STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055161	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Crest Rehabilitation Center	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)
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. 44309 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1), who had dizziness and was administered Meclizine (medication used to prevent and control nausea, vomiting, and dizziness) four times a day, had a comprehensive person-centered care plan with appropriate interventions for Resident 1's physical, mental and psychological wellbeing. This deficient practice caused an increased risk in adverse reactions (unwanted, uncomfortable, or dangerous effects that a drug may have) to Resident 1. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated the facility admitted the resident on 12/30/2022, with diagnoses including dementia (loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that the loss interferes with a person's daily life and activities), chronic pain syndrome (pain that lasts for longer than three months), and Type II diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 1/10/2024, indicated the resident's cognitive skills (brain's ability to think, remember, and express thoughts) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 1 required substantial / maximum assistance for toileting hygiene, lower body dressing and showering / bathing. A review of the physician History and Physical (H&P) dated 4/29/2024, indicated Resident 1 had fluctuating capacity to understand and make decisions. A review of the Physician's Order Summary Report, dated 6/3/2024, indicated Resident 1 was prescribed Meclizine 25 milligram (mg - a unit of measurement) to give one tablet by mouth four times a day for dizziness. A review of the Medication Administration Record (MAR) dated from 6/4 to 6/30/2024 indicated Resident 1 was administered Meclizine 25 mg, four times a day (each day). A review of the MAR dated from 7/1 to 7/31/2024 and from 8/1 to 8/31/2024 indicated Resident 1 received Meclizine 25 mg four times a day (for approximately three months). (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Order Summary Report, dated 9/12/2024 at 8:24 AM, indicated the order for Meclizine 25 mg one tablet by mouth four times a day for dizziness was changed to Meclizine 25 mg one tablet by mouth every six hours 'as needed' for dizziness. A review of Resident 1's Order Summary Report, dated 9/12/2024 at 8:25 AM, indicated the order for Meclizine 25 mg, one tablet by mouth four times a day for dizziness was 'discontinued' per Resident 1's family member request. During a telephone interview on 9/18/2024 at 3:22 PM, Resident 1's Physician (PHY1) stated he sometimes prescribed Meclizine 25 mg four times a day for dizziness as a scheduled medication to be administered. PHY 1 stated, When I prescribe Meclizine as a scheduled medication, I prescribe it for a short period of time and then as needed. PHY1 did not state a specific time period for administration of scheduled Meclizine. A review of Resident 1's medical record and care plans on 9/19/2024, indicated there were no person-centered care plan developed, with individualized interventions or monitoring for Resident 1 regarding dizziness or the administration of the medication Meclizine four times per day. During a telephone interview on 9/19/2024 at 12:05 PM, with the facility's Pharmacy Consultant (PC) stated Meclizine was normally prescribed as 'PRN' (as needed) order for vertigo and dizziness. The PC stated staff were required to monitor the resident who was taking Meclizine for potential side effects such as dry mouth, drowsiness, and fatigue. The PC stated Meclizine was one of the medications that can possibly be the cause of a resident's fall. The PC stated, I did not know that Resident 1 was prescribed Meclizine 25 mg four times a day since 6/3/2024. I am shocked that Meclizine was given to Resident 1 on a scheduled basis for almost three months. During a concurrent interview and record review on 9/19/2024 at 12:48 PM, with the facility's Director of Nursing (DON), Resident 1's care plans and physician's orders were reviewed. The DON stated there was no care plan for Resident 1's dizziness or the administration of Meclizine in Resident 1's medical record. The DON stated staff did not develop a care plan with person-centered interventions for Resident 1 and there was no monitoring for Meclizine. The DON stated staff were required to initiate a care plan for dizziness for Resident 1. The DON stated Resident 1 was transferred to GACH 1 because of dizziness and he was required to be monitored by staff for dizziness after his return. The DON stated if the staff would have developed a person-centered care plan for Resident 1's dizziness, they would have monitored Resident 1 for dizziness and they could have updated his physician whether he continued to experience dizziness. The physician could have revised the order for administration of Meclizine from scheduled order to a PRN (as needed). The DON stated the potential outcome of not developing care plan with appropriate interventions after resident change of condition was a lack of monitoring and delivery of appropriate services to the resident. The DON further stated the potential outcome of administering Meclizine as a scheduled medication for three months without monitoring and assessing the resident for the indication was placing the resident at risk for medication adverse side effects. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Care Plans-Comprehensive Person-Centered, revised March 2022, indicated the comprehensive person-centered care plan included measurable objectives and timeframes, described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental and psychological wellbeing. The policy indicated assessments of residents were ongoing and care plans were revised as information about the residents and resident's condition change. The interdisciplinary team reviews and updates the care plan when there was a significant change in condition. A review of the facility's policy and procedure titled, Change in Resident's Condition or Status, revised February 2021, indicated a significant change of condition was a major decline or improvement in the resident's status and required interdisciplinary review and /or revision to the care plan.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1), who was diagnosed with chronic pain syndrome (pain that lasts for longer than three months), received a Pain Assessment after a change of condition (a decline / worsening or improvement in a resident's mental, psychosocial, or physical functioning). This deficient practice had the potential to negatively affect Resident 1's psychosocial wellbeing and quality of life. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated the resident was admitted to the facility on [DATE], with diagnoses including dementia (loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that the loss interferes with a person's daily life and activities), chronic pain syndrome and Type II diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). A review of the Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 1/10/2024, indicated Resident 1's cognitive skills (brain's ability to think, remember, and make decisions) for daily decision making was moderately impaired (decisions poor, cues / supervision required) and that Resident 1 received scheduled pain medication for the last five days. According to a review of the Physician's Orders dated 4/12/2024, Resident 1 was to receive Acetaminophen tablet (medication used to treat mild pain) 325 milligrams (mg, unit of measurement), two tablets by mouth every four hours as needed for mild pain (rated at 1-3 using a pain rating scale of zero being no pain and 10 being the worst pain possible). The Physician's Order also indicated Resident 1 was to receive Duloxetine (medication used to treat pain caused by nerve damage) 60 mg one capsule by mouth at bedtime for chronic pain. A review of Resident 1's At Risk For Pain related to chronic pain care plan dated 4/15/2024 indicated the goal was for the resident to verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. The care plan interventions indicated to administer medications as ordered, to anticipate the resident's need for pain relief, to respond immediately to any complaint of pain, and to monitor / record / report to nurse his complaints of pain or requests for pain treatment. A review of the History and Physical (H&P) dated 4/29/2024, indicated Resident 1 had fluctuating (changing) capacity to understand and make decisions. A review of Resident 1's Medication Administration Records (MAR) dated 9/10/2024 at 11:53 AM and 4:05 PM, also dated 9/11/2024 at 6:21 PM indicated the resident received Acetaminophen 325 mg two tablets by mouth every four hours as needed for mild pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Change of Condition Evaluation / Situation-Background-Assessment and Recommendation (SBAR - a written communication tool that helps provide important information) dated 9/14/2024, indicated Resident 1 had pain on the right side of his head, chest, and hip. The SBAR form indicated Resident 1 was transferred to General Acute Care Hospital (GACH) 2 for further evaluation and treatment. A review of the Pain Assessments on 9/18/2024 at 2 PM, indicated Resident 1 did not receive a pain assessment after the change of condition on 9/14/2024. During a concurrent interview and record review on 9/18/2024 at 2:14 PM, with the Director of Nursing (DON), Resident 1's pain assessments and SBARs were reviewed. The DON stated Resident 1 had a change of condition for right side of head, chest, and hip pain on 9/14/2024, and was transferred to the GACH for the pain. The DON stated licensed staff did not complete a Pain Assessment form for Resident 1 and staff were required to complete a pain assessment after each change of condition for pain. The DON stated the potential outcome of not completing pain assessment form was incomplete care and delivery of necessary services to manage a resident's pain. A review of the facility's policy and procedures titled, Pain-Clinical Protocol, revised October 2022, indicated the nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there was a significant change of condition, and when there was onset for new pain or worsening of existing pain.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview and record review, the facility failed to ensure the facility's Pharmacy Consultant (PC) thoroughly completed a monthly Medication Regimen Review (MRR - a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences [unwanted, uncomfortable, or dangerous effects that a drug may have] and potential risks associated with medications) for one of two sampled residents (Resident 1). This deficient practice caused Resident 1 to receive medication that was not optimal his medical condition and increased the risk of adverse consequences from the medication therapy. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated the resident was admitted to the facility on [DATE], with diagnoses including dementia (loss of cognitive functioning - thinking, remembering, and reasoning to such an extent that the loss interferes with a person's daily life and activities), chronic pain syndrome (pain that lasts for longer than three months), and Type II diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 1/10/2024, indicated the resident's cognitive skills (brain's ability to think, remember and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 1 required substantial / maximum assistance for toileting hygiene, lower body dressing and showering / bathing. A review of Resident 1's Change of Condition Evaluation - Situation-Background-Assessment and Recommendation (SBAR- a written communication tool that helps provide important information) dated 6/2/2024 indicated Resident 1 had severe headache, dizziness, and fluctuating blood pressure. The SBAR form indicated Resident 1's family member requested 911 services and Resident 1 was transferred to the General Acute Care Hospital (GACH) 1. A review of Resident 1's Order Summary Report, dated 6/3/2024, indicated Resident 1 was to receive Meclizine 25 milligram (mg - a unit of measurement) one tablet by mouth four times a day for dizziness. According to a review of the Medication Administration Record (MAR) dated from 6/4 to 6/30/2024, Resident 1 was administered Meclizine 25 mg four times a day (each day for 26 days). A review of the facility's Pharmacy Consultant (PC) Medication Regimen Review (MRR) List for 6/1 - 6/20/2024, indicated the PC reviewed Resident 1's MAR and no recommendation was required. A review of the MAR dated from 7/1 to 7/31/2024 indicated Resident 1 was administered Meclizine 25 mg four times a day (each day). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the MAR dated from 8/1 - 8/31/2024 indicated Resident 1 was administered Meclizine 25 mg four times a day (each day). A review of the MRR List for 8/1 - 8/21/2024, indicated the PC reviewed Resident 1's MAR and no recommendation was required. According to a review of Resident 1's Order Summary Report, dated 9/12/2024, the order for Meclizine 25 mg one tablet by mouth four times a day for dizziness was changed to Meclizine 25 mg one tablet by mouth every six hours 'as needed' for dizziness. A review of Resident 1's Order Summary Report, dated 9/12/2024 at 8:25 AM, indicated the order for Meclizine 25 mg, one tablet by mouth four times a day for dizziness was discontinued per Resident 1's family member request. During a telephone interview on 9/18/2024 at 3:22 PM, Resident 1's Physician (PHY1) stated he sometimes prescribed Meclizine 25 mg four times a day for dizziness as a scheduled medication to be administered. PHY 1 stated, When I prescribe Meclizine as a scheduled medication, I prescribe it for a short period of time and then as needed. PHY1 did not state a specific time period for administration of scheduled Meclizine. PHY1 stated, Resident 1 visits his primary care physician as well. I don't remember prescribing Meclizine to Resident 1. I don't remember if his primary care physician ordered this medication or me. It is reasonable to administer Meclizine 25 mg four times a day to a resident to prevent vertigo. I don't think taking Meclizine 25 mg four times a day for three months is an excessive dose of medication for Resident 1. Every medication has its side effects. During a telephone interview on 9/19/2024 at 12:05 PM, the PC stated every month he reviewed all residents' medication regimens and makes recommendations if there were medication orders that required to be revised, changed, or discontinued. The PC stated, I did not know that Resident 1 was prescribed Meclizine 25 mg four times a day since 6/3/2024. I am shocked that Meclizine was given to Resident 1 on a scheduled basis for almost three months. I reviewed Resident 1's medication regimen for June, July, and August 2024. However, I did not notice that Resident 1 was prescribed Meclizine 25 mg four times a day. I should have re-evaluated the order for this medication based on Resident 1's symptoms. I did not do what was required. The PC stated the potential outcome of a resident taking Meclizine for an extensive dose was being exposed to side effect of the medication such as dry mouth, drowsiness, and fatigue. During a concurrent interview and record review on 9/19/2024 at 1:10 PM, with the facility's Director of Nursing (DON), Resident 1's MRR for the months of June, July, and August 2024 reviewed. The DON stated and confirmed, The PC did not have any recommendations regarding medications that Resident 1 were taking in June, July, and August 2024. The DON stated Resident 1 started taking Meclizine 25 mg four times a day for dizziness from 6/3/2024 and the order was changed to Meclizine 25 mg every 6 hours as needed for dizziness because of his family request. The DON stated the PC failed to review Resident 1's medications thoroughly for the months of June, July, and August 2024. The DON stated the potential outcome was placing the residents at risk for medication adverse side effects. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's undated policy and procedure titled, Medication Utilization and Prescribing-Clinical Protocol, indicated the consultant pharmacist can help by reviewing medication usage patterns and trends and by intensifying medication reviews of individuals taking medications that present higher risks. The physician will provide and/or document a rationale when the dose, duration, and frequency of a prescribed medication is greater than commonly accepted practice or the manufacturer's recommendations or the medication is considered high-risk compared to other available, relevant alternatives. The staff and the physician will periodically re-evaluate the conditions and symptoms for which each resident is receiving medications to ensure that the medication and dosage are still relevant and are not causing undesired complications. The staff and physician will monitor the progress of anyone with probable adverse drug reaction and anyone for whom medications have been adjusted because of possibility of an adverse reaction. A review of the facility's undated policy and procedure titled, Interim Medication Regimen Review, indicated the facility must ensure the Pharmacy Consultant had access to the resident's complete medical records. The consultants comprehensive monthly report will be provided to the facility either electronically and/or in written hard copy within five business day of completion of monthly consulting records.