STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055192	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence St Elizabeth Care Center	10425 Magnolia Blvd North Hollywood, CA 91601

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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:1. Remove 16 doses of morphine sulfate (a medication used to treat pain) 15 milligrams (mg - a unit of measure for mass) and 56 doses of oxycodone/APAP (a medication used to treat pain) 5/325 mg from the medication cart after the physician's orders were discontinued affecting two of three sampled residents (Residents 1 and 3.)2. Create a Controlled Drug Administration Record (a log signed by the nurse with the date and time each time a controlled substance is given to a resident) for one of two supplies of oxycodone (a medication used to treat pain) 5 mg affecting one of three sampled residents (Resident 2.) The deficient practices of failing to maintain accountability of controlled substances (medications with a high risk for abuse) increased the risk of diversion (any use other than that intended by the prescriber) and the risk that Residents 1, 2 and 3 could have received too much or too little medication possibly resulting in serious health complications requiring hospitalization. Findings: During an observation and concurrent interview of Medication Cart 2 on 10/28/25 at 1:02 p.m. with the Licensed Vocational Nurse (LVN)1 the following supplies of controlled medications were found in the medication cart:1. Thirteen doses of morphine sulfate 15 mg for Resident 12. Fifty-six doses of oxycodone/APAP 5 mg for Resident 3 A review of Resident 1's Controlled Drug Administration Record indicated three doses of morphine sulfate had been removed from the supply and administered to Resident 1 on 10/22/2025 at 12:00 a.m. and 6:00 a.m., and on 10/27/2025 at 6:00 a.m. A review of Resident 1's Controlled Drug Administration Record and pharmacy label on the medication supply indicated the instructions for use were morphine sulfate 15 mg by mouth every eight (8) hours as needed for severe pain and 1/2 tablet by mouth every eight (8) hours as needed for moderate pain. A review of Resident 1's admission Record (a record containing diagnostic and demographic resident information), dated 10/28/2025, the admission record indicated the resident was originally admitted to the facility on [DATE] with diagnoses including prostate cancer and collapsed vertebrae. A review of Resident 1's undated History and Physical (a record of a physician's comprehensive medical examination) did not indicate whether he had the capacity to understand and make medical decisions. A review of Resident 1's Order Audit Report (a report outlining a timeline of a physician's order), dated 10/28/2025, the order audit report indicated on 10/20/2025, Resident 1 was prescribed morphine sulfate 15 mg by mouth every eight (8) hours as needed for severe pain and 1/2 tablet by mouth every eight (8) hours as needed for moderate pain. Further review of the Order Audit Report indicated this physician order was discontinued on 10/21/2025. A review of Resident 3's Controlled Drug Administration Record and pharmacy label indicated the instructions for use were oxycodone/APAP 5/325 by mouth every four hours as needed for pain. Further review of the pharmacy label indicated the date of dispensing was 10/2/2025. A review of Resident 3's admission Record, dated 10/28/2025, the admission record indicated the resident was originally admitted to the facility on [DATE] with diagnoses including heart failure and swelling in the lungs. A review of Resident 3's History and Physical, dated 10/3/2025, the history and physical indicated she had the capacity to understand and make medical decisions. A review of Resident 3's Order Audit Report, dated 10/28/2025, the order audit report indicated on 10/2/2025, Resident 2 was prescribed oxycodone/APAP 5/325 to take one tablet by mouth every four hours as needed for pain. Further review of the Order Audit Report indicated this physician order was discontinued on 10/2/2025. During a concurrent interview with LVN 1, LVN 1 stated when controlled medications are discontinued, they should be immediately removed from the medication cart and surrendered to the Director of Nursing (DON) for safe, secure storage. LVN 1 stated the nurse or nurses receiving the discontinue orders for Resident 1's morphine and Resident 3's oxycodone/APAP failed to remove the corresponding medication supply from the medication cart. LVN 1 stated having discontinued controlled medications in the cart causes confusion for nursing staff and can lead to medication errors possibly resulting in overdose of narcotics leading to potentially serious medical complications. During an observation and concurrent interview of Medication Cart 1 on 10/28/2025 at 1:27 p.m. with the Licensed Vocational Nurse (LVN) 2 the following supplies of controlled medications were found in the medication cart:1. Fifteen tablets of oxycodone five mg for Resident 2 with instructions on the pharmacy label to take one tablet via gastrostomy tube (g-tube - a tube surgically implanted into the stomach for the administration of medication and nutrition) twice daily2. Thirty tablets of oxycodone five mg for Resident 2 with instructions on the pharmacy label to take one tablet via g-tube every one hour as needed for pain A review of Resident 2's Controlled Drug Administration Records indicated