STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055168	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Socal Post-Acute Care	7931 S. Sorenson Ave. Whittier, CA 90606

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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 - Some	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** 48661 Based on observation, interview, and record review the facility failed to account for and administer medications as ordered by the physician for two of two sampled residents (Resident 1 and Resident 2), by failing to: 1. Account for Resident 1 ' s Dilaudid 4 mg tablet bubble pack (also known as a blister pack, a card that packaged doses of medication within small, clear plastic bubbles [or blisters] for easy and safe administration) and the Controlled Medication Count Sheet (CMCS, form used to keep track of how much of a controlled medication was on hand, how much was given to a resident, and how much remained) for the bubble pack. 2. Administer Resident 2 ' s Alprazolam 0.25 mg tablet on 5/4/2025 at 3:30 AM (55 minutes earlier than what was ordered by the physician). 3. Document Resident 2 received Alprazolam 0.25 mg tablet on 5/4/2025 at 3:30 AM in the Medication Administration Record (MAR). 4. Implement Resident 2 ' s Care Plan interventions to administer anti-anxiety medications as ordered by the physician. These deficient practices had the potential for the loss of accountability which affected the controls against drug loss, diversion, or theft for Resident 1 and an inaccurate record and administration of a controlled medication that could have resulted in adverse reactions for Resident 2. Findings: a. During a review of Resident 1 ' s Admission Record (AR), the AR indicated the resident was readmitted to the facility on [DATE], with diagnoses that included orthopedic aftercare (the process of recovering from orthopedic surgery focusing on pain management, wound care, physical therapy, and lifestyle adjustments to promote healing and regain function) following surgical amputation (a surgical procedure where a part of a limb such as a finger, toe, hand, foot, arm, or leg, was removed - absence of left leg below knee, right leg below knee and right finger[s]), and Raynaud ' s syndrome (a condition where blood vessels in the fingers and toes react unusually strongly to cold or stress, causing them to narrow and restrict blood flow) without gangrene (a serious condition where tissue dies due to a lack of blood flow, often resulting in a loss of oxygen and nutrients). (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s Narcotic Use Care Plan dated 11/19/2024, the Care Plan indicated a goal for the resident to have no complications. The Care Plan interventions indicated to administer medications as ordered, monitor for signs and symptoms of complications, and monitor for pain every shift. During a review of Resident 1 ' s Pain Care Plan dated 11/19/2024, the Care Plan indicated a goal for the resident ' s pain to be r5elieved within 30 to 60 minutes of intervention for 90 days. The Care Plan interventions indicated to administer Dilaudid (a drug used to treat moderate to severe pain) as needed, assess for pain every shift and as needed, and assist in performing non-pharmacological interventions. During a review of Resident 1 ' s History and Physical (H&P) dated 11/27/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1 ' s Peripheral Neuropathy (nerve damage in your body, excluding the brain and spinal cord causing various symptoms like pain) Care Plan dated 11/29/2024, the Care Plan indicated a goal for the resident to have no complications. The Care Plan interventions indicated to administer pain medications as ordered, assist resident to participate with non-pharmacological interventions to relieve pain, and monitor skin status weekly and as needed. During a review of Resident 1 ' s Physician ' s Order dated 12/31/2024 at 3:07 PM, the Physician ' s Order indicated Dilaudid oral tablet 4 milligrams (mg, unit of measurement) (Hydromorphone hydrochloride [also known as Dilaudid]), give one tablet by mouth every four hours PRN for moderate to severe pain, hold if respiratory rate (RR, the number of breaths taken per minute, a normal resting RR for adults was between 12 and 20 breaths per minute) of less than 12. During a review of Resident 1 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 2/16/2025, the MDS indicated the resident ' s cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated Resident 1 received as needed (PRN) pain medication and had experienced occasional pain in the last five days. During a review of Resident 1 ' s Consolidated Delivery Sheets - Controlled Substances dated 5/2/2025 at 1:31 PM, the Delivery Sheets indicated Resident 1 ' s Dilaudid 4 mg tablet, quantity of 120 tablets were delivered from the pharmacy. The Delivery Sheets indicated LVN 1 signed for the delivery of Resident 1 ' s medications. During a review of Resident 1 ' s Delivery Track dated 5/2/2025 at 2:23 PM, The Delivery Track indicated Resident 1 ' s Dilaudid 4 mg tablet, quantity of 120 tablets were delivered from the pharmacy. The Delivery Track indicated LVN 1 signed for the delivery of Resident 1 ' s medications on 5/2/2025 at 2:21 PM. During a review of Resident 1 ' s Narcotic Inventory & Emergency Kit Endorsement Form dated May 2025, the Endorsement Form indicated from 5/1/2025 to 5/7/2025 the one duty and off duty facility staff signed the form with no discrepancies. During a review of Resident 1 ' s MAR dated May 2025, the MAR indicated Resident 1 received Dilaudid oral tablet 4 mg (Hydromorphone HCL), give one tablet by mouth every four hours PRN for moderate to severe pain, hold if RR of less than 12 was given a total of 10 times from 5/1/2025 to 5/7/2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s CMCS for Dilaudid 4 mg dated 5/2/20205, the CMCS indicated the quantity was 120 tablets. The CMCS only accounted for 60 tablets. During an observation on 5/7/2025 at 7:24 AM, Licensed Vocational Nurse (LVN) 1 and LVN 3 performed a narcotic count for change of shift report (handoff of information when one shift of healthcare workers ends and a new shift begins). LVN 3 was calling out the resident ' s name, medication, and the number of medications left from the CMCS. LVN 1 was repeating the resident ' s name, medication, and the number of medications left from the bubble pack. LVN 1 and LVN 3 after the narcotic count, signed the Narcotic Endorsement Sheet indicating both facility staff agreed on the number of narcotics left for each resident. During an interview on 5/7/2025 at 7:56 AM, LVN 1 stated the outgoing nurse would count the medications used during their shift on paper (CMCS) and the incoming nurse would confirm the amount on the bubble pack for how many there should have been. LVN 1 stated once a bubble pack was all used, the facility staff would shred the name tag and throw away the bubble pack, but the CMCS would be folded and kept inside the binder until medical records filed the CMCS later. During the same interview on 5/7/2025 at 7:56 AM, LVN 1 stated she was training Registered Nurse (RN) 1 and followed RN 1 to administer Resident 1 ' s pain medication. LVN 1 stated when RN 1 was about to take Resident 1 ' s pain medication from the bubble pack, LVN 1 realized there was only one bubble pack instead of two bubble packs. LVN 1 stated the reason she knew there should have been two bubble packs was because she was the one who signed for Resident 1 ' s medications when the pharmacy delivered them. LVN 1 stated the pharmacy delivered a quantity of 120 pills split into two bubble packs with two CMCS and each bubble pack had a sticker indicating the first and second bubble pack. LVN 1 stated one whole bubble pack and one CMCS was missing. LVN 1 stated on the remaining bubble pack, the sticker indicating whether the bubble pack was the first or second one was ripped off. During an observation of Resident 1 ' s Dilaudid 4 mg tablet bubble pack on 5/7/2025 at 8:48 AM, the bubble pack indicated a quantity of 120 pills but only had room to contain 60 pills on the bubble pack. To the left upper corner of the bubble pack there was a sticker indicating PRN and a sticker indicating Caution: opioid, risk of overdoes and addition. Below the caution sticker there was adhesive residue (sticky stuff that was left behind on a surface after a label or sticker was removed) with an area that had a piece of red sticker left over. During a telephone interview on 5/7/2025 at 9:56 AM, RN 1 stated on 5/5/2025 she performed the narcotic count with the outgoing facility staff and everything matched specifically. RN 1 stated during medication pass (the process of nurse distributing medications to patients at scheduled times) for Resident 1, LVN 1 who was training me noticed there was only one bubble pack, when there should have been two. RN 1 stated LVN 1 informed RN 1 not to touch anything. RN 1 stated when there were two bubble packs of the same medication, there would have been two CMCS for them indicating one bubble pack was one of one and the other bubble pack was two of two. RN 1 stated because the sticker on the bubble pack was gone, there was no indication that there would be two bubble packs. RN 1 stated During an interview on 5/7/2025 at 12:21 PM, Resident 1 stated she had a left and right leg amputation (a surgical procedure where a part of a limb, such as leg was removed and had been living at the facility since October 2024. Resident 1 stated she had neuropathy (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet) and had bad pain in the mornings. Resident 1 stated she would usually get pain medication twice a day, one in the morning and one in the evening. During an interview on 5/7/2025 at 1:14 PM, LVN 2 stated she worked the 3 PM to 11 PM shift on 5/2/2025 and remembered performing the narcotic count with LVN 1 for Resident 1. LVN 2 stated there were three bubble packs total for Resident 1, two full bubble packs and one bubble pack with a few pills left and three CMCS for each of the bubble packs. LVN 2 stated she did not know the quantity for Resident 1 ' s medication but should have known otherwise the facility staff could lose track of how many narcotics there actually were. LVN 2 stated if the facility did not have Resident 1 ' s narcotics then Resident 1 could be in pain and the facility would not have medication to alleviate the resident ' s pain. During an interview on 5/7/2025 at 1:35 PM, LVN 3 stated she worked the 11 PM to 7 AM shift on 5/2/2025 to 5/3/2025 and remembered performing the narcotic count with the outgoing nurse for Resident 1. LVN 3 stated she could not remember how many bubble packs Resident 1 had. LVN 3 stated the numbers on the resident ' s name tag were so tiny and did not check the quantity but should have to know how much medication should have been there. LVN 3 stated if the facility did not know the quantity of the medication, the medication could go missing and having the resident ' s medications were the resident ' s right and if the facility did not have the medication the resident would be in pain. During an interview on 5/7/2025 at 2:21 PM, LVN 4 stated she worked the 7 AM to 3 PM shift on 5/3/2025 and remembered performing the narcotic count with the outgoing nurse for Resident 1. LVN 4 stated there were two bubble packs, one bubble pack with one pill left and a new bubble pack with all 60 pills accounted for with two CMCS. LVN 4 stated she only checked the quantity of the medication when she received the medication from the pharmacy. LVN 4 stated checking the quantity of the medication would be hard to do for every resident but should have been done to make sure the correct amount was accounted for otherwise the medication could go missing. LVN 4 stated if Resident 1 ' s medication went missing, that would be bad because Resident 1 relied on her pain medication and if she did not receive the pain medication, Resident 1 would continue to be in pain. During an interview on 5/7/2025 at 4:55 PM, the Director of Nursing (DON) stated the facility staff should have been looking at the quantity of the medication, looking at the CMCS, and looking at the actual medication to compare and make sure everything was accounted for. The DON stated otherwise the medication could go missing and the facility would not be aware of the missing medication. b. During a review of Resident 2 ' s AR, the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included dementia (a progressive state of decline in mental abilities), unspecified psychosis (a mental health condition where a person experiences psychotic symptoms [like hallucinations or delusions] but did not meet the specific criteria for a more define disorder like schizophrenia [a serious mental disorder where a person ' s brain interprets reality in an unusual way, often leading to a disconnect from what others perceive as real), and encephalopathy (a disorder of the brain that affects how the brain works). During a review of Resident 2 ' s H&P dated 3/17/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident ' s active diagnoses included dementia, psychotic disorder, and encephalopathy. The MDS indicated the resident was on antipsychotic medication. During a review of Resident 2 ' s Alprazolam Care Plan dated 4/28/2025, the Care Plan indicated a goal for the resident to be free from discomfort or adverse reactions related to anti-anxiety therapy. The Care Plan interventions indicated to administer anti-anxiety medications as ordered by the physician, monitor for side effects and effectiveness every shift, and monitor the resident at least every two hours for safety. During a review of Resident 2 ' s Physician ' s Order dated 5/4/2025 at 10:31 PM, the Physician ' s Order indicated Alprazolam (a drug used to treat anxiety [a feeling of worry, nervousness, or fear, often about something in the future] disorders and panic attacks [a sudden, intense feeling of intense fear or discomfort]) oral tablet 0.25 mg, give one tablet by mouth every eight hours PRN for anxiety manifested by inability to cope with activities of daily living (ADLs, routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves) causing anger. During a review of Resident 2 ' s MAR dated May 2025, the MAR indicated the resident received Alprazolam 0.25mg, one tablet by mouth every eight hours PRN for anxiety manifested by inability to cope with ADLs causing anger on 5/3/2025 at 8:25 PM and on 5/4/2025 at 5 PM. The MAR indicated Resident 2 only had two doses of Alprazolam documented and no other doses were given to the resident. During a review of Resident 2 ' s Administration Progress Note dated 5/3/2025 at 8:25 PM, the Progress Note indicated Resident 2 received Alprazolam 0.25mg one tablet by mouth every eight hours PRN for anxiety manifested by inability to cope with ADLs causing anger. During a review of Resident 2 ' s Administration Progress Note dated 5/3/2025 at 10:24 PM, the Progress Note indicated the PRN Alprazolam 0.25mg administration was effective. During a review of Resident 2 ' s Nursing Progress Note dated 5/4/2025 at 3:30 AM, the Progress Note indicated Resident 2 was sleeping in bed with no acute distress, the resident ' s bed was low to the floor for safety, and the resident ' s call light was in easy reach. The Progress Note did not indicate the resident received Alprazolam PRN. During a review of Resident 2 ' s Administration Progress Note dated 5/4/2025 at 5 PM, the Progress Note indicated non-pharmacological interventions including distraction and maintaining a calm environment were ineffective and Resident 2 was being monitored by facility staff at the nurse ' s station. The Progress Note did not indicate which medication was given to Resident 2 but a medication was given for outbursts and attempts to flee. During a review of Resident 2 ' s Administration Progress Note dated 5/4/2025 at 6:22 PM,the Progress Note indicated the PRN Alprazolam 0.25mg administration was effective. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2 ' s Controlled Medication Count Sheet (CMCS) for Alprazolam 0.25 mg tablet dated 5/3/2025, the CMCS indicated Resident 2 received Alprazolam 0.25mg one tablet by mouth every eight hours PRN for anxiety manifested by inability to cope with ADLs causing anger on 5/3/2025 at 8:25 PM, on 5/4/2025 at 3:30 AM, and on 5/4/2025 at 7 PM. The CMCS indicated the second administration of Alprazolam 0.25 mg on 5/4/2025 at 3:30 AM was given to Resident 2, seven hours and five minutes after the first initial dose given on 5/3/2025 at 8:25 AM (55 minutes earlier than what was ordered by the physician). During a concurrent interview and record review of Resident 2 ' s CMCS on 5/7/2025 at 3:48 PM, LVN 2 stated Resident 2 ' s Alprazolam 0.25 mg tablets had a quantity of 42 pills and the resident currently had 39 pills indicating three pills were already dispensed. The CMCS indicated Resident 2 received Alprazolam 0.25 mg tablet on 5/3/2025 at 8:25 PM and then again on 5/4/2025 at 3:30 PM. LVN 2 stated the medication was given sooner than should have been which was not okay because Resident 2 could become lethargic (feeling tired, sluggish, and lacking energy or enthusiasm) if the medication was not given within the time frame and could affect the resident ' s ADLs. During a concurrent interview and record review of Resident 2 ' s MAR on 5/7/2025 at 3:55 PM, the DON stated the MAR did not indicate Resident 2 received Alprazolam 0.25 mg tablet at 3:30 AM on 5/4/2025 as indicated on the resident ' s CMCS. The DON stated the CMCS was accurate and the facility staff failed to document in the MAR the administration of the medication. During an observation of Resident 2 ' s Alprazolam 0.25 mg tablet bubble pack on 5/7/2025 at 4:27 PM, the bubble pack indicated a quantity of 42 pills and the bubble pack had 39 remaining pills. During an interview on 5/7/2025 at 4:47, the DON stated there was a discrepancy between the CMCS and the MAR. The DON stated the CMCS signified the facility staff took the medication from the bubble pack and the MAR indicates the medication was given. The DON stated the facility staff should have signed the MAR indicating the medication was given otherwise the facility staff would not know what happened to the medication and if the resident received the medication or not. The DON stated if the medication was not given the resident ' s behavior could get worse or increase. During a review of the facility ' s policy and procedure (P&P) titled, Documentation of Medication Administration revised April 2007, the P&P indicated The facility shall maintain a medication administration record to document all medications administered. The P&P indicated Administration of medication must be documented immediately after (never before) it is given. Documentation must include, as a minimum name and strength of the drug; dosage; method of administration; date and time of administration; signature and title of the person administering the medication n; and resident response to the medication. During a review of the facility ' s P&P titled, Administering Oral Medications revised October 2010, the P&P indicated, The purpose of this procedure is to provide guidelines for the safe administration of oral medications. Verify that there is a physician ' s medication order for this procedure. The P&P indicated, Check the label on the medication and confirm the medication name and dose with the MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of the facility ' s P&P titled Controlled Substances revised April 2019 with the DON, the P&P indicated, Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift. The P&P indicated, Upon receipt: the nurse receiving the medication and the individual delivering the medication verify the name, dose, and quantity of each controlled substance. Upon administration: the nurse administering the medication is responsible for recording: name of the resident receiving the medication; name; strength and dose of the medication; time of administration; method of administration; quantity of the medication remaining; and signature of nurse administering medication. The P&P indicated, At the end of each shift: controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together. Any discrepancies in the controlled substance count are documented and reported to the Director of Nursing services immediately. The DON stated the facility staff were not following the policy and instead of focusing on the quantity received, the facility staff were focusing on the number of medications left. The DON stated if the facility did not follow the policy, the facility could be missing narcotics and the resident ' s pain could get worse if no pain medication were available.