STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055697	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Costa Del Sol Healthcare	1016 S. Record St. Los Angeles, CA 90023

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 0624 Level of Harm - Actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to ensure two of three sampled residents (Residents 1 and 2) were prepared for a safe discharge from the facility when the following occurred: 1. On [DATE], facility staff discharged Resident 1, who required extensive assistance with activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and mobility, without arrangements for home health services (a wide range of health care services that you can get in your home for an illness or injury), as ordered by the physician. 2. On [DATE], facility staff discharged Resident 2, who had physician orders for continuous oxygen therapy (a treatment that provides you with extra oxygen to breathe in), without ensuring Resident 2 had the required equipment and instructions for continuous oxygen therapy. These deficient practices resulted in Resident 1 confined in her wheelchair from [DATE] through [DATE], resulting in macerated (skin condition that occurs when skin is exposed to moisture for an extended period), red skin to her buttocks and perineum (tiny patch of sensitive skin between the genitals) from sitting in her stool and urine. Emergency services [NAME] Resident 1 general acute care hospital (GACH) 1 on [DATE] and diagnosed with bilateral lower extremity venous stasis rash (a skin condition where blood pools in the lower legs due to poor circulation causing the skin to become swollen, itchy, discolored, dry, cracked, and inflamed). These deficient practices also placed Resident 2 at risk for harm of low oxygen levels, respiratory distress, and death due to lack of education and preparation regarding her orders for continuous oxygen therapy. Findings: 1. During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's admitting diagnoses included generalized muscle weakness, unsteadiness on feet, history of falling, lack of coordination, heart attack (life-threatening emergency where blood flow to the heart is blocked), chronic embolism and thrombosis (a condition where blood clots form in a vein, usually in the legs, potentially breaking off and traveling to the lungs) of the right lower extremity. During a review of Resident 1's History and Physical (H&P), dated [DATE], the H&P indicated Resident 1 had the capacity to understand and make decisions. (continued on next page)

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

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F 0624 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's discharge Minimum Data Set (MDS, a resident assessment tool required by the federal government), dated [DATE], the MDS indicated Resident 1 did not have cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 1 required set-up and/or clean-up assistance for brushing her teeth, upper body dressing, and personal hygiene, and required supervision or touch assistance for toileting hygiene, showering or bathing, and lower body dressing. The MDS indicated Resident 1 required partial to moderate assistance to move 50 feet and 150 feet while in a manual wheelchair. The MDS also indicated Resident 1 was frequently incontinent (inability to control) of bowel and bladder function. During a review of Resident 1's Nurse Practitioner (NP, an Advanced Practice Registered Nurse with advanced clinical training) progress note, dated [DATE], written by NP 1, the progress note indicated Resident 1 was at high risk for health complications due to her comorbidities (simultaneous presence of two or more diseases or medical conditions), including her diagnoses of lack of coordination, obesity, chronic embolism and thrombosis, and activities of daily living (ADL, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) dysfunction. The progress note indicated Resident 1 required frequent evaluation. The progress note indicated neglecting regular monitoring and management could result in an acute increase in severity of symptoms, complications, and possible rehospitalization . During a review of Resident 1's physician orders, dated [DATE], the orders indicated to discharge Resident 1 home with a Home Health Agency (HHA) 1. During a review of Resident 1's Discharge Summary, dated [DATE], the Discharge Summary indicated on [DATE] Resident 1 was discharged home with home health services through HHA 1. The Discharge Summary indicated Resident 1 required extensive assistance for ADLs and mobility and indicated Resident 1's skin was intact at the time of discharge. During a review of the email correspondence between HHA 1 and the Social Services Director (SSD), dated [DATE], the email correspondence indicated the SSD received the referral documents on [DATE] at 1:11 PM and sent the referral to HHA 1 on [DATE] at 1:47 PM. During a review of Resident 1's physician's order, dated [DATE] (4 days after being discharged home), the order indicated May [discharge] with [HHA 2] . The SSD entered the order. During a review of Resident 1's social services progress note, dated [DATE] at 4:24 PM, the note indicated Home health referral was sent to [HHA 3] . waiting for response . During an interview on [DATE] at 9:30 AM, with Resident 1, Resident 1 stated she was confined to her wheelchair in the entryway of her apartment since she was discharged home from the facility on [DATE]. Resident 1 stated she slept in the wheelchair and urinated and had bowel movements into the incontinence brief because she could not get up on her own. Resident 1 stated that prior to leaving the facility, the Social Services Director (SSD) informed her she would receive help from HHA 1. Resident 1 stated the SSD instructed her to contact HHA 1 upon discharge. Resident 1 stated that when she contacted HHA 1 at the number provided by the SSD, HHA 1 informed her they did not receive a referral or orders for her to receive home health services. (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 10:19 AM, with Case Manager (CM) 1 from HHA 1, CM 1 stated that when a resident was referred for home health services, the discharging facility would send a referral along with information about the resident. CM 1 stated she never spoke with anyone from the facility regarding Resident 1, and HHA 1 never received any referrals or faxes from the facility for Resident 1. During an interview on [DATE] at 11:23 AM, with Resident 1, Resident 1 stated she had not showered or bathed since returning home on [DATE]. Resident 1 stated she had trouble walking and could not do anything for herself by herself. Resident 1 stated she was handicapped and could not stand. Resident 1 stated her Family Friend (FF 1) came to help her change her incontinence brief on [DATE], but FF 1 was not available all the time because she worked. Resident 1's speech was rapid and frantic during the interview. Resident 1 stated she had no family to help her because they were all deceased . Resident 1 stated she was all alone . During an interview on [DATE] at 12:30 PM, with FF 1, FF 1 stated she lived in the same apartment complex as Resident 1 and had been helping Resident 1 for a few years. FF 1 stated Resident 1 used to be able to walk with a walker, do her own laundry, and only needed help with errands requiring her to drive. FF 1 stated Resident 1 did not require a wheelchair before the resident's admission to the facility. FF 1 stated she was surprised the facility discharged Resident 1 in her current condition because Resident 1 could not care for herself and was not receiving help from anyone else. FF 1 stated Resident 1 had been confined to her wheelchair since arriving home, from the facility on [DATE]. FF 1 stated Resident 1 had not bathed or slept, and urinated, and had bowel movements in her wheelchair, because she was unable to get up on her own. FF 1 stated she had to help Resident 1 change her incontinence brief on [DATE] because Resident 1 was soiled and could not change the brief by herself. During an interview on [DATE] at 4:59 PM, with Resident 1, Resident 1 stated she was suffering from severe pain in her left leg, extending from her knee to her ankle. Resident 1 also stated her right ankle was swollen. Resident 1 stated she was supposed to elevate her legs, but she could not elevate them while in the wheelchair. During an interview on [DATE] at 5:31 PM, with FF 1, FF 1 stated she went to help Resident 1 change her incontinence brief and stated Resident 1's perineum and buttocks were red and raw . During an interview on [DATE] at 8:45 AM, with CM 1 from HHA 1, CM 1 stated she received a referral via email from the facility's SSD, around 2:00 PM on [DATE], for Resident 1 to receive home health services. CM 1 stated this was the first referral received for Resident 1, and stated the physician order for discharge and referral for home health services was dated [DATE]. CM 1 stated home health services were not provided due to the delayed receipt of the referral. During an interview on [DATE] at 9:17 AM, with the Administrator (ADM) for HHA 2, the ADM stated the SSD sent a referral via email on [DATE] requesting home health services for Resident 1. The ADM stated HHA 2 sent a Registered Nurse to see Resident 1 on [DATE], and the SSD called on [DATE] and informed HHA 2 that HHA 1 would be seeing Resident 1, and HHA 2's services were no longer needed. (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review, on [DATE] at 9:47 AM, with the SSD, Resident 1's physician orders, progress notes, and Discharge Summary dated [DATE], were reviewed. The SSD stated the Discharge Summary, dated [DATE], indicated Resident 1 was discharged home on [DATE] and Resident 1 was supposed to receive home health services through HHA 1. The SSD stated she did not confirm that HHA 1 would be providing services prior to discharging Resident 1 on [DATE]. The SSD stated the progress notes indicated from [DATE] to [DATE], Resident 1 had not received home health services as originally indicated in the physician order dated [DATE]. The SSD stated it was important for residents to have confirmed arrangements for home health services prior to discharge to ensure the residents received the care needed once they left the facility. The SSD stated it was not safe to discharge Resident 1 without ensuring home health services would be provided, as ordered by the physician. The SSD stated Resident 1 required extensive assistance with ADLs (routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) at the time of discharge and home health services were necessary to carry out those tasks. During a concurrent interview and record review, on [DATE] at 10:11 AM, with Licensed Vocational Nurse (LVN) 1, Resident 1's Discharge Summary, dated [DATE], was reviewed. LVN 1 stated Resident 1's Discharge Summary indicated Resident 1 required extensive assistance with ADLs and could not stand up or walk by herself. LVN 1 stated the Discharge Summary indicated Resident 1 was incontinent of bowel and bladder and Resident 1's skin was intact at time of discharge. LVN 1 stated it was not safe for Resident 1 to be discharged home without someone available to help her, or arrangements for home health services. LVN 1 stated Resident 1 was at risk for injury, skin breakdown and urinary tract infection (UTI, an infection in the bladder/urinary tract) from her incontinence and inability to perform hygiene tasks on her own, hospitalization , and death. During an interview on [DATE] at 12:32 PM, with FF 1, FF 1 stated Resident 1 called emergency personnel due to increasingly severe pain in her legs. FF 1 stated emergency personnel assessed Resident 1 took her to GACH 1 on [DATE]. During a concurrent interview and record review on [DATE] at 1:32 PM, with the Director of Nursing (DON), Resident 1's Admission Record and NP progress notes dated [DATE] were reviewed. The DON stated Resident 1's Admission Record indicated a diagnosis of a heart attack, chronic embolism, and thrombosis of the right lower extremity. The DON stated Resident 1's prolonged confinement to her wheelchair from [DATE] to [DATE] placed her at risk for repeat formation of a thrombosis, which could lead to another heart attack. The DON stated Resident 1 would also be unable to apply compression to her lower extremities or elevate her lower extremities due to obesity if she was confined to her wheelchair. During a review of Resident 1's GACH 1 records, dated [DATE], the records indicated Resident 1 was brought to the emergency department on [DATE] with complaints of severe lower extremity pain and injury. The records indicated Resident 2 had bilateral grade 4 pitting edema (the most severe type of swelling, where a deep indentation remains in the skin for more than 30 seconds after pressure is applied). The records indicated Resident 2 had an anxious affect (a feeling of fear, dread, and uneasiness) and weak strength in both legs. The records indicated Resident 2 was diagnosed with bilateral lower extremity venous stasis rash and the emergency department physician recommended hospitalization for further evaluation and management. (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	2. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted on [DATE]. Resident 2's admitting diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD, chronic lung disease causing difficulty in breathing), and heart failure (a heart disorder which causes the heart to not pump the blood efficiently). During a review of Resident 2's H&P, dated [DATE], the H&P indicated Resident 2 had capacity for medical decision making. The H&P further indicated that prior to admission to the facility, Resident 2 had been hospitalized due to COPD exacerbation and difficulty breathing. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had moderate cognitive impairment (a stage of cognitive decline where a person has difficulty with complex tasks and navigating to new places), The MDS indicated Resident 2 required supervision and/or touching assistance for picking up small objects. During a review of Resident 2's physician's order, dated [DATE], the order indicated Resident 2 was to be discharged home with HHA 3. During a review of Resident 2's NP Progress Note, dated [DATE], the NP progress note indicated Resident 2's primary diagnosis was COPD, and Resident 2 was at high risk for complications, including increased likelihood of hospital readmission due to complications from pulmonary dysfunction (a general term for diseases that affect the lungs or respiratory system). During a review of Resident 2's physician orders, dated [DATE], the orders indicated Resident 2 was supposed to receive continuous oxygen therapy for desaturation (when blood oxygen levels drop below normal) related to her COPD diagnosis. The order did not specify an oxygen flow rate (the measurement of how much oxygen is delivered to a patient per minute). During a review of Resident 2's care plan titled, Altered Respiratory Status/Difficulty Breathing related to COPD , dated [DATE], the staff's interventions indicated to administer oxygen therapy as ordered to prevent complications related to difficulty breathing or poor oxygen absorption. During a review of Resident 2's Interdisciplinary (IDT, group of different disciplines working together towards a common goal of a resident) Conference Note, dated [DATE], the note indicated Resident 2 informed the SSD that she had a portable oxygen delivery device in her personal possession. The note indicated Resident 2's orders for oxygen therapy were not for continuous oxygen and only as needed. The IDT note did not indicate that any teaching was provided to Resident 2 about her orders for continuous oxygen therapy, or if the personal oxygen delivery device Resident 2 had in her possession was assessed for functionality or the resident's ability to self-administer oxygen. During a review of Resident 2's Discharge Summary, dated [DATE], the Discharge Summary indicated on [DATE], Resident 2 was discharged home from the facility with FF 2. The Discharge Summary indicated Resident 2 required oxygen equipment after her discharge from the facility. The Discharge Summary did not indicate that any instructions or teaching were provided to Resident 2 or FF 2 at the time of discharge related to her orders for continuous oxygen therapy. The Discharge Summary did not indicate Resident 2's portable oxygen delivery device was checked for functionality. (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 1:01 PM, with FF 2, FF 2 stated on [DATE], he assisted Resident 2 with her discharge from the facility because Resident 2 did not have any living children. FF 2 stated at discharge, the facility informed Resident 2 that her oxygen equipment would not be delivered until Tuesday, [DATE], at the earliest. FF 2 stated Resident 2 informed staff that she had a portable oxygen delivery device in her possession at the facility she would be taking home. FF 2 stated the facility did not check the functionality of the portable oxygen delivery device in Resident 2's possession. FF 2 stated the facility did not provide any instructions or teaching about how much oxygen Resident 2 required, or whether the oxygen therapy was needed continuously. During a concurrent interview and record review, on [DATE] at 1:41 PM, with LVN 1, Resident 2's IDT Conference Note and Discharge Summary, both dated [DATE], were reviewed. LVN 1 stated the IDT Conference Note and the Discharge Summary did not indicate Resident 2 or FF 2 were provided any teaching related to the resident's orders for continuous oxygen therapy. LVN 1 further stated the IDT Conference Note and Discharge Summary did not indicate that Resident 2's portable oxygen delivery device was checked by facility's staff to ensure it was able to provide continuous oxygen as ordered. LVN 1 stated Resident 2 was at risk for difficulty breathing, desaturation, hospitalization , and death from not receiving teaching related to oxygen administration, and assessment of her portable oxygen delivery device to ensure it worked and could meet the resident's needs. During a review of the facility's policy and procedure (P&P) titled, Discharge Summary and Plan , dated , d+[DATE], the P&P indicated the staff was supposed to ensure the post-discharge plan included arrangements that had been made for follow-up care and services. The P&P indicated the resident (or their representative) was supposed to be involved in the post-discharge planning process and informed of the final post-discharge plan.