

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055161	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2024
NAME OF PROVIDER OR SUPPLIER Garden Crest Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 909 Lucile Ave. Los Angeles, CA 90026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48026</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of two licensed nurses (licensed Vocational Nurse 4 [LVN 4] did not continue to provide care to residents in the facility during the period LVN 4's Cardiopulmonary resuscitation (CPR - is a lifesaving technique that's useful in many emergencies in which someone's breathing or heartbeat has stopped) certification had expired (no longer valid).</p> <p>This deficiency had the potential for LVN 4 not to stay up to date on the latest CPR techniques and placing the residents at increased risk to experience a decline in health status, function, hospitalization , and death.</p> <p>Findings:</p> <p>During a concurrent observation and record review of LVN 4's CPR card, indicated LVN 4's CPR card had expired on [DATE].</p> <p>During an interview of LVN 4 on [DATE] at 4:04 PM, LVN 4 acknowledged that LVN 4's CPR card expired on [DATE]. LVN 4 stated LVN 4 took a CPR class on [DATE] but had not yet received the renewed CPR card via email but will follow-up. LVN 4 stated facility's Director of Staff Development (DSD - responsible for planning and implementing the facility's orientation and educational programs for all employees) reminded her sometime in [DATE] about getting the CPR card renewed. LVN 4 stated LVN 4 made a mental note when to get the CPR renewed, but was just late in getting it done. LVN 4 stated LVN 4 continued to work in the facility after LVN 4/s CPR card had expired. LVN 4 stated LVN 4 was scheduled to return to work in the facility on [DATE]. When asked why it is important to renew a CPR card, LVN stated LVN 4 may miss out on new CPR information.</p> <p>During an interview with DSD on [DATE] at 4:14 PM, DSD stated sometime in ,d+[DATE], she reminded LVN 4 her CPR card will expire on [DATE]. DSD stated DSD did not follow up to ensure LVN 4's CPR card was renewed. DSD stated CPR card must be current, so nurses know the latest technique in performing CPR.</p> <p>During an interview with Director of Nursing (DON) on [DATE] at 11:31 AM, DON stated, all staff including (Registered Nurses [RN], LVN, Certified Nursing Assistants [CNA]) must have current a CPR card when performing nursing tasks, if not, the staff cannot work until they do.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's ,d+[DATE] schedule, indicated, LVN 4 worked on the following days after LVN 4's CPR card expired on [DATE] and worked on [DATE] - [DATE], [DATE] - [DATE], [DATE] - [DATE], and [DATE] -[DATE].</p> <p>A review of the facility's ,d+[DATE] schedule, indicated, LVN 4 worked from 7 AM to 3 PM on [DATE] - [DATE], [DATE] - [DATE], [DATE] - [DATE], and [DATE] -[DATE].</p> <p>A review of the facility's ,d+[DATE] schedule, indicated, LVN 4 worked from 11 PM - 7 AM shift on [DATE].</p> <p>A review of the facility's ,d+[DATE] schedule, indicated, LVN 4 worked a double shift from 7 AM - 3 PM, and 3 PM - 11 PM) on [DATE].</p> <p>A review of the facility's LVN job description dated [DATE], indicated, nurses who provided nursing services have the skills, experience and knowledge to do a particular task or activity which includes proper licensure and certification, if required.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48026</p> <p>Based on observation, interview, and record review, the facility failed to ensure licensed nurses documented that:</p> <ol style="list-style-type: none"> 1) 26 of 26 medications were administered on residents' medication administration record (MAR - a report detailing the drugs administered to a patient by a licensed healthcare professional at a facility) for Residents 2, 5, and 9. 2) Eight of Eight removed narcotic medications on the controlled drug record (narcotic sheet - a document to track the administration of controlled substances [narcotic medications which have a potential for abuse and may also lead to physical or psychological dependence]) for Residents 2, 5, 8, and 9. 3) The blood pressures (BP) were taken and or readings recorded prior to the administration of BP medications for Residents 2, 5. <p>These deficiencies had the potential to:</p> <ol style="list-style-type: none"> 1. Misrepresent the actual medications administered to residents, 2. Undercount the actual narcotics taken, residents may receive double doses of medications, and 3. 3. Misrepresentation of the narcotic medication inventory on hand on each shift. <p>Findings:</p> <p>A review of Resident 8's admission record indicated Resident 8 was admitted on [DATE] with the diagnoses of chronic obstructive pulmonary disease (a chronic inflammatory lung diseases that causes obstructed airflow from the lungs), acute and chronic respiratory failure with hypoxia (the respiratory system cannot adequately provide oxygen to the body leading to insufficient amount of oxygen at the tissue level), and supraventricular tachycardia (a condition where the heart suddenly beats much faster than normal).</p> <p>A review of Resident 8's history and physical (H&P - a physician's first complete patient examination) dated 01/18/2023, indicated, Resident 8 was interactive and answered questions appropriately.</p> <p>A review of Resident 8's Order Summary Report (a list of all types of physician orders) with an order and start date of 12/21/2023, indicated, diltiazem should be held for systolic BP (SBP - the top number on a BP measures the pressure in the arteries when the heart beats) of less than 100 or HR of less than 60.</p> <p>A review of Resident 9's H&P dated 2/27/2024, indicated Resident 9 does not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 9's admission record indicated, Resident 9 was admitted on [DATE] with the diagnoses of cerebral infarction (damage to the tissues in the brain due to loss of oxygen to the area), and hemiplegia (paralysis that affects one side of the body) and hemiparesis (weakness or the inability to move one side of the body, making it hard to perform everyday activities) following cerebral infarction.</p> <p>A review of Resident 9's Minimum Data Set (MDS - a required standardized assessment and care planning tools), dated 3/05/2024, indicated, Resident 9 had severely impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life).</p> <p>A review of Resident 2's admission record indicated Resident 2 was admitted on [DATE] with the diagnoses of acquired absence of the left toe (amputation of the left toe), type 2 diabetes mellitus (a long-lasting condition when the pancreas does not produce enough insulin or when body cannot effectively use the insulin it produces causing blood glucose [sugar] to go high), peripheral vascular disease (reduced circulation of blood to a body part due to a narrowed or blocked blood vessel), and hypertensive chronic kidney disease (elevated BP cause by kidney disease).</p> <p>A review of Resident 2's Order Summary Report (a list of all types of physician orders) with an order and start date of 3/12/2024, indicated, amlodipine should be held for systolic BP (SBP - the top number on a BP measures the pressure in the arteries when the heart beats) of less than 100.</p> <p>A review of Resident 2's H&P dated 3/13/2024, indicated, Resident 2 had the decision-making capacity.</p> <p>A review of Resident 2's MDS dated [DATE], indicated, Resident 2 was cognitively intact (mental ability to make decisions on activities of daily living).</p> <p>A review of the facility's Room Change form indicated, Resident 2's room was changed on 3/19/2024.</p> <p>A review of Resident 5's admission record indicated Resident 5 was admitted on [DATE] with diagnoses of acquired absence of left toe, atherosclerosis of native arteries of extremities (a disease causing narrowing and hardening of the arteries that supply blood in the legs and feet), essential hypertension (abnormally high BP not caused by a medical condition), and polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body).</p> <p>A review of Resident 2's MAR, dated 3/26/2024 at 2 PM, indicated heparin sodium injection (decreases the clotting ability of the blood and prevent clots from forming), hydralazine (used to treat high BP), and Tylenol extra strength (provides temporary relief of minor aches and pains), were not documented as administered by Licensed Vocational Nurse 8 (LVN 8). The MAR indicated no BP was taken on 3/26/2024 at 2:00 PM, which was required prior to the administration of hydralazine by LVN 8.</p> <p>A review of Resident 2's Weights and Vitals Summary dated March 2024, indicated, no BP was recorded/taken on 3/26/2024 at 2 PM.</p> <p>A review of the facility's assignment dated 3/26/2024 for the 7 AM - 3 PM shift, indicated, LVN 8 was assigned to care for all residents in Station B nurse's station, including Resident 2.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 8's MDS dated [DATE], indicated, Resident 8 was cognitively intact.</p> <p>A review of Resident 5's Order Summary Report with an order date of 3/31/2024 and start date of 4/01/2024, indicated, amlodipine (Medication to treat/control high blood pressure) should be held for SBP of less than 100.</p> <p>A review of Resident 9's MAR for 3/2024 and 4/2024, indicated, no doses of morphine sulfate (used to treat moderate to severe pain when alternative pain relief medicines are not effective or not tolerated) were administered to Resident 9.</p> <p>A review of Resident 9's narcotic sheet for 3/2024 and 4/2024, indicated, morphine sulfate was not taken/removed from the morphine medication bottle.</p> <p>A review of Resident 2's MAR dated 4/2/2024 at 2 PM, indicated, heparin sodium injection, hydralazine, and Tylenol extra strength were not documented as given by LVN 8. The MAR indicated no BP was taken on 4/2/2024 at 2 PM, prior to LVN 8 administering hydralazine to Resident 2.</p> <p>A review of Resident 2's Weights and Vitals Summary dated April 2024, indicated, no BP was taken on 4/02/2024 at 2 PM.</p> <p>A review of the facility's 7 AM - 3 PM shift assignment dated 4/02/2024, indicated, LVN 8 was assigned to care for all residents in Station B nurses' station, including Resident 2.</p> <p>A review of Resident 5's H&P dated 4/5/2024, indicated, Resident 5 was, very sharp and great recall of information and had the decision-making capacity.</p> <p>A review of Resident 5's MDS dated [DATE], indicated, Resident 5 was cognitively intact.</p> <p>A review of Resident 5's Weights and Vitals Summary dated April 2024, indicated, BP of 128/77 was taken on 4/08/2024 at 8:34 AM.</p> <p>A review of Resident 5's MAR dated 4/08/2024 at 9 AM, indicated, amlodipine (medication that relaxes the blood vessels and lowers BP), aspirin (medication use that is associated with a decreased risk of stroke), polyethylene glycol (used in the management and treatment of constipation), venlafaxine (medication used for the symptomatic treatment of neuropathic [nerve damage] pain), vitamin B12 (supplement - essential for red blood cell formation, nerve function), vitamin D3 (helps body absorbs calcium and phosphorus), chlorhexidine gluconate mouthwash (treats gum disease and for oral hygiene), rivaroxaban (medication used to prevent blood clots and reduces risk of heart attack and stroke), gabapentin (medication used to treat nerve pain and partial seizures), and cephalexin (antibiotic medication used to treat a wide variety of bacterial infections) were not documented as given by LVN 4. The MAR indicated BP was not charted which was required prior to the administration of amlodipine by LVN 4.</p> <p>A review of the facility's 7 AM - 3 PM shift assignment dated 4/08/2024 indicated, LVN 4 was assigned to care for all residents in Station B nurses' station, including Resident 5.</p> <p>A review of the facility's Room Change form indicated, Resident 2's room was changed on 4/10/2024.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 5's narcotic sheet dated 4/13/2024 at 10 AM and 4/14/2024 at 10 AM, indicated, hydromorphone (a narcotic drug can treat moderate to severe pain) were removed from the blister pack by LVN 8.</p> <p>A review of Resident 5's MAR dated 4/13/2024 at 10 AM and 4/14/2024 at 10 AM, indicated, hydromorphone were not documented as given by LVN 8.</p> <p>A review of Resident 5's narcotic sheet dated 4/16/2024 at 9:31 PM, indicated, hydromorphone was removed from the blister pack by LVN 10.</p> <p>A review of Resident 5's MAR dated 4/16/2024 at 9:31 PM, indicated hydromorphone was not documented as given by LVN 10.</p> <p>A review of the facility's 3 PM - 11 PM shift assignment dated 4/16/2024, indicated, LVN 10 was assigned to care for all residents in Station B nurses' station, including Resident 5.</p> <p>A review of Resident 8's MAR dated 4/17/2024, indicated, Anoro Ellipta Aerosol inhaler powder (medication - an inhaler that relaxes the lung muscles around the airways by opening up to breathe more easily), and budesonide suspension (medication used to prevent difficulty breathing, chest tightness, wheezing, and coughing) were not documented as given by LVN 8. The MAR indicated diltiazem (medication that relaxes the blood vessels, lowers BP, and increase the supply of blood and oxygen to the heart while reducing its workload) was not documented as given on 4/17/2024 at 9 AM and at PM. The MAR indicated BP and HR were not charted which was required prior to the administration of diltiazem by LVN 8.</p> <p>A review of Resident 8's narcotic sheet dated 4/17/2024 at 1:00 PM, indicated, tramadol (a strong narcotic used to treat moderate to severe pain) was removed from a blister pack by LVN 8.</p> <p>A review of Resident 8's Weights and Vitals Summary dated April 2024, indicated, no BP and HR were taken on 4/17/2024 at 9 AM and at 1 PM.</p> <p>A review of the facility's 7 AM - 3 PM shift assignment dated 4/17/2024, indicated, LVN 8 was assigned to care for all residents in Station A nurses' station, including Resident 8.</p> <p>A review of Resident 2's narcotic sheet dated 4/20/2024 at 5:14 AM, indicated, oxycodone (a narcotic drug helps control persistent or severe pain) was removed from the blister pack (a form of tamper-evident packaging where medications are individually sealed in a bubble) by LVN 5.</p> <p>A review of Resident 2's MAR dated 04/20/2024 at 5:14 AM, indicated, oxycodone was not documented as given by LVN 5.</p> <p>During an interview with Resident 2 on 4/20/2024 at 8:42 AM, Resident 2 stated he received never missed any of his medications, including his heparin sodium injection, hydralazine, Tylenol extra strength, and oxycodone medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with Resident 8 on 4/20/2024 at 9:18 AM, Resident 8 stated Resident 8 did not think Resident 8 missed any of her medications. Resident 8 stated nurses always check her BP prior to administration of her heart medicine. Resident 8 stated Resident 8 takes her heart medicine every day.</p> <p>During an interview with Resident 5 on 4/20/2024 at 10:34 AM, Resident 5 stated, Resident 5 never missed any of her medications, including hydromorphone. Resident 5 stated, if the nurse forgets to give them to me, I remind her.</p> <p>During an observation of Resident 9's morphine sulfate bottle on 4/20/2024 at 1:35 PM, the morphine sulfate bottle was not sealed and had 27 mL (milliliter - a unit of measure in fluid volume; 1 mL = 0.001 liter) in a 30 mL bottle.</p> <p>During an interview of LVN 1 on 4/20/2024 at 1:35 PM, LVN 1 stated Resident 9's morphine sulfate bottle was not sealed. LVN 1 stated the bottle may have been opened by a nurse who may have administered the medication but did not document, a nurse may have removed the medication from the bottle but at the last minute, decide not to administer the medication. LVN 1 was asked why documentation on the MAR was important. LVN 1 stated administration of medication must be documented or else it was not given. LVN 1 was asked by documentation on the narcotic sheet was important. LVN 1 stated narcotics are controlled substances and nurses are accountable to what narcotic was given or discarded. LVN 1 stated documentation in the MAR are the narcotic sheet were important to ensure resident did not get medications twice in a short time. LVN 1 stated if Resident 9 did not receive prescribed morphine sulfate when needed, then Resident 9's pain level will increase throughout the day. LVN 1 stated if Resident 9 received morphine sulfate twice in less than 4 hours, Resident 9 may experience dizziness, have low energy, low respiratory rate and BP which may require hospitalization .</p> <p>During an interview of RNS 2 on 4/20/2024 at 2:19 PM, RNS 2 stated morphine sulfate bottle opened meant a nurse may had taken a dose or more from the medication bottle. RNS 2 stated when morphine sulfate was not documented in the MAR as administered or on the narcotic sheet as discarded, it meant the nurse may have administered the morphine or discarded the morphine prior to administration but was not documented. RNS 2 stated if morphine was given twice in less than 4 hours between doses, Resident 9 might respiratory rate and heart rate (HR) decrease so low that Resident 9 may require hospitalization for higher level of care.</p> <p>A review of Resident 9's narcotic sheet for March 2024, indicated Resident 9's morphine sulfate was discarded and signed by two nurses on 4/20/2024.</p> <p>A review of Resident 9's MD order dated 4/20/2024 at 7:22 PM, indicated, Resident 9's morphine sulfate was discontinued.</p> <p>During an interview with LVN 10 on 4/22/2024 at 6:44 PM, LVN 10 stated LVN 10 administered the hydromorphone to Resident 5 on 4/16/2024. LVN 10 stated LVN 10 had forgotten to document hydromorphone as administered to Resident 5. LVN 10 stated if the documentation was late, other nurses might think hydromorphone was not given, Resident 5 will receive double dose of hydromorphone which can lead to overdosing causing Resident 5 dizziness to change in level of consciousness which would require hospitalization .</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with LVN 8 on 4/23/2024 at 9:37 AM, LVN 8 stated he administered heparin sodium injection, hydralazine, and Tylenol extra strength on 3/26/2024 at 2 PM and on 4/02/2024 at 2 PM to Resident 2. LVN 8 stated LVN 8 forgot to document the medications as administered on 3/26/2024 and on 4/02/24 to Resident 2. LVN 8 stated when administration of medications on 3/26/2024 and 4/23/2024 were not documented, Resident 2 may potentially receive a dose twice, had the risk of having hypertension (very high BP), increase in pain, and blood clots requiring hospitalization .</p> <p>During an interview with LVN 8 on 4/23/2024 at 9:37 AM, LVN 8 stated LVN 8 administered Anoro Ellipta Aerosol inhaler powder, and budesonide suspension as ordered on 4/17 at 9:00 AM to Resident 8. LVN 8 stated LVN 8 remembered giving these medications because if LVN 8 did not administer the medications, the resident will remind him. LVN 8 was asked if diltiazem was given to Resident 8 on 4/17 at 9 AM and at 1 PM, LVN 8 stated he gave these medications. When asked how remembered giving the medications, LVN 8 stated resident 8 would have reminded him. LVN 8 was shown the April 2024 Weights and Vitals Summary document and acknowledged the BP and HR were not taken prior to the administration of diltiazem on 4/17/2024 at 9:00 AM and 1:00 PM. LVN 8 stated he forgot to chart the BP and HR, but these vital signs were taken prior to the administration of diltiazem.</p> <p>During an interview with LVN 8 on 4/23/2024 at 9:37 AM, LVN 8 stated LVN 8 gave Resident 5's doses of hydromorphone on 4/13/2024 and 4/14/2024. LVN 8 stated LVN 8 had forgotten to document the hydromorphone as given to Resident 5. LVN 8 stated if the hydromorphone were not given to the Resident 5 on 4/13/2024 and 4/14/2024, Resident 5 would suffer the entire day due to pain, have facial grimacing, and potential to withdraw from activities, not able to sleep or eat or even hospitalized if the pain became unbearable.</p> <p>During an interview with LVN 4 on 4/23/2024 at 2:59 PM, LVN 4 stated LVN 4 gave all 10 medications (amlodipine, aspirin, polyethylene glycol, venlafaxine, vit B12, vit B3, chlorhexidine gluconate mouthwash, rivaroxaban, gabapentin, and cephalexin) to Resident 5 on 4/08/2024. LVN 4 stated LVN 4 had forgotten to document the administration of 10 medications to Resident 5. LVN 4 stated LVN 4 forgot to enter Resident 5's BP as ordered on 4/08/2024 on the MAR. LVN 4 stated if the 10 medications were not administered to Resident 5, Resident 5 would continue to have hypertension, potential for blood lots, increase pain, bleeding gums and may end up in the hospital if the bleeding or blood clots cannot be controlled.</p> <p>During an interview with LVN 5 on 4/23/2024 at 3:45 PM, LVN 5 stated LVN 5 administered the medication, oxycodone, to Resident 2. LVN 5 stated LVN 5 thought LVN 5 had documented the administration of oxycodone as ordered on 4/23/2024 to Resident 2. LVN 5 stated when administration of medication was not documented, Resident 2 would continue to suffer from pain, be uncomfortable, not able to go back to sleep, and not able to eat. LVN 5 stated when Resident 2's pain is too severe, respiration rate may adversely affect requiring a trip to the hospital.</p> <p>A review of the facility's policy and procedure (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Charting and Documentation dated July 2017, indicated, medications administered are to be documented in the resident medical record, and documentation will be complete and accurate.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's P&P titled Controlled Substances dated November 2023, indicated, the nurse who administered the medication is responsible for recording the time and method of administration. The P&P indicated the nurse administering the medication is responsible for recording the quantify of the medication remaining and the signature of the nurse administering the medication.</p> <p>A review of the facility's P&P titled Administering Medications dated November 2023, indicated, vital signs, when necessary, were verified for each resident prior to administering medications. The P&P indicated, if a drug is withheld, refused, or given at a time other than the scheduled time, the nurse shall initial the MAR for that drug and dose. The P&P indicated, as required, the nurse who administered the medications records in the resident's medical records the date, time, dose, route of administration, and the signature and title of the nurse who administered the medications.</p>		