

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055527	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/06/2024
NAME OF PROVIDER OR SUPPLIER Los Palos Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1430 West 6th Street San Pedro, CA 90732	

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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425</p> <p>Based on interview and record review, the facility failed to include the resident representative in the plan of care for one of three residents (Resident 1) when Resident 1 ' s representative was not informed of Resident 1 ' s change of condition which resulted in Resident 1 being late to his appointment.</p> <p>This deficient practice had the potential to violate Resident 1's right to have their representative participate in his care.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with the diagnoses including malignant neoplasm of the bone and articular cartilage (bone cancer) and congestive heart failure (a serious condition that occurs when the heart can't pump enough blood to meet the body's needs).</p> <p>During a review of Resident 1 ' s History and Physical (H&P) dated 8/31/2024, the H & P indicated Resident 1 was awake and alert.</p> <p>During a review of Resident 1 ' s Nursing Progress Note dated 9/4/2024, the Nursing Progress Note indicated upon Resident 1 ' s transfer to the infusion appointment, Resident 1 had shortness of breath, and a blood oxygen level (SaO2) of 88% (normal level should be between 92-100%) on four liters (unit of measurement) per minute (LPM) of oxygen via nasal cannula (NC). The Nursing Progress Note indicated a breathing treatment was given to Resident 1 which was helpful and SaO2 increased to 93%. The Nursing Progress Note indicated there was no documentation by the licensed nurse notifying Resident 1 ' s representative of Resident 1 requiring a breathing treatment and that he was going to be late to his infusion appointment.</p> <p>During an interview on 9/6/2024 at 10:32 a.m. with the Minimum Data Set Nurse (MDSN), the MDSN stated when the resident experiences a change in condition or there is a change in the treatment plan, the resident representative should be notified. The MDSN stated there was no documentation of the resident representative being notified of Resident 1 requiring a breathing treatment prior to leaving for his appointment.</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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/6/2024 at 12:36 p.m. with the Registered Nurse Supervisor 1 (RNS 1), the RNS 1 stated the resident representative should be notified when there is a change of condition or change in care. The RNS 1 stated the resident representative should be part of the decision-making process regarding care and treatment.</p> <p>During a review of the facility ' s policy and procedure (P/P) titled Resident Rights revised 2/2021, the P/P indicated one of the resident ' s rights included being informed of and participating in, his or her care planning and treatment.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425</p> <p>Based on interview and record review, the facility failed to ensure pain management was provided according to professional standards of practice for one of three residents (Resident 1). The facility failed to:</p> <ol style="list-style-type: none"> 1. Document the administration of seven doses of Norco [a narcotic (a drug that works in the brain to dull the sense of pain) to relieve moderate to severe pain] from 9/1/2024 through 9/3/2024 on Resident 1 ' s administration record. 2. Assess and document Resident 1 ' s pain using the pain rating scale (a subjective [personal view] measure in which individuals rate their pain on an 11-point scale; 0 = no pain, 1-3 = mild pain, 4-6 =moderate pain, 7 to 9 = severe pain, and 10 = worst possible pain). 3. Assess and document the effectiveness of Norco after administration according to the facility ' s policy and procedure (P/P) titled Pain Assessment and Management. <p>This deficient practice had the potential to result in unrecognized unrelieved pain for Resident 1 and placed Resident 1 at risk to suffer unnecessary pain.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with the diagnoses including malignant neoplasm of the bone and articular cartilage (bone cancer).</p> <p>During a review of Resident 1 ' s History and Physical (H&P) dated 8/31/2024, the H &P indicated Resident 1 was awake and alert.</p> <p>During a review of Resident 1 ' s Clinical Record (Care Plan section) dated 8/30/2024, the Care Plan indicated Resident 1 was at risk for pain related to impaired mobility. The Care Plan interventions included complete pain assessment and monitor the effectiveness of pain medication.</p> <p>During a review of Resident 1 ' s Physician Order dated 8/30/2024, the Physician Order indicated Resident 1 was to receive one tablet of Norco 5-325 milligrams ([mg]unit of measurement) every four hours as needed for moderate pain 4-6 ordered on 8/30/2024.</p> <p>During a review of Resident 1 ' s Controlled Medication Count Sheet, the count sheet indicated Resident 1 received Norco 5-325 mg one tablet on the following days and times:</p> <ol style="list-style-type: none"> 1. On 9/1/2024 at 7:56 a.m. 2. On 9/1/2024 at 4:40 p.m. 3. On 9/2/2024 at 8:00 a.m. <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. On 9/2/2024 at 12:00 p.m.</p> <p>5. On 9/2/2024 at 4:00 p.m.</p> <p>6. On 9/3/2024 at 8:30 a.m.</p> <p>7. On 9/3/2024 at 12:30 p.m.</p> <p>During a review of Resident 1 ' s Medication Administration Record (MAR) for the month of 8/2024, the MAR indicated there was no documentation that Norco 5-325 mg was administered to Resident 1 from 9/1/2024 through 9/4/2024.</p> <p>During a review of Resident 1 ' s Nursing Progress Notes dated 9/2/2024 and timed 11:03 a.m., the Nursing Progress Notes indicated the licensed nurses administered one tablet of Norco 5-325 mg to Resident 1 for pain level of 8 out of 10. The Nursing Progress Notes indicated the licensed nurse documented the pain medication was effective at the same time the medication was administered to Resident 1.</p> <p>During a review of Resident 1 ' s Nursing Progress Notes dated 9/3/2024 and timed 10:52 a.m., the Nursing Progress Notes indicated the licensed nurses administered one tablet of Norco 5-325 mg to Resident 1 for lower back pain 8 out of 10. The Nursing Progress Notes indicated the licensed nurse documented the pain medication was effective at the same time the medication was administered to Resident 1.</p> <p>During an interview on 9/6/2024 at 10:32 a.m., the Minimum Data Set Nurse (MDSN) stated Norco 5-325 mg was given to Resident 1 a total of seven times according to the Narcotic Count Sheet and there was no documentation of the administration on the MAR. The MDSN stated the nursing progress note dated 9/2/2024 and timed at 11:03 a.m. indicated the medication was effective at the same time as administered. The MDSN stated on 9/2/2024, the licensed nurses documented Norco 5-325 mg was administered a total of three times on 9/2/2024 however there were no nursing progress notes addressing Resident 1 ' s pain assessment, Norco 5-325 mg administration, nor reassessment of the effectiveness of the pain medication for the additional two doses administered on 9/2/2024. The MDSN stated on 9/3/2024 at 10:52 a.m. the licensed nurses documented Norco 5-325 mg as administered but also documented the Norco 5-325 mg was effective at the same time as administered. The MDSN stated she was not sure which Norco administration the nursing progress note was addressing since Resident 1 received medication at 8:30 a.m. and 12:30 p.m. The MDSN stated when administering narcotics, the administration should be documented in the MAR, the narcotic count sheet, and the licensed nurse should follow up with the resident if the pain medication was effective. The MDSN stated if the pain medication is ineffective, the resident would still experience pain and might require further intervention.</p> <p>During an interview on 9/6/2024 at 12:36 p.m. with the Registered Nurse Supervisor 1 (RNS 1), the RNS 1 stated when a resident requires pain medication, the licensed nurse should assess the resident ' s pain including location and intensity, provide the pain medication according to the physician ' s order, and document the administration on the MAR and narcotic count sheet. RNS 1 stated the licensed nurse should evaluate the effectiveness of the medication after one hour of administration to ensure the resident ' s pain was relieved and if further intervention is needed. RNS 1 stated the medication administration report should be accurate because there is a risk of providing an extra dose if the medication administration is not documented.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility ' s P/P titled Pain Assessment and Management dated October 2022, the P/P indicated during the pain assessment the licensed nurse should gather the following information as indicated from the resident including the characteristics of pain (location, intensity of pain -as measured on a standardized pain scale, pattern of pain, and the frequency and duration of pain. The P/P indicated when opioids (medication used to relieve moderate to severe pain) are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose. The P/P indicated the licensed staff should document the resident ' s reported level of pain with adequate detail (i.e. enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program.</p>