and informed [NAME] 1 to perform hand hygiene and put on new gloves. 2. Review of the facility's P&P titled Quaternary Ammonium Log Policy dated 2023 showed the following:- Test the concentration of the sanitation solution per the instructions on the test strips; and- Test the sanitation solution at least every shift and record the readings twice a day. On 9/29/25 at 0908 hours, an observation and interview was conducted in the kitchen with Dietary Aide 1. Dietary Aide 1 was asked to provide the ammonia quaternary test strips to test the sanitizing solution in the red bucket. Dietary Aide1 stated the test strips provided were unusable because the strips inside the container were wet. On 9/29/25 at 0910 hours, the Dietary Manager stated they did not have extra test strips for the ammonia sanitizing solution. On 9/29/25 at 1010 hours, an interview and facility document review was conducted with the Dietary Manager in the kitchen. The Dietary Manager verified the Quaternary Ammonium Log had missing entries for 9/28 and 9/29/25. 3. Review of the facility's P&P titled Procedure for Refrigerated Storage dated 2023 showed the supplemental shakes which are taken from the frozen state and thawed in the refrigerator must be dated as soon as they are placed in the refrigerator. On 9/29/25 at 0845 hours, an observation and concurrent interview was conducted with the Dietary Manager in the walk-in refrigerator of the kitchen. An opened box containing the individual health shakes had a received and use by date written on the box. The health shake box had manufacturer's instructions to store frozen or thaw at or below 40 degrees Fahrenheit, and to use the thawed products within 14 days. The box was observed without a date label on when the health shakes were removed from the freezer. The Dietary Manager verified the box did not have a date when the health shakes were pulled out from the freezer. When asked about the thawing process of the health shakes, the Dietary Manager stated he did not know for how long the health shakes could be stored in the refrigerator once transferred out from the freezer. The Dietary Manager further stated he did not have a system in place to monitor the dates of the health shakes once they thawed. 4. Review of the facility's P&P titled Dress Code dated 2023 showed the appearance is very important in maintaining a high standard of food service. Proper dress code included hair nets for hair and if applicable, beards and any facial hair must wear a beard restraint.a. On 9/30/25 at 1148 hours, an observation was conducted the kitchen during the tray line preparation. Dietary Aide 6 was observed with uncovered hair while she worked in the food preparation area.b. On 9/30/25 at 1152 hours, an observation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on interview and facility P&P review, the facility failed to ensure safe food handling of the food brought for the residents from the outside sources. * The facility failed to ensure the visitors who brought food for the residents from outside sources and employees who handled the outside food were educated on safe food handling. This failure poses the risk of food contamination which could lead to food borne illnesses to all 77 residents who resided in the facility. Findings: Review of the facility's P&P titled Food Brought by Family and Visitors revised on 3/2022 showed the safe food handling practices are explained to family/visitors in a language and format they understand. On 9/30/25 at 0900 hours, an interview was conducted with LVN 6. LVN 6 was asked to explain the process when the visitors would bring food for the residents from the outside sources, LVN 6 stated they would check the diet order and tell the visitors the food must be labeled. When asked for how long the food brought in from the outside source could stay in the refrigerator, LVN 6 stated he was not sure on how long the food could be stored in the refrigerator. LVN 6 was asked if he received in-service training on safe food handling, LVN 6 stated the Dietary Manager provided the training on safe food handling. On 10/1/25 at 1033 hours, an interview was conducted with the IP. When asked if he conducted in-service training on safe food handling related to the food brought in from outside sources, the IP stated the in-service was about dating the food. The IP further stated he provided the P&P titled Food Brought by Family and Visitors to the employees. When asked how the visitors were educated on safe food handling, the IP stated the Dietary Manager would discuss safe food handling with the family members upon admission or quarterly. On 10/1/25 at 1050 hours, an interview was conducted with the Dietary Manager. The Dietary Manager stated he was not involved in educating the visitors or family members on safe food handling related to the food brought in from outside sources. The Dietary Manager further stated he had never been asked to provide such training for the visitors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and facility P&P review, the facility failed to ensure the refuse was stored in a sanitary manner. * The facility failed to ensure the two of two garbage dumpsters' lid and one of one recycling dumpster's lid were fully closed. * The facility failed to ensure the broken items/equipment were disposed of properly. These failures had the potential for pest contamination.Findings: According to the USDA Food Code 2022, Chapter 5 Water, Plumbing, and Waste, Section 5-501.113 Covering Receptacles showed outside garbage receptacles shall be kept covered with tight-fitting lids or covers. Review of the facility's P&P titled Miscellaneous Areas dated 2023 showed the garbage and trashcans must be inspected daily, no debris is on the ground or surrounding area, and that the lids are closed. The trash collection area is a potential feeding ground for vermin and rodents and must be kept clean. 1. On 9/29/25 at 1139 hours, an observation was conducted of the facility's outside recycling dumpster and two outside garbage dumpsters. The recycling dumpster was observed with the lid partially propped open by a cardboard box, preventing the lid from fully closing. The two garbage dumpsters were observed with the lid partially propped open by the garbage bags, preventing the lid from fully closing. On 9/29/25 at 1143 hours, an observation and interview was conducted with the Maintenance Director at the facility's trash collection area. The Maintenance Director verified the above findings and stated the dumpster lids should be fully closed. 2. On 9/29/25 at 1140 hours, an observation was conducted at the facility's trash collection area. The following were observed:- more than five large wooden crates adjacent to the recycling dumpster;- a shower chair, bedside table, two long wooden tables were observed behind the metal storage container in the facility compound; and- five bed frames and a front wheel walker was observed behind the facility building. On 9/29/25 at 1143 hours, an observation and concurrent interview was conducted with the Maintenance Director. The Maintenance Director verified the above findings and stated the items behind the facility were broken equipment, but he would try to save the parts he could reuse. The Maintenance Director further stated the equipment behind the storage container were not being used and needed to be discarded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and facility document review, the facility failed to ensure the Facility Assessment was complete. * The facility failed to ensure the Facility Assessment addressed or included the active involvement of required individuals in developing the Facility Assessment, a plan to maximize recruitment and retention of direct care staff, and a contingency plan for staffing needs. These failures had the potential to not meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed.Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. Also included the staffing resources necessary to care for the residents, including the weekends; a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for staffing needs for the events not to activate the facility's emergency plan. Review of the Facility's Assessment reviewed on 8/21/25, did not show the direct care staff member, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment, a plan to maximize recruitment and retention of the direct care staff, and a contingency plan for staffing needs. On 9/30/25 at 1031 hours, an interview and concurrent Facility Assessment document review was conducted with the Administrator. The Administrator reviewed the Facility Assessment review dated 8/21/25, and verified there were no direct care staff, direct care representatives, residents' representatives, and family members actively involved in developing the Facility Assessment. The Administrator further verified there were no documentation of a plan to maximize recruitment and a contingency plan for staffing needs in the Facility Assessment. The Administrator stated she was not aware of the current guidance. The Administrator verified and acknowledged the Facility Assessment was not complete and updated based on the latest guidance from the CMS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capistrano Beach Care Center	35410 Del Rey Dana Point, CA 92624

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to maintain an accurate medical record for one of 23 final sampled residents (Resident 5). * Resident 5's medical record had conflicting documented information as to whether Resident 5 had formulated an advance directive for health care. This failure had the potential for not meeting Resident 5's requests specific to his healthcare.Findings: Medical record review for Resident 5 was initiated on 11/17/25. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's Advanced Healthcare Directive Acknowledgement Form dated 9/8/25, showed Resident 5 had not formulated an advanced directive. Review of Resident 5's POLST dated 9/8/25, showed Resident 5's advance directive was not available. On 11/17/25 at 1449 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD verified Resident 5's Advanced Healthcare Directive Acknowledgement Form dated 9/8/25, showed Resident 5 had not formulated an advanced directive. However, Resident 5's POLST dated 9/8/25, showed Resident 5's advanced directive was not available. The SSD verified Resident 5's medical record showed conflicting documented information as to whether Resident 5 had formulated an advanced directive. The SSD stated she would contact Resident 5's responsible party to determine whether Resident 5 had formulated an advanced directive. The SSD stated if she determined Resident 5 had formulated an advanced directive, she would then request a copy and ensure the advanced directive was included in Resident 5's medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to implement their infection control program in accordance with the facility's P&P. * The facility failed to implement their infection control surveillance program for the months of January through November 2025. The facility conducted surveillance of resident infections based on whether the residents were prescribed antimicrobial medications. The facility failed to determine whether the residents who exhibited signs and symptoms of infection and were not prescribed antimicrobial medications met the facility's criteria for infection (utilizing McGeer's Criteria) and thus, failed to include these residents in the facility's infection control surveillance program. This failure posed the risk for not identifying the residents' infections and controlling the potential transmission of communicable diseases to other residents throughout the facility. * The facility failed to establish specific testing protocols and acceptable ranges for control measures, to reduce Legionella risk. This failure posed the risk for Legionella growth in the facility building water system. Legionella has the potential to cause a serious type of pneumonia called Legionnaires disease in the vulnerable resident population. * LVN 7 failed to ensure the contaminated equipment was disinfected prior to use on Resident 42. This failure posed the risk for the spread of pathogens.Findings: 1. Review of the facility's P&P titled Surveillance for Infections revised 9/2017 showed the infection preventionist (IP) will conduct ongoing surveillance for healthcare associated infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcomes and that may require transmission-based precautions and other preventative interventions. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and HAIs, to guide appropriate interventions, and to prevent future infections. Infections that will be included in routine surveillance include those with evidence of transmissibility in a healthcare environment and pathogens associated with serious outbreaks. The nursing staff will monitor residents for signs and symptoms that may suggest infection, according to current criteria and definitions of infections, and will document and report suspected infections to the charge nurse as soon as possible. The charge nurse will notify the attending physician and IP of suspected infections. The IP is responsible for gathering and interpreting surveillance data. On 11/17/25 at 1047 hours, an interview and concurrent facility document review was conducted with the IP. The IP was asked to describe the facility's resident infection surveillance program. The IP stated he was responsible for the surveillance of the residents' infections in the facility. The IP stated the infection surveillance was necessary to identify the residents' infections to guide appropriate interventions and mitigate the spread of infections. The IP stated when a resident exhibited signs and/or symptoms of an infection and was prescribed antimicrobial medications, the licensed nurse who received the antimicrobial order would then initiate the facility's McGeer's criteria form. The IP stated the facility utilized McGeer's criteria to determine if a resident had an infection. The IP stated the information specific to the resident's infections was documented on the facility's monthly Infection Prevention and Control Surveillance log. Review of the facility's monthly Infection Prevention and Control Surveillance Logs from January through October 2025 showed the following resident infection surveillance data for HAIs, CAIs, and residents who did not meet McGeer's criteria (DNMC): (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capistrano Beach Care Center	35410 Del Rey Dana Point, CA 92624

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 1/2025: HAI – 14, CAI – 21, and DNMC – 18 - 2/2025: HAI – 11, CAI – 20, and DNMC – 4 - 3/2025: HAI – 10, CAI – 16, and DNMC – 7 - 4/2025: HAI – 9, CAI – 18, and DNMC – 2 - 5/2025: HAI – 12, CAI – 13, and DNMC – 6 - 6/2025: HAI – 4, CAI – 12, and DNMC – 10 - 7/2025: HAI – 12, CAI -26, and DNMC – 5 - 8/2025: HAI – 11, CAI 12, and DNMC – 8 - 9/2025: HAI – 11, CAI – 21, and DNMC – 6 - 10/2025: HAI – 12, CAI – 19, and DNMC -7 Further review of the facility's monthly Infection Prevention and Control Surveillance logs from January through October 2025 showed documentation that all the residents included on the facility's Infection Prevention and Control Surveillance logs were prescribed antimicrobial medications. The IP was asked when a resident at the facility exhibited signs and/or symptoms of infection and was not prescribed antimicrobial medications, if the facility initiated the McGeer's criteria form and included these residents in the facility's infection surveillance program (for the months of January through October 2025). The IP stated the facility did not initiate the McGeer's criteria form for the residents who exhibited signs and/or symptoms of infections and were not prescribed antimicrobial medications. The IP was asked how many residents in the facility had infections (met McGeer's criteria) and were not prescribed antimicrobial medications (from January through October 2025). The IP stated he was uncertain as the facility did not initiate the McGeer's criteria form for the residents who exhibited signs and/or symptoms of infections and were not prescribed antimicrobial medications. 2. According to the CMS QSO 17-30 titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaire's Disease dated 6/2/17, the facilities must develop and adhere to the policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. These facilities must have water management plans and documentation that, at a minimum, ensure each facility: * Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

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Capistrano Beach Care Center	35410 Del Rey Dana Point, CA 92624

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* Develops and implements a water management program that considers the ASHRAE (American Society of Heating Refrigerating and Air-Conditioning Engineers) industry standards and the CDC (Centers for Disease Control and Prevention) toolkit; and * Specifies testing protocols and acceptable ranges for control measures and documents the results of testing and corrective actions when control limits are not maintained. Review of the facility's P&P titled Legionella Water Management Program reviewed 9/2022 showed the facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. The water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE recommendations for developing a Legionella water management program. The water management program includes the following elements: Specific measures used to control the introduction and/or spread of Legionella (e.g., temperature, disinfectants). The control limits or parameters that are acceptable and that are monitored. A system to monitor control limits and the effectiveness of control measures. A plan for when control limits are not met and/or control measures are not effective, and documentation of the program. On 11/19/25 at 0907 hours, an interview and concurrent facility record review was conducted with the Administrator. Review of the facility's Water Management Program for Legionella Control (undated) failed to show specific testing protocols and acceptable ranges for the control measures. The Administrator verified the facility's Water Management Program for Legionella Control (undated) failed to show specific testing protocols and acceptable ranges for the control measures. 3. Review of the facility's P&P titled Cleaning and Disinfection of Resident-Care Items and Equipment revised 9/2022 showed the [NAME] Classification System is used to distinguish the level of sterilization/disinfection necessary for items used in resident care: Non-critical items are those that come in contact with intact skin but not mucous membranes. Non-critical resident-care items include bedpan, blood pressure cuffs, crutches and computer. Non-critical items require cleaning followed by either low- or intermediate-level disinfection following manufacturers' instructions. Disinfection is performed with an EPA-registered disinfectant labeled for use in healthcare settings. All applicable label instructions on EPA-registered disinfectant products are followed. On 11/18/25 at 1600 hours, a medication pass observation was conducted with LVN 7. LVN 7 obtained the sphygmomanometer (medical device used for measuring blood pressure) from the medication cart and fell to the floor. LVN 7 did not disinfect the sphygmomanometer cuff. LVN 7 went inside Resident 42's room and placed the sphygmomanometer on Resident 42's left upper arm to check the resident's blood pressure. On 11/18/25 at 1608 hours, an interview was conducted with LVN 7. LVN 7 verified the sphygmomanometer was on the floor and when she picked it up, she did not clean or disinfect prior to using it on Resident 42. On 11/19/25 at 0956 hours, an interview was conducted with the DON. The DON verified and acknowledged the above findings. The DON stated any equipment used for the residents needed to be clean or disinfected prior to use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capistrano Beach Care Center	35410 Del Rey Dana Point, CA 92624

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/19/25 at 1052 hours, an interview was conducted with the Administrator and DON. The Administrator and DON verified and acknowledged the above findings.

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	055585	A. Building B. Wing	11/19/2025

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. (continued on next page)

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	055585	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capistrano Beach Care Center	35410 Del Rey Dana Point, CA 92624

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and facility P&P review, the facility failed to ensure the essential equipment was maintained in proper working condition. * The kitchen walk-in freezer had ice build-up which prevented the door from closing completely. * The walk-in refrigerator fan cover had black debris and brown residue resembling rust. * The floor tiles under the kitchen oven were not intact and clean. These failures had the potential for the equipment to not function the way it was intended.Findings: According to the USDA Food Code 2022, Chapter 4 Equipment, Utensils, and Linens, Section 4-501.11 Good Repair and Proper Adjustment, equipment shall be properly maintained. 1. Review of the facility's P&P titled Procedure for Freezer Storage dated 2023 showed the freezer doors are to close tightly to prevent storage temperature fluctuations. Review of the facility's document titled Sanitation and Food Safety Checklist dated 6/16/25, completed by RD 1 showed there was ice build up on the freezer door and was not able to fully close. Review of the facility's document titled Sanitation and Food Safety Checklist dated 7/28/25, completed by RD 1 showed the walk-in freezer could not maintain the temperature range. Review of the facility's document from a third-party maintenance company dated 7/29/25, showed a service report for the walk-in freezer. The service report showed an itemized bill that listed a thermostatic expansion valve replacement, drier filter replacement, service port replacement and refrigerant. However, review of the facility's document titled Sanitation and Food Safety Checklist dated 8/29/25, completed by RD 2 showed the walk-in freezer had ice build-up and water on the floor outside of the unit. a. On 9/29/25 at 0834 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with the Dietary Manager. An ice build-up was observed on the floor, ceiling, and the top boxes on the shelves of the walk-in freezer. The Dietary Manager acknowledged the findings. b. On 9/29/2 at 0844 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with the Dietary Manager. There was ice build-up around the interior and exterior bottom lining of the walk-in freezer door. The ice build-up prevented the door from properly closing. The Dietary Manager acknowledged the findings. On 9/29/25 at 0956 hours, an interview and concurrent observation was conducted with the Maintenance Director. The Maintenance Director verified the above findings. On 11/18/25 at 1346 hours, an interview was conducted with the Dietary Manager. The Dietary Manager stated the staff members were aware of the ice build-up in the walk-in freezer and have been chipping the ice off every day. On 11/18/25 at 1355 hours, an interview and facility record review was conducted with the Administrator. The Administrator stated they were made aware of the ice build-up in the walk-in freezer. The Administrator hired a third-party maintenance vendor to assess and fix the walk-in freezer on 7/29/25. When the Administrator was asked if he was aware of RD 2's 8/2025 report where RD 2 documented in the Sanitation and Food Safety Checklist about the walk-in freezer had ice build-up and water on the floor outside of the unit, the Administrator stated he never received RD 2's report or heard any issues regarding the ice-build-up. The Administrator stated RD 2 should have communicated these issues to him. 2. On 9/29/25 at 0834 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with the Dietary Manager. The walk-in refrigerator fan cover had black debris and brown residue which resembled rust. The Dietary Manager acknowledged the findings. On 9/29/25 at 0956 hours, an interview and concurrent observation of the walk-in refrigerator was conducted with the Maintenance Director. The Maintenance Director stated he wiped down the fans every six months. The Maintenance Director verified the above findings. 3. According to the USDA Food Code 2022, Chapter 6 Physical Facilities, Section 6-201.11 Floors, Walls, and Ceilings showed floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth any easily cleanable. Review of the facility's P&P titled General Cleaning of Food & Nutrition Services Department dated 2023 showed the floors must be scheduled for routine cleaning and maintained in good condition. On 9/29/25 at 0956 hours, during the initial tour of the kitchen, an observation and concurrent interview was conducted with the Maintenance Director. The tiles next to the stove were chipped and were noted peeling off with black residue. There were missing tiles and exposed cement material observed underneath the stove. The Maintenance Director verified the above findings. On 11/18/25 at 1534 hours, an interview was conducted with the Administrator, DON, and RCDM. The Administrator, DON, and RCDM acknowledged and verified all of the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055585	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capistrano Beach Care Center	35410 Del Rey Dana Point, CA 92624

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitation in the kitchen was maintained. * The facility failed to ensure the kitchen was free from flies. This failure posed the risk for the pests to contaminate the residents' food.Findings: Review of the facility's Matrix showed 77 residents consumed food prepared in the kitchen. Review of the facility's P&P titled Miscellaneous Areas dated 2023 showed the flies are carriers of disease and are a constant enemy of high standards of sanitation in the Food and Nutrition Services Department. Review of the facility's P&P title Sanitation dated 2023 showed monthly a pest control company will inspect and service the Food and Nutrition Services department. Review of the facility's documents from a pest elimination company dated 6/18, 8/5, and 9/8/25, showed the pests treated/inspected for were for flies. On 9/29/25 at 0827 and 0910 hours, an observation was conducted during the initial kitchen tour. The door to the kitchen was adjacent to the back door of the facility which led to the trash dumpster in the parking lot. Three files were observed in the kitchen near the food preparation area. On 9/30/25 at 0836 and 1105 hours, a follow-up observation was conducted in the kitchen. Two flies were observed in the kitchen near the food preparation area. On 10/1/25 at 1049 hours, another follow-up observation was conducted in the kitchen. One fly was observed in the kitchen near the food preparation area. On 10/1/25 at 1012 hours, an interview was conducted with the Maintenance Director. The Maintenance Director was made aware of the findings and stated a pest elimination company installed an insect control box on the kitchen wall for pest control in early September 2025; however, the Maintenance Director further stated he did not know if the fly pest control had improved.