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	11/21/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to reconcile (process of reviewing resident medications to identify the most accurate list of all medications and resolve any discrepancies) the medication list for 1 of 3 sampled residents (Resident 1) upon re-admission or transfer back to the facility from the General Acute Care Hospital (GACH) on 11/18/2025.This deficient practice resulted in Resident 1 receiving incorrect doses of Ibuprofen (medication used to reduce pain and inflammation) and Norco ([Hydrocodone and Acetaminophen], medication used to treat moderate to severe pain). The failures also had the potential for unrelieved pain and worsening of symptoms or condition for Resident 1. Findings:During a review of Resident 1 admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] with diagnoses including Lupus (an autoimmune disease where the body's immune system mistakenly attacks its own tissues and organs, leading to inflammation and damage that can affect joints, skin, kidneys, blood cells, brain, heart, and lungs), Post traumatic stress disorder ([PTSD], a mental health condition that can develop after a person experiences or witnesses a traumatic event) and hypertension (high blood pressure).During a review of Resident's 1 Minimum Data Set ([MDS] a resident assessment tool) dated 11/17/2025, the MDS indicated Resident 1 had no cognitive (ability to think and reason) impairment and the ability to make her needs known.During a review of Resident 1 Change in Condition Evaluation (COC), dated 11/17/2025, the COC indicated Resident 1 complained of back pain radiating to the left side, dizziness, nausea and had an elevated blood pressure of 223/137 mmHg ([millimeters of mercury] standard unit of measuring blood pressure). The COC indicated Resident 1 was transferred to the GACH on 11/17/2025 at 5:54 p.m.During a review of Resident 1's GACH Discharge Medication Reconciliation Order Report dated 11/17/2025, the Report indicated Resident 1 was prescribed Ibuprofen 600 milligrams ([mg.] metric unit of measurement, used for medication dosage and/or amount) one tablet orally (by mouth) every 6 hours as needed for pain and Norco 5/325 mg. one tablet orally every 6 hours as needed for pain. During a review of Resident 1's GACH prescription Form dated 11/17/2025, the Form indicated Resident 1 had a prescription for Ibuprofen 600 mg. one tablet every 6-8 hours as needed (prn) for fever, pain and Norco 5/325 mg. one tablet every 6 hours prn for pain. During a review of Resident 1's Nurses' Notes dated 11/18/2025, the Notes indicated Resident 1 returned to the facility from the GACH on 11/18/2025 at 12:30 a.m. The Nurses' Notes did not indicate a Medication Reconciliation was completed upon transfer back to the facility. During a review of Resident 1's Medication Administration Record (MAR) dated November 2025, the MAR indicated: On 11/18/2025 and 11/20/2025 during the day shift, Resident 1 was given Ibuprofen 800 mg prn for moderate pain (pain rating reference 1-3 mild pain; 4-6 moderate pain; 7-10 severe pain). On 11/18/2025 during the day, evening and night shift, 11/19/2025 during the day and evening shift, and 11/20/2025 during the day and evening shift, Resident 1 was given Norco 10-325 mg prn for severe pain.During a review of Resident 1's Nurses' Notes dated 11/20/2025, the Notes indicated Resident 1 handed written prescriptions from the GACH visit on 11/17/2025 to the Assistant Director of Nursing (ADON). The Notes indicated the prescription was (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sent to the physician on 11/20/2025. During an interview on 11/21/2025 at 2:50 p.m., with the ADON, the ADON stated she was unaware Resident 1 returned from the ER visit with new prescriptions. The ADON stated Resident 1 provided her with the new prescriptions on 11/20/2025 and she contacted Resident 1's physician to reconcile the prescription (on 11/20/2025).During an interview on 11/24/2025 at 11 a.m., with Registered nurse (RN 1), RN 1 stated he forgot to ask Resident 1 about the discharged paper from the ER visit on 11/17/2025 because Resident 1 was very agitated, complaining and demanding for her pain medication. RN 1 stated that he should have gotten the discharged paper and the prescriptions from Resident 1, reconciled the new prescription with her physician before administering medication to the resident.During an interview on 11/24/25 at 2 p.m., with the Director of Nursing (DON), the DON stated, during a readmission or transfer back of residents from the GACH, the licensed nurse should obtain the discharged records from and reconcile any prescriptions with the primary care physician before administering medicationsDuring a review of the facility's Policy and Procedure (P&P) titled, Reconciliation of Medications on Admission, dated 7/2017, the P&P indicated that the purpose of the policy is to ensure medication safety by accurately accounting for the resident's medications, route and dosage upon admission or readmission to the facility.During a review of the facility's P&P titled, Medication Administration dated February 2024, the P&P indicated medications are administered in a safe, timely manner and as prescribed.