

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Costa Del Sol Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286</p> <p>Based on interview and record review, the facility did not ensure staff provided assistance to one of two sampled residents (Resident 61), to accommodate the resident's preference for getting out of bed at least once a day to sit in his wheelchair.</p> <p>This deficient practice had the potential to cause avoidable psychosocial distress and frustration for Resident 61 from an inability to participate in his preferred activity.</p> <p>Findings:</p> <p>A review of Resident 61's Admission Record indicated the facility originally admitted Resident 61 on 12/13/2022. Resident 61's admitting diagnoses included symptoms and signs involving the musculoskeletal system, reduced mobility, and difficulty or inability to move his right side following a stroke (interruption of blood flow to the brain).</p> <p>A review of Resident 61's H&P, dated 2/8/2024, indicated Resident 61 had the capacity to understand and make decisions.</p> <p>A review of Resident 61's MDS, dated [DATE], indicated Resident 61 had mild cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 61 had impairments to the upper extremities on both sides of his body (shoulder, elbow, wrist, and hands), and impairments to the lower extremity on one side of his body (hip knee, ankle, and foot). The MDS indicated Resident 61 required substantial/maximal assistance from staff (staff provide more than half the effort in lifting, holding, or supporting the resident's body) to get dressed and put on footwear. The MDS further indicated Resident 61 required substantial/maximal assistance from staff to roll from side to side, to transition from a lying position to a sitting position, and to transfer from the bed to a wheelchair.</p> <p>During an observation on 5/13/2024 at 11:00 a.m., in Resident 61's room, observed Resident 61 lying in bed watching TV. Resident 61's wheelchair was parked at his bedside.</p> <p>During a concurrent observation and interview on 5/13/2024 at 11:33 a.m., in Resident 61's room, observed Resident 61 lying in bed watching television. Resident 61 stated he suffered a stroke and had difficulty with his mobility on his own.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 5/14/2024 at 9:56 a.m., observed Resident 61 lying in bed watching TV. Resident 61 stated he wanted to get dressed and get up to go outside. Resident 61 stated he required a wheelchair and help from staff to get dressed and transfer to his wheelchair. Resident 61 stated that when he asked staff to assist him, the certified nursing assistants (CNAs) repeatedly told him they had around 10 patients in their assignment, and if someone called off from work their assignment increased to 14 to 16 patients, and they did not have time to help him. Resident 61 stated that the last time he got out of bed was on 5/10/2024.</p> <p>During a concurrent observation and interview on 5/15/2024 at 2:06 p.m., in Resident 61's room, observed Resident 61 lying in bed and watching TV. Resident 61 stated he would like to get out of bed every day, but on average he gets out of bed twice a week. Resident 61 stated that before he can ask for assistance to get out of bed, staff tell him they are too busy or have too many patients, so he doesn't ask to get out of bed.</p> <p>During a concurrent observation and interview, on 5/16/2024 at 9:06 a.m., observed Resident 61 lying in bed and watching television. Resident 61's wheelchair was parked next to his bed. Resident 61 stated he wanted to get out of bed but did not ask because he was not sure who his nurse was. Resident 61 stated he had not been offered to get out of bed (on 5/16/2024).</p> <p>During an interview on 5/16/2024 at 9:22 a.m., with the Activity Director (AD), the AD stated the facility had a patio where residents could sit outside if they wanted. The AD stated that there were no restrictions on residents using the patio and that there just needed to be staff available to supervise. The AD stated it was important for residents to do activities that they preferred.</p> <p>During an interview on 5/16/2024 at 11:45 a.m., with the Director of Nursing (DON), the DON stated staff should assist with transferring residents to their wheelchairs and supervise them in the patio as needed. The DON stated that sitting in a wheelchair while out on the patio was not a hazardous activity, and stated it was not appropriate for staff to tell the resident that they were too busy to assist him. The DON stated that if staff were busy, they should come back once their task was completed to follow up on the resident's request or identify another staff member that could assist.</p> <p>A review of the facility policy and procedure (P&P) titled Accommodation of Needs, dated 3/2021, indicated the facility's environment and staff behaviors are directed towards assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. The P&P indicated the resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943</p> <p>Based on observation, interview, and record review, the facility failed to accurately assess functional limitation (limited ability to move a joint that interferes with daily functioning) in range of motion ([ROM] full movement potential of a joint [where two bones meet]) for five of seven sampled residents (Resident 8, 27, 49, 61, and 63) with limited mobility (ability to move) and ROM limitations.</p> <p>This deficient practice had the potential to affect the provision of care.</p> <p>Findings:</p> <p>a. A review of Resident 8's Admission Record, indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including hemiplegia or hemiparesis (weakness or inability to move one side of the body) affecting the left non-dominant (used less often) side, dementia (decline in mental ability severe enough to interfere with daily life), contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness) to both knees, and muscle weakness.</p> <p>A review of Resident 8's Rehab - Joint Mobility Screen ([JMS] brief assessment of a resident's range of motion in both arms and both legs), dated 10/31/2023, indicated Resident 8 had ROM impairments, including severe impairment (approximately 25 percent [%] or less full ROM) in the left shoulder, left elbow, left wrist, and left hand and moderate impairment (approximately 50% full ROM) in both hips and both knees.</p> <p>A review of Resident 8's Minimum Data Set ([MDS] a comprehensive assessment and care planning tool), dated 11/29/2023, indicated Resident 8 had ROM limitations in one arm and one leg.</p> <p>A review of Resident 8's Rehab - JMS, dated 2/24/2024, indicated Resident 8 had ROM impairments, including severe impairment in the left shoulder, left elbow, left wrist, left hand, both hips, and both knees.</p> <p>A review of Resident 8's MDS, dated [DATE], indicated Resident 8 did not have any ROM limitations in both arms and had ROM limitations in both legs.</p> <p>During an observation on 5/13/2024 at 12:49 p.m., in Resident 8's room, Resident 8 was observed lying in bed with left shoulder rotated toward the body, the left elbow bent, the left wrist bent downward, and the left hand was in a closed fist.</p> <p>During a concurrent observation and interview on 5/14/2024 at 8:54 a.m., in Resident 8's room, Resident 8 was observed awake, lying in bed, and spoke clearly. Resident 8's left arm continued to be positioned with the left shoulder rotated toward the body, the left elbow bent, the left wrist bent downward, and the left hand in a closed fist. Resident 8 moved the left leg but stated the left leg was weak.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 5/14/2024 at 4:38 p.m. with the MDS Coordinator (MDS 1), Resident 8's Rehab - JMS and MDS assessments were reviewed. MDS 1 stated Resident 8's MDS assessments, dated 11/29/2023 and 2/29/2024, was not accurate and should have indicated one arm and both legs had ROM limitations. MDS 1 stated the MDS provided an overall picture of the resident's status. MDS 1 stated it was important for the MDS assessments to be accurate to ensure the resident (in general) did not have any significant changes or decline and to ensure the resident was receiving care.</p> <p>b. A review of Resident 27's Admission Record, indicated Resident 27 was initially admitted to the facility on [DATE] and readmitted Resident 27 on 3/30/2023. The Admission Record indicated Resident 27's diagnoses included Parkinson's disease (brain disorder that causes unintended or uncontrollable movements and difficulty with balance and coordination), contractures on both knees, and muscle weakness.</p> <p>A review of Resident 27's Rehab - JMS, dated 10/5/2023, indicated Resident 27 had ROM impairments including, moderate impairment (approximately 50 percent [%] full ROM) in both shoulders and minimal impairment (75% of full ROM) in the left elbow, both hands, and both knees.</p> <p>A review of Resident 27's MDS, dated [DATE], indicated Resident 27 did not have any ROM impairments in both arms and both legs.</p> <p>A review of Resident 27's Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Evaluation and Plan of Treatment, dated 10/10/2023, indicated Resident 27 had ROM impairments in both shoulders, both elbows, and both hands.</p> <p>A review of Resident 27's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation, dated 10/12/2023, indicated Resident 27 had ROM impairments in both knees.</p> <p>A review of Resident 27's MDS, dated [DATE], indicated Resident 27 did not have any ROM impairments in both arms and both legs.</p> <p>A review of Resident 27's PT Discharge Summary, dated 2/22/2024, indicated Resident 27 had ROM limitations in both knees.</p> <p>A review of Resident 27's OT Discharge Summary, dated 2/23/2024, indicated Resident 27 had ROM limitations in both shoulders, both elbows, and both hands.</p> <p>A review of Resident 27's OT Evaluation and Plan of Treatment, dated 3/4/2024, indicated Resident 27 had ROM limitations in both shoulders, both elbows, both wrists, and both hands.</p> <p>A review of Resident 27's PT Evaluation and Plan of Treatment, dated 3/4/2024, indicated Resident 27 had ROM limitations in both knees.</p> <p>A review of Resident 27's MDS, dated [DATE], indicated Resident 27 did not have any ROM impairments in both arms and both legs.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation 5/13/2024 at 1:26 p.m., in Resident 27's room, Resident 27's shoulders were both rotated toward Resident 27's body, both elbows were bent, both wrists were bent downward, and both hands were in a closed fist position.</p> <p>During an observation on 5/14/2024 at 11:46 a.m., in Resident 27's room, with Restorative Nursing Aide 1 (RNA 1), Resident 27's body was turned toward the right side of the bed. RNA 1 provided PROM exercises to both arms and both legs.</p> <p>During an interview on 5/14/2024 at 11:59 a.m., with RNA 1, RNA 1 stated Resident 27 had stiffness throughout both arms and both knees.</p> <p>During a concurrent interview and record review on 5/14/2024 at 4:28 p.m. with the MDS Coordinator (MDS 1), Resident 27's OT Evaluation and Discharge Summary, PT Evaluation and Discharge Summary, and MDS Assessments were reviewed. MDS 1 stated Resident 27's MDS assessments, dated 10/5/2023, 1/5/2024, and 4/5/2024, were inaccurate and should have indicated Resident 27 had ROM limitations in both arms and both legs in accordance with the OT and PT Evaluations. MDS 1 stated it was important for the MDS assessments to be accurate to ensure the resident (in general) did not have any significant changes or decline and to ensure the resident was receiving care.</p> <p>c. A review of Resident 49's Admission Record, indicated Resident 49 was admitted to the facility on [DATE] with diagnoses including fracture (break in the bone) of the right femur (hip bone), presence of a right artificial hip joint, dementia, and contracture of the right elbow, both knees, and right hip. The Admission Record also indicated Resident 49 was admitted to palliative care (specialized medical care that focuses on providing patients relief from pain and other symptoms of a serious illness) on 2/28/2024.</p> <p>A review of Resident 49's Rehab - JMS, dated 2/29/2024, indicated Resident 49 had ROM impairments in both arms and both legs, including moderate impairment (approximately 50 percent [%] full ROM) in the left shoulder, severe impairment (approximately 25% or less full ROM) in the right shoulder, minimal impairment (75% of full ROM) in the left elbow, severe impairment in the right elbow, moderate impairment in the right wrist, minimal impairment in the right hand, moderate impairments in both hip and the left knee, and severe impairment in the right knee.</p> <p>A review of Resident 49's MDS, dated [DATE], indicated Resident 49 did not have any ROM impairment in both arms and had a ROM impairment in one leg.</p> <p>During an interview on 5/14/2024 at 4:28 p.m. with MDS 1, MDS 1 stated it was important for the MDS assessments to be accurate to ensure the resident did not have any significant changes or decline and to ensure the resident was receiving care.</p> <p>During a concurrent interview and record review on 5/16/2024 at 9:51 a.m. with MDS 1, MDS 1 reviewed Resident 49's Rehab - JMS, dated 2/29/2024, and stated Resident 49 had ROM limitations in both arm and both legs.</p> <p>During a concurrent interview and record review on 5/16/2024 at 9:55 a.m. with MDS 1, MDS 1 reviewed Resident 49's MDS, dated [DATE], and stated the MDS was inaccurate and should have indicated Resident 49 had ROM impairments in both arms and both legs.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. A review of Resident 61's Admission Record, indicated Resident 61 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (weakness and inability to move one side of the body) following a cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the right dominant side, dysphagia (difficulty swallowing) following a cerebral infarction, history of falling, and reduced mobility.</p> <p>A review of Resident 61's Rehab - JMS, dated 3/8/2024, indicated Resident 61 had ROM impairments in both arms, including severe impairment (approximately 25 percent [%] or less full ROM) in both shoulders, the right elbow, and the right hand.</p> <p>A review of Resident 61's MDS, dated [DATE], indicated Resident 61 did not have any ROM limitations in both arms and both legs.</p> <p>During a concurrent observation and interview on 5/13/2024 at 1:05 p.m., in Resident 61's room, Resident 61 was observed awake and lying in bed. Resident 61 used the left hand to eat from the meal tray. Resident 61 had difficulty lifting both arms at the shoulder joint, had some active movement in the right elbow, and had difficulty moving the fingers on the right hand.</p> <p>During an observation on 5/14/2024 at 1:37 p.m., in Resident 61's room, with Restorative Nursing Aide 1 (RNA 1), Resident 61 required RNA 1's physical assistance to perform exercises to both arms and the right leg. Resident 61 moved the left leg without any physical assistance from RNA 1.</p> <p>During an interview on 5/14/2024 at 4:28 p.m. with the MDS 1, MDS 1 stated it was important for the MDS assessments to be accurate to ensure the resident (in general) did not have any significant changes or decline and to ensure the resident was receiving care.</p> <p>During a concurrent interview and record review on 5/16/2024 at 10:17 a.m. MDS 1, Resident 61's Rehab - JMS, dated 3/8/2024, and MDS, dated [DATE], were reviewed. MDS 1 stated Resident 61 has a diagnosis of hemiplegia, affecting the right arm and leg of Resident 61's body. MDS 1 stated Resident 61's MDS, dated [DATE], was inaccurate and should have indicated Resident 61 had ROM impairments to both arms and one leg.</p> <p>e. A review of Resident 63's Admission Record, indicated Resident 63 was admitted to the facility on [DATE] and readmitted Resident 63 on 12/12/2023. The Admission Record indicated Resident 63 had diagnoses including muscle weakness, history of falling, and contracture to both elbows, both hands, both hips, and both knees.</p> <p>A review of Resident 63's Rehab - JMS, dated 12/16/2023, indicated Resident 63 had ROM limitations including, moderate impairment (approximately 50 percent [%] full ROM) in both shoulders, both elbows, both hips, and the right knee, minimal impairment (75% of full ROM) in both hands, and severe impairment (approximately 25% or less full ROM) in the left knee.</p> <p>A review of Resident 63's MDS, dated [DATE], indicated Resident 63 did not have any ROM limitations in both arms and had ROM limitations in both legs.</p> <p>During an interview on 5/14/2024 at 4:28 p.m. with MDS 1, MDS 1 stated it was important for the MDS assessments to be accurate to ensure the resident did not have any significant changes or decline and to ensure the resident was receiving care.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 5/16/2024 at 10:08 a.m. with MDS 1, Resident 63's Rehab - JMS, dated 12/16/2023, and MDS assessment, dated 12/19/2023, were reviewed. MDS 1 stated Resident 63's MDS, dated [DATE], was inaccurate and should have indicated Resident 63 had ROM impairments to both arm and both legs.</p> <p>A review of the facility's undated Policy and Procedure (P&P) titled, Accuracy of the Resident Assessment, indicated any person completing the MDS must sign and certify the accuracy of that portion of the assessment.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>47286</p> <p>Based on interview and record review, the facility did not ensure the Preadmission Screening and Resident Review (PASRR, a federal requirement to help ensure that individuals with a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) screening was accurate, and determination for necessity of potential necessary services was completed for one of two sampled residents (Resident 10).</p> <p>This deficient practice had the potential for Resident 10 to not receive required services and care for her diagnosed mental disorders.</p> <p>Findings:</p> <p>A review of Resident 10's Admission Record indicated the facility admitted Resident 10 on 3/15/2024. Resident 10's admitting diagnoses included anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), unspecified, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).</p> <p>A review of Resident 10's Minimum Data Set (MDS, a comprehensive care-screening and care-planning tool), dated 3/21/2024, indicated Resident 10 had anxiety disorder, depression, and schizophrenia.</p> <p>A review of Resident 10's PASRR Level I Screening, dated 3/8/2024, indicated the individual completing the screening was to mark yes or no to indicate if Resident 10 had a serious diagnosed mental disorder. The PASRR was marked no, indicating Resident 10 did not have a serious mental disorder.</p> <p>During an interview on 5/15/2024 at 9:22 a.m., with the Admission Coordinator (AC), the AC stated the PASRR Level I screenings were conducted in the hospital and sent to the facility, along with the resident's medical records, prior to the resident's admission. The AC stated that once the PASRR Level I screening and medical records were received, she reviewed the documents with the Director of Nursing (DON) for accuracy. The AC stated the PASRR was conducted to determine the presence of a mental illness or disorder. The AC further stated the PASRRs of all potential new admissions to the facility were reviewed to ensure that the facility had the resources needed, and could provide the required services, for residents with mental disorders.</p> <p>During a concurrent interview and record review, on 5/15/2024 9:46 a.m., with the DON, Resident 10's Level I PASRR dated 3/8/2024 and Resident 10's admitting diagnoses was reviewed. The DON stated Resident 10 had depressive disorder, anxiety disorder, and schizophrenia, and stated these diagnoses were not indicated on the resident's PASRR Level I dated 3/8/2024. The DON stated this discrepancy was not caught during the facility's review of the Resident 10's PASRR, and therefore Resident 10 was not referred to the appropriate state-designated mental health authorities for further evaluation and completion of a Level II evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility policy and procedure (P&P) titled Admission Criteria, dated 3/2019, indicated all new admissions and readmissions are screened for mental disorders (MD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. The P&P indicated if the level I screen indicates that the individual may meet the criteria for a MD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. The P&P indicated upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343</p> <p>Based on observation, interview, and record review, the licensed nursing staff failed to follow professional standards of practice and implement the physician's written order for the administration of routine medications to one of three sampled residents (Resident 13).</p> <p>This deficient practice had the potential to place Resident 13 at risk to have complications of high blood pressure, avoidable harm, heart attack (heart muscle begins to die because not getting enough blood flow), respiratory distress, and chronic obstructive pulmonary disease (COPD, a lung disease causing restricted airflow and breathing problem) exacerbation (worsening of symptoms).</p> <p>Findings:</p> <p>A review of Resident 13's Admission Record (Face Sheet), indicated Resident 13 was admitted to the facility on [DATE]. Resident 13's diagnoses included COPD, hypertension (high blood pressure), dementia (a loss of brain function such as memory, language, thinking), and depression (feeling of sadness and loss of interest).</p> <p>A review of Resident 13's History and Physical (H&P), dated 3/21/2024, indicated Resident 13 had the capacity to understand and make decisions.</p> <p>A review of Resident 13's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 3/28/2024, indicated Resident 13 had the capacity to understand and make decisions. The MDS indicated Resident 13 required maximum assistance (helper does more than half the effort) from staff for toileting hygiene, shower, and moderate assistance (helper does less than half the effort) from staff for eating, oral hygiene, and personal hygiene.</p> <p>A review of Resident 13's care plan initiated 3/21/2024, indicated Resident 13 was at risk for complications related to not receiving medication on time. The staffs interventions indicated to administer medication as ordered and give anti hypertension medications as ordered.</p> <p>During an observation on 5/14/2024 at 8:30 a.m., in Resident 13's room, Resident 13 was observed lying in bed, covered with a blanket, eyes closed, and visibly sleeping.</p> <p>During an observation on 5/14/2024 at 9:44 a.m., in Resident 13's room, Resident 13 was observed in bed, eyes closed, and visibly sleeping.</p> <p>During a concurrent observation and interview on 5/14/2024 at 11:10 a.m., in Resident 13's room, Resident 13 was observed lying in bed, awake. Resident 13's breakfast tray was observed on the top of the resident's bedside table next to the bed. Resident 13 stated she just woke up and had not eaten her breakfast or received her morning medications. Resident 13 stated she was feeling dizzy.</p> <p>A review of Resident 13's Medication Administration Records (MAR) for the month of 4/2024 and 5/2024, indicated Resident 13 was to receive the following medications:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Costa Del Sol Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. Amlodipine Besylate (used to treat high blood pressure) oral tablet 5 milligrams([mg]- a unit of measurement of weight), give 5 mg by mouth one time a day at 9:00 a.m.</p> <p>b. Metoprolol Succinate (used to treat high blood pressure) oral tablet 25 mg, give 3 tablets of 25 mg (75mg) by mouth one time a day at 9:00 a.m.</p> <p>c. Aspirin (medication used to lower risk of heart attack) 81 mg oral tablet, give 81 mg by mouth one time a day at 9:00 a.m.</p> <p>d. Sertraline (used to treat depression) oral tablet 100 mg, give 100 mg by mouth one time a day at 9:00 a.m.</p> <p>e. Folic Acid (vitamin important in red blood cell formation and healthy cell growth and function) oral tablet 1 mg, give 1 mg by mouth one time a day at 9:00 a.m.</p> <p>f. Albuterol Sulfate (medication works by relaxing and opening the airways, used for COPD) Nebulization Solution 2.5 mg inhale (breathe) orally via nebulizer every four (4) hours at 8:00 a.m., 12:00 p.m., 4:00 pm., 8:00 p.m.</p> <p>During an interview on 5/14/2024 at 12:47 p.m. with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated she had not administered Resident 13's morning medications. LVN 3 stated Resident 13's morning medications should have been administered at 9:00 a.m. LVN3 stated Resident 13 was sleeping and she did not want to wake the resident. LVN 3 stated it was important to administer medications timely and follow the physician's orders. LVN 3 stated Resident 13 not receiving medications as scheduled placed Resident 13 at risk for high blood pressure, heart attack, and heart failure (condition when heart doesn't pump enough blood for your body).</p> <p>During an interview on 5/14/2024 at 2:07 p.m., with the Director of Nursing (DON), the DON stated licensed staff must follow the physician's orders and administer medications timely as scheduled. The DON stated not administering medications timely placed residents at risk for health complications, and hospitalization .</p> <p>A review of the facility's policy and procedure (P&P) titled Medication Administration, undated, indicated:</p> <ol style="list-style-type: none"> 1. Medications are administered as prescribed in accordance with good nursing principles and practices. 2. Medications are administered in accordance with written orders of the attending physician. 3. Routine medications are administered according to the medication administration schedule. 		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343</p> <p>Based on observation, interview, and record review, the facility failed to ensure fingernail care was provided, and grooming and personal hygiene was maintained for two of eight sampled residents (Resident 52 and 77), who were unable to carry out activities of daily living (ADLs, self-care activities performed daily).</p> <p>This deficient practice had the potential for a negative impact on Resident 52's and Resident 77's quality of life and self-esteem.</p> <p>Findings:</p> <p>1. A review of Resident 52's Admission Record (Face Sheet), indicated Resident 52 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 52's diagnoses included diabetes (high blood sugar), hypertension (high blood pressure), dementia (a loss of brain function such as memory, language, thinking), and dysphagia (difficulty swallowing).</p> <p>A review of Resident 52's Minimum Data Set ([MDS] a comprehensive standardized assessment and care-screening tool) dated 2/13/2024, indicated Resident 52 had the capacity to understand and make decisions. Resident 52 required maximum assistance (helper does more than half the effort) from staff for oral hygiene, toileting, dressing, bathing, and personal hygiene.</p> <p>A review of Resident 52's History and Physical (H&P), dated 3/27/2023, indicated Resident 52 had the capacity to understand and make decisions.</p> <p>During a concurrent observation and interview on 5/13/2024 at 9:58 a.m., with Resident 52, in Resident 52's room, Resident 52 was observed lying in bed watching television. Resident 52's fingernails were long with dark residue under the nail bed. Resident 52 stated he did not remember when the last time his fingernails were cleaned or cut. Resident 52 stated his fingernails looked long and dirty. Resident 52 stated he would like to have his fingernails clean and cut by staff.</p> <p>During a concurrent observation and interview on 5/13/2024 at 10:15 a.m., with Certified Nursing Assistant 10 (CNA 10), in Resident 52's room, CNA 10 stated CNAs were responsible for cleaning and trimming the residents' fingernails. CNA 10 acknowledged that Resident 52's fingernails were long and dirty. CNA 10 stated residents' fingernails should be cleaned daily and trimmed as needed. CNA 10 stated it was important that Resident 52's fingernails were cleaned and trimmed to prevent infection, cuts, and injuries.</p> <p>2. A review of Resident 77's Face Sheet, indicated Resident 77 was admitted to the facility on [DATE]. Resident 77's diagnoses included diabetes, hypertension, dementia, and dysphagia.</p> <p>A review of Resident 77's MDS dated [DATE], indicated Resident 77 usually made self-understood and understood others. The MDS indicated Resident 77 required moderate assistance from staff for ADLs.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 5/13/2024 at 11:07 a.m., with Resident 77, in Resident 77's room, Resident 77 was observed seated on the bed and brushing his hair. Resident 77's fingernails were long with dark residue under the nail bed. Resident 77 stated he did not remember when his fingernails were last cleaned and trimmed.</p> <p>During an interview on 5/13/2024 at 12:14 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated residents' fingernails should be checked daily to determine if they needed to be trimmed or cleaned. LVN 3 stated Resident 77's fingernails were an issue because Resident 77 could rub his eye and could end up with an eye infection. LVN 3 stated Resident 77 could touch other residents or other items and transfer any bacteria on his hands to others. LVN 3 stated Resident 77 could scratch himself and develop a wound that could get infected.</p> <p>During an interview on 5/14/2024 at 3:25 p.m., with Registered Nurse 1 (RN 1). RN 1 stated long and dirty fingernails was a safety risk and placed residents at risk for infection. RN 1 stated residents could scratch themselves, could get injured, and long fingernails could grow bacteria, fungus (living thing produce organisms), and infection.</p> <p>During an interview on 5/14//2024 at 3:43 p.m., with the Director of Nursing (DON), the DON stated it was the CNAs' responsibility to make sure the residents' fingernails were cleaned daily and trimmed as needed. The DON stated residents should be provided with care and services necessary to maintain good personal hygiene.</p> <p>A review of the facility's policy and procedure (P&P) titled Activities of Daily Living (ADLs), undated, indicated, residents who are unable to carry out activities of daily living independently will receive services necessary to maintain good grooming, personal hygiene. The P&P indicated appropriate care services will be provided for residents who are unable to carry out ADLs independently including hygiene (bathing, dressing, and grooming).</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131</p> <p>Based on observation, interview, and record review, the facility failed to ensure fingernail care was provided, and grooming and personal hygiene was maintained for two of eight sampled residents (Resident 52 and 77), who were unable to carry out activities of daily living (ADLs, self-care activities performed daily).</p> <p>This deficient practice had the potential for a negative impact on Resident 52's and Resident 77's quality of life and self-esteem.</p> <p>Findings:</p> <p>1. A review of Resident 52's Admission Record (Face Sheet), indicated Resident 52 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 52's diagnoses included diabetes (high blood sugar), hypertension (high blood pressure), dementia (a loss of brain function such as memory, language, thinking), and dysphagia (difficulty swallowing).</p> <p>A review of Resident 52's Minimum Data Set ([MDS] a comprehensive standardized assessment and care-screening tool) dated 2/13/2024, indicated Resident 52 had the capacity to understand and make decisions. Resident 52 required maximum assistance (helper does more than half the effort) from staff for oral hygiene, toileting, dressing, bathing, and personal hygiene.</p> <p>A review of Resident 52's History and Physical (H&P), dated 3/27/2023, indicated Resident 52 had the capacity to understand and make decisions.</p> <p>During a concurrent observation and interview on 5/13/2024 at 9:58 a.m., with Resident 52, in Resident 52's room, Resident 52 was observed lying in bed watching television. Resident 52's fingernails were long with dark residue under the nail bed. Resident 52 stated he did not remember when the last time his fingernails were cleaned or cut. Resident 52 stated his fingernails looked long and dirty. Resident 52 stated he would like to have his fingernails clean and cut by staff.</p> <p>During a concurrent observation and interview on 5/13/2024 at 10:15 a.m., with Certified Nursing Assistant 10 (CNA 10), in Resident 52's room, CNA 10 stated CNAs were responsible for cleaning and trimming the residents' fingernails. CNA 10 acknowledged that Resident 52's fingernails were long and dirty. CNA 10 stated residents' fingernails should be cleaned daily and trimmed as needed. CNA 10 stated it was important that Resident 52's fingernails were cleaned and trimmed to prevent infection, cuts, and injuries.</p> <p>2. A review of Resident 77's Face Sheet, indicated Resident 77 was admitted to the facility on [DATE]. Resident 77's diagnoses included diabetes, hypertension, dementia, and dysphagia.</p> <p>A review of Resident 77's MDS dated [DATE], indicated Resident 77 usually made self-understood and understood others. The MDS indicated Resident 77 required moderate assistance from staff for ADLs.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 5/13/2024 at 11:07 a.m., with Resident 77, in Resident 77's room, Resident 77 was observed seated on the bed and brushing his hair. Resident 77's fingernails were long with dark residue under the nail bed. Resident 77 stated he did not remember when his fingernails were last cleaned and trimmed.</p> <p>During an interview on 5/13/2024 at 12:14 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated residents' fingernails should be checked daily to determine if they needed to be trimmed or cleaned. LVN 3 stated Resident 77's fingernails were an issue because Resident 77 could rub his eye and could end up with an eye infection. LVN 3 stated Resident 77 could touch other residents or other items and transfer any bacteria on his hands to others. LVN 3 stated Resident 77 could scratch himself and develop a wound that could get infected.</p> <p>During an interview on 5/14/2024 at 3:25 p.m., with Registered Nurse 1 (RN 1). RN 1 stated long and dirty fingernails was a safety risk and placed residents at risk for infection. RN 1 stated residents could scratch themselves, could get injured, and long fingernails could grow bacteria, fungus (living thing produce organisms), and infection.</p> <p>During an interview on 5/14//2024 at 3:43 p.m., with the Director of Nursing (DON), the DON stated it was the CNAs' responsibility to make sure the residents' fingernails were cleaned daily and trimmed as needed. The DON stated residents should be provided with care and services necessary to maintain good personal hygiene.</p> <p>A review of the facility's policy and procedure (P&P) titled Activities of Daily Living (ADLs), undated, indicated, residents who are unable to carry out activities of daily living independently will receive services necessary to maintain good grooming, personal hygiene. The P&P indicated appropriate care services will be provided for residents who are unable to carry out ADLs independently including hygiene (bathing, dressing, and grooming).</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943</p> <p>Based on observation, interview, and record review, the facility failed to ensure five of seven sampled residents (Resident 8, 27, 49, 61, and 65) with limited mobility (ability to move) and range of motion ([ROM] full movement potential of a joint [where two bones meet]) received services to maintain mobility and ROM by failing to:</p> <p>a. Apply Resident 8's left elbow extension splint (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) five times per week during 5/2024 in accordance with the physician orders and care plan.</p> <p>b. Provide Resident 61 with PROM to the right leg and active assistive range of motion (AAROM, use of muscles surrounding the joint to perform the exercise but required some help from a person or equipment) exercises to both arms and the left leg during 5/2024 in accordance with the physician orders and care plan.</p> <p>c. Provide Resident 27, 49, and 65 with passive range of motion (PROM, movement of joint through the ROM with no effort from the person) exercises during 5/2024 for both legs and both arms in accordance with the physician orders and care plan.</p> <p>These failures had the potential for Resident 8, 27, 49, 61, and 65 to develop ROM limitations, including but not limited to the development or worsening of contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness).</p> <p>Cross reference F725.</p> <p>Findings:</p> <p>a. A review of Resident 8's Admission Record, indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including hemiplegia or hemiparesis (weakness or inability to move one side of the body) affecting the left non-dominant (used less often) side, dementia (decline in mental ability severe enough to interfere with daily life), contractures to both knees, and muscle weakness.</p> <p>A review of Resident 8's Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Evaluation and Plan of Treatment, dated 1/27/2024, indicated Resident 8 had impaired ROM in the left shoulder, left elbow, left wrist, and left hand. The OT Evaluation indicated Resident 8's left elbow was bent at 90 degrees.</p> <p>A review of Resident 8's Order Summary Report which included physician orders, dated 2/21/2024, indicated the Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) program to apply the left elbow extension splint during the day for two hours, five days per week.</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 8's care plan, dated 2/21/2024, indicated Resident 8 was at risk for decline and/or complication in ROM, decreased mobility and movement, decreased muscle strength, and required an RNA ROM program to the left arm. The interventions indicated to provide Resident 8 with RNA to apply the left elbow extension splint two hours per day, five days per week.</p> <p>A review of Resident 8's Minimum Data Set ([MDS] a comprehensive assessment and care planning tool), dated 2/29/2024, indicated Resident 8 had clear speech, had difficulty communicating some words, usually understood others, and had severely impaired cognition (ability to think, understand, learn, and remember).</p> <p>A review of Resident 8's RNA Task Schedule (record of nursing assistant tasks) for 5/2024, indicated to apply the left elbow extension splint for two hours per day, five days per week was blank on 5/1/2024, 5/6/2024, 5/9/2024, 5/10/2024, and 5/15/2024.</p> <p>During an observation on 5/13/2024 at 12:49 p.m., in Resident 8's room, Resident 8 was observed lying in bed with left shoulder rotated toward the body, the left elbow bent, the left wrist bent downward, and the left hand was in a closed fist. An elbow splint was not applied to Resident 8's left arm.</p> <p>During a concurrent observation and interview on 5/14/2024 at 8:54 a.m. in Resident 8's room, Resident 8 was observed awake, lying in bed, and spoke clearly. Resident 8's left arm continued to be positioned with the left shoulder rotated toward the body, the left elbow bent, the left wrist bent downward, and the left hand in a closed fist. An elbow splint was not applied to Resident 8's left arm. Resident 8 stated a staff member (unknown) did place a splint on the left elbow, but Resident 8 stated the splint caused much pain when applied to the left arm.</p> <p>During an observation on 5/14/2024 at 11:34 a.m., in Resident 8's room, Resident 8 was observed with a splint applied to the left elbow.</p> <p>During a concurrent interview and record review on 5/16/2024 at 11:13 a.m. with the Director of Staff Development (DSD) and the Director of Rehabilitation (DOR), Resident 8's physician orders for RNA, dated 2/21/2024, and the RNA Task Schedule for 5/2024 was reviewed. The DSD reviewed Resident 8's RNA Task Schedule for 5/2024 and stated the splint was not applied to Resident 8's left elbow five times per week in accordance with the physician orders. The DSD stated Resident 8 did not receive RNA services five times per week in 5/2024 since there was only one RNA staff working. The DOR stated RNA services were important to prevent decline in ROM, function, and mobility.</p> <p>b. A review of Resident 61's Admission Record, indicated Resident 61 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following a cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the right dominant side, dysphagia (difficulty swallowing) following a cerebral infarction, history of falling, and reduced mobility.</p> <p>A review of Resident 61's physician orders, dated 2/8/2024, indicated for RNA to perform AAROM exercises to the left leg and PROM to the right leg, five times per week or as tolerated, to maintain current level of function. Another physician order, dated 3/8/2024, indicated for RNA to provide Resident 61 with AAROM exercises to both arms, five times per week or as tolerated.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 61's Rehab - Joint Mobility Screen ([JMS] brief assessment of a resident's range of motion in both arms and both legs), dated 3/8/2024, indicated Resident 61 had ROM impairments in both arms, including severe impairment (approximately 25 percent [%] or less full ROM) in both shoulders, the right elbow, and the right hand.</p> <p>A review of Resident 61's MDS, dated [DATE], indicated Resident 61 had clear speech, had difficulty communicating some words, usually understood others, and had moderately impaired cognition.</p> <p>A review of Resident 61's undated care plan, indicated Resident 61 was at risk for decline and/or complication with ROM in joints, decreased mobility and movement, decreased muscle strength, and required an RNA program to provide ROM to both arms and both legs. The interventions indicated to provide Resident 61 with RNA for AAROM exercises to the left leg and both arms and PROM to the right leg, five times per week or as tolerated.</p> <p>A review of Resident 61's RNA Documentation Survey Report (record of nursing assistant tasks) for 5/2025, indicated to provide AAROM exercises to both arms and the left leg and PROM exercises to the right leg was blank for 5/1/2024, 5/6/2024, 5/9/2024, 5/10/2024, and 5/15/2024.</p> <p>During a concurrent observation and interview on 5/13/2024 at 11:33 a.m., in Resident 61's room, Resident 61 stated he had a stroke affecting the right side of the body. Resident 61's fingers of the right hand remained straight and unable to bend. Resident 61 stated a nurse (unknown) came once to assist with exercises on both hands but did not provide exercises to both legs. Resident 61 stated the nurse came once and had not returned in the past three to four weeks.</p> <p>During a concurrent observation and interview on 5/13/2024 at 1:05 p.m., in Resident 61's room, Resident 61 was observed awake and lying in bed. Resident 61 used the left hand to eat from the meal tray. Resident 61 stated he received exercises once a day every three to four weeks and did not receive exercises multiple times per week. Resident 61 had difficulty lifting both arms at the shoulder joint, had some motion in the right elbow, and had difficulty moving the fingers on the right hand.</p> <p>During an observation on 5/14/2024 at 1:37 p.m., in Resident 61's room, with Restorative Nursing Aide 1 (RNA 1), RNA 1 performed AAROM exercises to both arms and the left leg and PROM to the right leg.</p> <p>During a concurrent interview and record review on 5/16/2024 at 12:40 p.m. with the DOR and DSD, Resident 61's physician orders, dated 2/8/2024 and 3/8/2024, and the RNA Documentation Survey Report for 5/2024 was reviewed. The DSD stated Resident 61 did not receive RNA for AAROM to both arms and the left leg and PROM to the right leg, five per week in accordance with the physician orders since there was only one RNA staff working during 5/2024. The DOR stated RNA services were important to prevent decline in ROM, function, and mobility.</p> <p>c. A review of Resident 27's Admission Record, indicated Resident 27 was initially admitted to the facility on Resident 27 on 8/5/2021 and readmitted Resident 27 on 3/30/2023. The Admission Record indicated Resident 27's diagnoses included Parkinson's disease (brain disorder that causes unintended or uncontrollable movements and difficulty with balance and coordination), contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness) on both knees, and muscle weakness.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Costa Del Sol Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 S. Record St. Los Angeles, CA 90023	
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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 27's MDS, dated [DATE], indicated Resident 27 had clear speech, had difficulty communicating some words, usually understood others, and had severely impaired cognition.</p> <p>A review of Resident 27's Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) Evaluation and Plan of Treatment, dated 3/4/2024, indicated Resident 27 had impaired ROM in both shoulders, elbows, wrists, and hands.</p> <p>A review of Resident 27's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation and Plan of Treatment, dated 3/4/2024, indicated Resident 27 had impaired ROM in both knees.</p> <p>A review of Resident 27's physician orders, dated 3/4/2024 and 3/5/2024, indicated for RNA to provide PROM exercises to both legs, four times per week as tolerated. Another physician order, dated 3/5/2024, indicated for RNA to provide Resident 27 with PROM exercises to both arms at all joints, four times per week as tolerated.</p> <p>A review of Resident 27's care plan, dated 3/4/2024, indicated Resident 27 was at risk for decline and/or complication with ROM in joints, decreased mobility and movement, decreased muscle strength, and required an RNA program for both arms and both legs. The interventions indicated to provide Resident 27 with RNA for PROM in both arms and both legs, four times per week.</p> <p>A review of Resident 27's RNA Task Schedule for 5/2024, indicated RNA to perform PROM to both arm and both legs was blank for 5/1/2024, 5/5/2024, 5/6/2024, 5/10/2024, and 5/15/2024.</p> <p>During an observation on 5/13/2024 at 9:44 a.m., in Resident 27's room, Resident 27 was observed lying in bed with both elbows bent and both hands positioned in a closed fist.</p> <p>During a concurrent observation and interview on 5/13/2024 at 1:26 p.m., in Resident 27's room, Resident 27's eyes were observed closed but the resident responded to questions. Resident 27 stated he rarely received exercises but was unable to specify how often exercises were performed. Resident 27's shoulders were both rotated toward Resident 27's body, both elbows were bent, both wrists were bent downward, and both hands were in a closed fist position.</p> <p>During an observation on 5/14/2024 at 11:46 a.m., in Resident 27's room, with RNA 1, Resident 27's body was turned toward the right side of the bed. RNA 1 provided PROM exercises to both arms and both legs.</p> <p>During an interview on 5/14/2024 at 11:59 a.m., with RNA 1, RNA 1 stated Resident 27 had stiffness throughout both arms and both knees.</p> <p>During an interview on 5/14/2024 at 3:34 p.m. with the DOR, the DOR stated the purpose of the RNA program was to maintain a resident's ROM. The DOR stated Resident 27 was receiving PT, OT, and RNA services at the same time since Resident 27's diagnosis of Parkinson's disease placed Resident 27 at increased risk for decline in ROM.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 5/16/2024 at 11:59 a.m. with the DOR and DSD, Resident 27's physician orders for RNA, dated 3/4/2024 and 3/5/2024, and RNA Task Schedule for 5/2024 was reviewed. The DSD stated Resident 27 did not receive RNA for PROM to both arms and both legs four times per week in accordance with the physician orders during 5/2024 since there was only one RNA staff working. The DOR stated RNA services were important to prevent decline in ROM, function, and mobility.</p> <p>d. A review of Resident 49's Admission Record, indicated Resident 49 was admitted to the facility on [DATE] with diagnoses including fracture (break in the bone) of the right femur hip bone, presence of a right artificial hip joint, dementia, and contracture of the right elbow, both knees, and right hip. The Admission Record also indicated Resident 49 was admitted to palliative care (specialized medical care that focuses on providing patients relief from pain and other symptoms of a serious illness) on 2/28/2024.</p> <p>A review of Resident 49's Rehab - JMS, dated 2/29/2024, indicated Resident 49 had ROM impairments in both arms and both legs, including moderate impairment (approximately 50 percent [%] full ROM) in the left shoulder, severe impairment (approximately 25% or less full ROM) in the right shoulder, minimal impairment (75% of full ROM) in the left elbow, severe impairment in the right elbow, moderate impairment in the right wrist, minimal impairment in the right hand, moderate impairment in both hips and the left knee, and severe impairment in the right knee.</p> <p>A review of Resident 49's physician orders, dated 3/1/2024, indicated for the RNA to provide gentle PROM exercises to both arms and both legs, five times per week as tolerated.</p> <p>A review of Resident 49's care plan, dated 1/3/2024, indicated Resident 49 was at risk for decline and/or complication with ROM in joints, decreased mobility and movement, decreased muscle strength, and required an RNA program for both legs. The interventions, initiated 3/1/2024, indicated to provide Resident 49 with RNA for PROM in both legs, five times per week.</p> <p>A review of Resident 49's MDS, dated [DATE], indicated Resident 49 had clear speech, had difficulty communicating some words, usually understood others, and had severely impaired cognition.</p> <p>A review of Resident 49's RNA Task for 5/2024, indicated to provide PROM to both arms and both legs was blank for 5/1/2024, 5/6/2024, 5/10/2024, and 5/15/2024.</p> <p>During a concurrent observation and interview on 5/14/2024 at 8:59 a.m., in Resident 49's room, Resident 49 was observed turned facing the left side of the bed. Resident 49's right shoulder was rotated toward the body, right elbow was bent, and the right wrist was bent. Resident 49's moved the fingers of the right hand without any assistance. Resident 49 stated he did not like the exercises due to pain.</p> <p>During an observation and interview on 5/14/2024 at 11:38 a.m., with RNA 1, in Resident 49's room, RNA 1 attempted to perform exercises with Resident 49, who refused the perform exercises with RNA due to pain. RNA 1 stated the nurse would be notified of Resident 49's pain and would attempt again after Resident 49 received pain medication.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 5/16/2024 at 12:19 p.m. with the DOR and DSD, Resident 49's physician orders, dated 3/1/2024, and RNA Task Schedule for 5/2024 was reviewed. The DSD stated Resident 49 did not receive RNA for PROM to arms and both legs, five per week in accordance with the physician orders during 5/2024 since there was only one RNA staff working. The DOR stated RNA services were important to prevent decline in ROM, function, and mobility.</p> <p>e. A review of Resident 65's Admission Record, indicated Resident 65 was admitted to the facility on [DATE] and readmitted Resident 65 on 9/6/2023. Resident 65's diagnoses included muscle weakness, encephalopathy (disease that affects the brain, causing changes in its function), anxiety disorder (feelings of worry or fear that are strong enough to interfere with one's daily activities), dementia, and dysphagia. The Admission Record also indicated Resident 65 was admitted to palliative care on 10/25/2023.</p> <p>A review of Resident 65's physician orders, dated 11/17/2023 and 3/12/2024, indicated for the RNA to provide PROM exercises to both legs, seven times per week as tolerated. The order dated 3/12/2024, indicated for RNA to provide PROM exercises to both arms, five times per week as tolerated.</p> <p>A review of Resident 65's care plan, dated 11/17/2023, indicated Resident 65 was at risk for decline and/or complication with ROM in joints, decreased mobility and movement, decreased muscle strength, and required an RNA program. Interventions indicated to provide Resident 65 with PROM exercises to both arms, five times per week, and both legs, seven times per week, as tolerated.</p> <p>A review of Resident 65's Rehab - JMS, dated 2/2/2024, indicated Resident 65 had ROM impairments, including minimal impairment (75 percent [%] of full ROM) in both elbows and the right hand.</p> <p>A review of Resident 65's MDS, dated [DATE], indicated Resident 65 had clear speech, had difficulty communicating some words, usually understood others, and had severely impaired cognition.</p> <p>A review of Resident 65's RNA Documentation Survey Report for 5/2025, indicated to provide PROM to both arms, five times per week, and PROM to both legs, seven times per week, was blank on 5/1/2024, 5/4/2024, 5/5/2024, 5/6/2024, 5/9/2024, 5/10/2024, and 5/15/2024.</p> <p>A review of Resident 65's Rehab - JMS, dated 5/13/2024, indicated Resident 65 had ROM limitations in both arms and both legs. Resident 65's ROM impairments included moderate impairment (approximately 50% full ROM) in the left shoulder, severe impairment (approximately 25% or less full ROM) in the right shoulder, minimal impairment in both elbows, and moderate impairment in both wrists, the right hand, both hips, and both knees. The recommendations indicated Resident 65 will receive PT and OT evaluations due to the ROM decline which was anticipated due to Resident 65's palliative care status.</p> <p>During a concurrent observation and interview on 5/13/2024 at 12:54 p.m., in Resident 65's room, Resident 65 was observed awake, alert, and lying in bed. Resident 65's body was turned toward the right side and both hips and knees were in a bent position. Resident 65 slightly lifted both arms at the shoulder joint, bent both arms at the elbow joint, and slightly opened both hands. Resident 65 stated the RNA had just performed exercises with Resident 65.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 5/16/2024 at 12:45 p.m. with the DOR and DSD, Resident 65's physician orders, dated 11/17/2023 and 3/12/2024, and RNA Documentation Survey Report for 5/2024 was reviewed. The DSD stated Resident 65 did not receive RNA for PROM to arms, five times per week, and both legs, seven times per week in accordance with the physician orders during 5/2024 since there was only one RNA staff working. The DOR stated RNA services were important to prevent decline in ROM, function, and mobility.</p> <p>A review of the facility's Policy and Procedure (P&P) titled, Resident Mobility and Range of Motion, revised 7/2017, indicated residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47286</p> <p>48131</p> <p>Based on observation, interview, and record review, the facility failed to ensure a safe and hazard free environment was maintained for one of three sampled residents (Resident 75) when a pool of enteral nutrition (form of nutrition that is delivered as a liquid) was observed on the floor in Resident 75's room.</p> <p>This deficient practice had the potential to cause avoidable harm to Resident 75 related to slips, falls, and possible subsequent injury associated with a fall.</p> <p>Findings:</p> <p>A review of Resident 75's Admission Record indicated the facility admitted Resident 75 on 1/15/2024. Resident 75's admitting diagnoses included abnormalities of gait (manner of walking) and mobility and generalized muscle weakness.</p> <p>A review of Resident 75's Minimum Data Set (MDS, a comprehensive care-screening and care-planning tool), dated 4/22/2024, indicated Resident 75 had intact cognitive skills for daily decision making (normal ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 75 required set-up or clean-up assistance with ambulation (walking), meaning staff assisted only prior to or following the activity.</p> <p>A review of Resident 75's care plan indicated Resident 75 was at high risk for falls related to generalized weakness, gait/balance problem and impaired mobility. Goals of Resident 75's care included not sustaining serious injury.</p> <p>During a concurrent observation and interview, on 5/13/2024 at 10:07 a.m., in Resident 75's room, Resident 75 was observed ambulating in his room without staff assistance. There was a pool of enteral nutrition (liquid nutrients) flowing from his roommate's bedside and extending into his side of the room. The pool of enteral nutrition was accumulating on the left side of Resident 75's bed, extending to the space underneath his bed. Resident 75 stated he usually ambulates in his room and around the facility without staff supervision.</p> <p>During a concurrent observation and interview, on 5/13/2024 at 10:16 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated there was a pool of enteral nutrition on the ground. LVN 1 stated this accumulation of liquid on the ground was a slipping hazard for Resident 75 and stated Resident 75 could sustain a fall.</p> <p>During an interview on 5/16/2024 at 10:52 a.m., with the Director of Nursing (DON), the DON stated that the floors and walkways in the facility should be clean and clear of spills and accumulated liquids because they created a risk for slips and falls.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility policy and procedure (P&P) titled Safety and Supervision of Residents, dated 7/2017, indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>47286</p> <p>Based on observation, interview, and record review, facility staff failed to administer enteral nutrition (the delivery of nutrients through a gastrostomy tube [a flexible plastic tube placed into the stomach wall]) as ordered for one of two sampled residents (Resident 27).</p> <p>This deficient practice had the potential to cause avoidable complications, such as malnutrition and/or delays in health promotion and maintenance for Resident 27.</p> <p>Findings:</p> <p>A review of Resident 27's Admission Record indicated the facility originally admitted Resident 27 on 8/5/2021, and most recently readmitted Resident 27 on 3/30/2023. Resident 27's admitting diagnoses included gastrostomy status (the creation of an artificial external opening into the stomach for nutritional support), protein-calorie malnutrition (the state of inadequate intake of food [as a source of protein, calories, and other essential nutrients]), muscle wasting and atrophy (decrease in size of muscle tissue), dysphagia (difficulty or discomfort in swallowing).</p> <p>A review of Resident 27's active physician orders, dated 5/13/24, indicated Resident 27 was receiving enteral nutrition through a gastrostomy tube.</p> <p>A review of Resident 27's Minimum Data Set (MDS, a comprehensive care screening and care planning tool), dated 4/5/2024, indicated Resident 27 had a gastrostomy tube, and received 51 percent (%) or more of his total calories from enteral nutrition.</p> <p>A review of Resident 27's care plan, dated 3/31/2023, and revised on 8/3/2023, indicated Resident 27 required tube feeding [enteral nutrition] related to dysphagia. The care plan indicated the goals of care included Resident 27 remaining free of side effects or complications related to tube feeding and maintaining adequate nutritional and hydration status. The interventions indicated to achieve these goals staff were to administer GT [enteral nutrition] as ordered and indicated.</p> <p>During an observation on 5/13/2024 at 9:58 a.m., at Resident 27's bedside, observed Resident 27's enteral nutrition bottle connected to a feeding pump. The pump was programmed to infuse the enteral nutrition at a rate of 65 milliliters per hour (a unit for measuring the rate of administration). Resident 27's gastrostomy tube was connected to the feeding pump, and the opening of the gastrostomy tube was closed. Resident 27 was not receiving any enteral nutrition, and the enteral nutrition was observed flowing onto the floor and soaked into the towel and sheets of his bed.</p> <p>During a concurrent observation and interview, on 5/13/2024 at 10:16 a.m., at Resident 27's bedside, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 27 was supposed to be receiving enteral nutrition and stated the enteral nutrition was not being administered as ordered. LVN 1 stated the access to Resident 27's gastrostomy tube was closed. LVN 1 stated she was not sure how long it had been closed. LVN 1 stated there was a potential that Resident 27 would not meet his caloric needs.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/16/2024 at 10:53 a.m., with the Director of Nursing (DON), the DON stated that if a resident did not receive their enteral nutrition as ordered, the resident's condition could decline, and there was potential for the resident to suffer unwanted weight loss. The DON stated it was important for residents to receive their enteral nutrition as ordered to meet their nutritional needs.</p> <p>A review of the facility policy and procedure (P&P) titled Enteral Nutrition, dated 11/2018, indicated it was the facility's policy that adequate nutritional support through enteral nutrition is provided to residents as ordered.</p> <p>A review of the facility P&P titled Enteral Feedings - Safety Precautions, dated 11/2018, indicated the purpose of the P&P was to ensure the safe administration of enteral nutrition. The P&P further indicated staff were supposed to regularly inspect tubing for proper and secure connections.</p>

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343</p> <p>Based on observation, interview, and record review, the licensed nurses failed to follow the facility policy and procedure (P&P) for initiation and maintenance of intravenous therapy ([IV] a way to give fluids, medicine, nutrition, or blood directly into the blood stream through a vein) for one of two residents (Resident 243) by:</p> <ol style="list-style-type: none"> 1. Failing to label and date a peripheral intravenous catheter ([PIV] a short catheter inserted through a peripheral vein for the administration of solution or medication) site. 2. Failing to change the PIV site and dressing when the site appeared compromised. 3. Failing to remove the PIV after IV treatment was complete. <p>This deficient practice had the potential to result in harm and lead to development of infection, infiltration (accidental leakage of non-vesicant solutions out of the vein into the surrounding tissue) and phlebitis (inflammation of a vein) for Resident 243.</p> <p>Findings:</p> <p>A review of Resident 243's Admission Record (Face Sheet), indicated Resident 243 was admitted to the facility on [DATE] with diagnoses including diabetes (high blood sugar), urinary tract infection ([UTI]- infection in the bladder), hypertension (high blood pressure), and muscle weakness (a lack of strength in the muscles).</p> <p>A review of Resident 243's History and Physical (H&P), dated 5/11/2024, indicated Resident 243 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 243's Order Summary Report, dated 5/9/2024, indicated IV site to the right forearm. The order summary report indicated Ceftriaxone Sodium (medication that works by killing bacteria [infection]), use two (2) grams ([GM]-a unit of measurement of weight) intravenously, one time a day for UTI until 5/10/2024.</p> <p>During a concurrent observation and interview on 5/13/2024 at 10:50 a.m. with Resident 243, in Resident 243's room, Resident 243 was observed lying in bed, well groomed, and dressed appropriately. Resident 243 was observed with a PIV to the right forearm. The dressing was visibly soiled (dirty), dislocated (to move from proper place), and undated. Resident 243 stated she felt discomfort at the PIV site.</p> <p>During a concurrent observation and interview on 5/13/2024 at 11:57 a.m., with Licensed Vocational Nurse 3 (LVN 3), in Resident 243's room, LVN 3 confirmed Resident 243's PIV dressing was soiled, dislocated, and undated. LVN 3 stated it was the LVNs responsibility to assess the resident's PIV site for signs and symptoms of infection, soiled dressings, or dislocation, and report to the registered nurse (RN). LVN 3 stated it was the RNs responsibility to change the PIV and dressing.</p> <p>(continued on next page)</p>		

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

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 5/13/2024 at 3:45 p.m., with RN 1, in Resident 243's room, RN 1 stated she was not aware Residents 243's PIV dressing was soiled, dislocated, and undated. RN 1 stated she was not aware of Resident 243's having discomfort at the PIV site. RN 1 stated Resident 243's IV treatment was completed on 5/10/2024. RN 1 stated the PIV should have been removed to prevent infection.</p> <p>A review of facility's policy and procedure (P&P) titled Peripheral and Midline IV Dressing Changes, revised 3/2022, indicated:</p> <ol style="list-style-type: none"> 1. To prevent complications associated with intravenous therapy, including catheter-related infections associated with contaminated, lessened, or soiled site dressings. 2. Perform site care and dressing change if the dressing is compromised (damp, loosened or visibly soiled). 3. Maintain sterile dressing (transparent semi-permeable membrane [TMS] dressing or sterile gauze) for all peripheral catheter sites. 4. Change dressing if it becomes damp, loosened, or visibly soiled every 2 days. 5. Change immediately if the dressing or site appears compromised. 6. Label dressing with the date and time of dressing change, and initials.

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343</p> <p>Based on observation, interview, and record review, the facility failed to provide respiratory services for three of four sampled residents (Resident 13, 57, and 69) by failing to:</p> <p>a. Ensure Resident 13 was provided a nebulizer machine (a device used to administer medication in the form of a mist inhaled into the lungs), incentive spirometer (device that measures the volume of the air inhaled into the lungs during inspiration), oxygen cylinder (medical device to provide supplemental oxygen to resident), nasal cannula (a device used to deliver supplemental oxygen placed directly on the resident's nostrils), respiratory treatment via nebulizer every four hours, and incentive spirometer treatment twice per day.</p> <p>This deficient practice had the potential to cause shortness of breath, avoidable harm, respiratory distress, and chronic obstructive pulmonary disease ([COPD]- a lung disease causing restricted airflow and breathing problems) exacerbation (worsening symptoms).</p> <p>b. Ensure Resident 57 was provided a humidifier (a device that adds moisture to the air to prevent dryness) while receiving more than 4 liters of oxygen via a nasal cannula.</p> <p>This deficient practice had the potential to cause discomfort and nosebleed associated with dry nasal mucous membranes (moist tissue that lines the inside of the nose).</p> <p>c. Ensure Resident 69 had a physician order for the administration of oxygen therapy.</p> <p>This deficient practice had the potential to cause complications associated with oxygen therapy.</p> <p>Findings:</p> <p>1. A review of Resident 13's Admission Record (Face Sheet), indicated Resident 13 was admitted to the facility on [DATE] with diagnoses including COPD, hypertension (high blood pressure), dementia (a loss of brain function such as memory, language, thinking), and depression (feeling of sadness and loss of interest).</p> <p>A review of Resident 13's History and Physical (H&P), dated 3/21/2024, indicated Resident 13 had the capacity to understand and make decisions.</p> <p>A review of Resident 13's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 3/28/2024, indicated Resident 13 required maximum assistance (helper does more than half the effort) from staff for toileting hygiene and showering, and moderate assistance (helper does less than half the effort) from staff for eating, oral hygiene, and personal hygiene.</p> <p>A review of Resident 13's Order Summary Report, dated 4/4/2024 and 5/1/2024, indicated to administer oxygen at 2 liters (l, unit of measurement) per minute (lpm) as needed for shortness of breath (SOB), incentive spirometer twice a day (BID) while awake, and Albuterol Sulfate Nebulization Solution (medication which works by relaxing and opening the airways) 2.5 milligram ([mg]-a measure of weight), inhale (breathe) orally via nebulizer every four (4) hours for COPD.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 5/13/2024 at 8:30 a.m., in Resident 13's room, Resident 13 was observed lying in bed, covered with a blanket, eyes closed, and visibly sleeping. There was no oxygen equipment, nebulizer machine, or incentive spirometer observed.</p> <p>During an observation on 5/13/2024 at 10:44 a.m., in Resident 13's room, there was no oxygen equipment, nebulizer machine, or incentive spirometer observed.</p> <p>During an observation on 5/13/2024 at 2:20 p.m., in Resident 13's room, there was no oxygen equipment, nebulizer machine, or incentive spirometer observed.</p> <p>During a concurrent interview and record review on 5/13/2024 at 4:30 p.m., with Registered Nurse 1 (RN 1), Resident 13's order summary reports, dated 4/2024, and 5/2024 was reviewed. The order summary reports indicated to administer oxygen at 2 lpm as needed for SOB, and incentive spirometer BID while awake. The order summary reports indicated Albuterol Sulfate Nebulization Solution 2.5 mg inhale orally via nebulizer every four (4) hours for COPD.</p> <p>During a concurrent observation and interview on 5/13/2024 at 4:35 p.m., with RN 1, in Resident 13's room. RN 1 confirmed there was no oxygen equipment, nebulizer, or incentive spirometer supplies in Resident 13's room. RN 1 stated Resident 13 should had been provided with the required respiratory treatment supplies per the facility's policy. RN 1 was not able to explain why Resident 13 was not provided with oxygen equipment, a nebulizer, and incentive spirometer supplies. RN 1 stated not having the required respiratory treatment supplies available when needed would mean the licensed staff would not be able to provide Resident 13 with respiratory treatment as ordered, which placed Resident 13 at risk for respiratory distress, avoidable SOB, COPD exacerbation, and hospitalization .</p> <p>During a concurrent observation and interview on 5/14/2024 at 10:10 a.m., with Resident 13, in Resident 13's room, Resident 13 was observed lying in bed reading a newspaper. There was no oxygen equipment, nebulizer machine, or incentive spirometer observed. Resident 13 stated she had resided in the facility for two months and did not remember receiving respiratory treatment since admission.</p> <p>During an interview on 5/14/2024 at 10:25 a.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated she was the medication pass nurse. LVN 3 stated she did not provide Resident 13's respiratory treatment. LVN 3 stated Respiratory Therapist 1 (RT 1) was providing respiratory treatment for Resident 13.</p> <p>During an interview on 5/14/2024 at 1:45 p.m., with RT 1, RT 1 stated she was providing Resident 13's respiratory treatment during her work hours from 7:30 a.m., to 2:00 p.m., three times per week. RT 1 stated when she was not on duty, the licensed staff should provide Resident 13 's respiratory treatment.</p> <p>During a concurrent interview and record review on 5/14/2024 at 2:20 p.m., with RT 1, Resident 13's Medication Administration Record (MAR), dated 5/13/2024 was reviewed. The MAR indicated, on 5/13/2024, for the 8:00 a.m., and 12:00 p.m. administration time, there were no licensed staff initials in the box for Resident 13's Albuterol Sulfate Nebulization Solution 2.5 mg, to demonstrate the medication was administered. The MAR also indicated, on 5/13/2024, for 8:00 a.m., and 12:00 p.m. administration time, there were no licensed staff initials in the box for Resident 13's incentive spirometer, to demonstrate the treatment was provided.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 5/14/2024 at 2:20 p.m., with RT 1, in Resident 13's room, RT 1 confirmed there was no oxygen equipment, nebulizer machine, and supplies, or incentive spirometer observed. RT 1 stated Resident 13 should had been provided needed respiratory treatment supplies and which should have been available in the resident's room. RT 1 stated if respiratory treatment supplies were not available in Resident 13 's room, licensed staff would not be able to provide Resident 13's respiratory treatment as ordered. RT 1 stated Resident 13 would not receive respiratory treatment as ordered. RT 1 stated it placed Resident 13 at risk for respiratory distress, avoidable COPD exacerbation, and hospitalization .</p> <p>A review of the facility's Policy and Procedure (P&P) titled Oxygen Administration revised 10/2010, indicated the following:</p> <ol style="list-style-type: none"> 1. Provide safe oxygen administration. 2. Review physician's orders for oxygen administration. 3. Assemble the equipment and supplies. 4. Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and nasal catheter. 5. Equipment and supplies necessary: <ol style="list-style-type: none"> a. Portable oxygen cylinder (medical device to provide supplemental oxygen to resident). b. Nasal cannula, nasal catheter, mask. c. Humidifier bottle. d. No Smoking/Oxygen in Use sign. e. Personal protective equipment (gowns, gloves, mask). <p>A review of the facility's P&P titled Administering Medications through a Small Volume (Handheld) Nebulizer, revised 10/2010, indicated the following:</p> <ol style="list-style-type: none"> 1. Review current orders. 2. Assemble the equipment and supplies: <ol style="list-style-type: none"> a. nebulizer kit, including nebulizer, medication cup, T- piece, mouthpiece (or face mask), and tubing. 3. Assemble equipment and supplies on the resident's overbed table. 4. Store equipment in a plastic bag with resident's name, date. <p>A review of the facility's P&P titled Medication Administration, undated, indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Medications are administered as prescribed in accordance with good nursing principles and practices.</p> <p>2. Medications are administered in accordance with written orders of the attending physician.</p> <p>49131</p> <p>2. A review of Resident 57's Admission Record (Face Sheet), indicated Resident 57 was admitted to the facility on [DATE], with diagnoses of acute respiratory failure with hypoxia (a medical condition where you don't have enough oxygen in the body), shortness of breath, and pneumonia (an infection in the lungs).</p> <p>A review of Resident 57's MDS, dated [DATE], indicated Resident 57 was severely impaired (unable to) in making decisions regarding tasks of daily life.</p> <p>A review of Resident 57's Order Summary Report, dated as of 5/16/2024, indicated Resident 57 had an order for oxygen at 2 to 5 lpm as needed to maintain an oxygen saturation (measurement of how much oxygen is in the blood) above 90 percent (%) via nasal cannula or mask.</p> <p>During a concurrent observation and interview on 5/14/2024 at 12:32 p.m. with RT 1, in Resident 57's room, RT 1 stated a resident would need a humidifier when receiving oxygen at 4 lpm or more. RT 1 looked at Resident 57's oxygen machine and stated Resident 57 was receiving 4.5 lpm of oxygen and there was no humidifier. RT 1 stated a humidifier was important when a resident was receiving oxygen more than 4 lpm of oxygen because not doing so could dry out their nose and could cause a nosebleed.</p> <p>During an interview on 5/16/2024 at 11:41 a.m. with the Director of Nursing (DON), the DON stated when a resident was receiving oxygen above 4 lpm, they should have a humidifier to ensure the mucous membranes were kept moist. The DON stated not doing so could cause discomfort and nosebleeds for the resident.</p> <p>A review of the facility P&P titled Oxygen Administration, revised 10/2010, indicated when the staff is preparing to administer oxygen, they need to gather a humidifier bottle, ensure there is enough water in the humidifier bottle so that the water bubbles as oxygen flows through. The staff also needs to periodically re-check the water level in the humidifier bottle.</p> <p>3. A review of Resident 69's Admission Record, indicated Resident 69 was admitted to the facility on [DATE], with diagnoses including shortness of breath, fluid overload (too much fluid in the body), heart failure (condition where the heart does not pump blood as normal), and end stage renal disease (disease where the kidneys no longer work).</p> <p>A review of Resident 69's MDS, dated [DATE], indicated Resident 69 was cognitively intact (ability to reason, understand, remember, judge, and learn).</p> <p>A review of Resident 69's care plan, dated 4/26/2024 indicated Resident 69 was receiving oxygen therapy and had difficulty breathing due to pulmonary edema (water in the lung). The staff interventions included to provide Resident 69 with oxygen as ordered and to monitor for respiratory distress (condition where the body needs more oxygen)</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>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286</p> <p>Based on interview and record review, the facility failed to provide timely pain management to two of two sampled residents (Resident 47 and 61).</p> <p>This deficient practice had the potential to cause avoidable discomfort and distress related to uncontrolled pain for Resident 47 and Resident 61.</p> <p>Findings:</p> <p>1. A review of Resident 47's Admission Record indicated the facility originally admitting Resident 47 on 7/22/2023. Resident 47's admitting diagnoses included lumbar spinal fusion (surgery to permanently join together two or more bones in the lower region of the spine), pain due to internal orthopedic prosthetic devices, implants, and grafts (a medical device manufactured to replace a missing joint or bone, or to support a damaged bone), and chronic pain.</p> <p>A review of Resident 47's History and Physical (H&P), dated 7/23/2023, indicated Resident 47 had the capacity to understand and make decisions.</p> <p>A review of Resident 47's Minimum Data Set (MDS, a comprehensive care planning and care screening tool), dated 4/26/2024, indicated Resident 47 did not exhibit any signs of disorganized thinking (rambling or irrelevant conversation, unclear or illogical now of ideas, or unpredictable switching from subject to subject) or delusions (misconceptions or beliefs that are firmly held, contrary to reality). The MDS indicated Resident 47 required setup assistance to supervision/touch assistance from staff for repositioning and activities of daily living (ADLs, self-care activities performed daily such as eating, getting dressed, personal hygiene).</p> <p>A review of Resident 47's physician orders indicated Resident 47 was receiving the following medications for pain:</p> <p>a. Bengay (topical analgesic [drug that reduces pain] used for temporary muscle and joint pain) Greaseless External Cream 10-15 percent (%) applied to the skin on his right shoulder and lower back every six (6) hours as needed for chronic pain, ordered on 7/22/2023.</p> <p>b. Hydrocodone-Acetaminophen (Vicodin, used to relieve moderate to severe pain) Oral Tablet 5-325 milligrams (mg, a unit of dose measurement) by mouth every six (6) hours as needed for moderate pain (pain rated from 7 to 10 in intensity, on a scale of 1 to 10), ordered on 8/16/2023.</p> <p>c. Acetaminophen (Tylenol, mild pain reliever) Oral Tablet 325 mg by mouth every four (4) hours as needed for mild pain (pain rated from 1 to 3 in intensity, on a scale of 1 to 10) ordered on 10/16/23.</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 concurrent observation and interview, on 5/13/2024 at 10:32 a.m., in the hallway, Resident 47 approached State Agency Surveyor and requested pain medication for his back. An unidentified facility staff approached Resident 47, and Resident 47 requested pain medication from the unidentified staff. The unidentified facility staff escorted Resident 47 back to his room and stated they would report the request to Resident 47's nurse.</p> <p>During a concurrent observation and interview, on 5/13/2024 at 11:02 a.m., in Resident 47's room, Resident 47 was observed lying in bed. Resident 47 stated, Can you follow-up on my pain medications? My back hurt likes hell. Resident 47 stated he had not received any pain medication yet and stated he had reported his pain to his nurse.</p> <p>A review of Resident 47's Medication Administration Record (MAR), dated 5/2024, indicated Resident 47 received Hydrocodone-Acetaminophen on 5/13/2024 at 11:08 a.m., after initially reporting his back pain at 10:32 a.m. The MAR indicated that no other pain medication or non-medication pain interventions were provided prior to the administration Hydrocodone-Acetaminophen.</p> <p>A review of Resident 47's care plan, dated 7/23/2023 and revised on 7/24/2023, indicated Resident 47 suffered from chronic pain related to spinal fusion. The care plan indicated Resident 47's goals of care indicated Resident 47 will voice a level of comfort. The staff's interventions indicated to achieve this goal; staff were to respond immediately to any complaints of pain.</p> <p>A review of Resident 47's care plan, dated 7/24/2023, indicated Resident 47 had an alteration in musculoskeletal status related to spinal fusion. The care plan indicated Resident 47's goal of care included Resident 47 being free from pain or at a level of discomfort acceptable to the resident. The staff interventions indicated to achieve this goal; staff were to give analgesics as ordered by the physician.</p> <p>During an interview on 5/14/2024 at 2:26 p.m., with Certified Nursing Assistant (CNA) 10, CNA 10 stated that if a resident was reporting that they were in pain, it should be reported to the charge nurse right away.</p> <p>During an interview on 5/14/2024 at 2:47 p.m., with Licensed Vocational Nurse (LVN) 4, LVN 4 stated that if a resident was reporting pain, or appeared to be in pain, the resident's pain level should be assessed and pain medication should be administered right away, along with non-medication interventions.</p> <p>2. A review of Resident 61's Admission Record indicated the facility originally admitted Resident 61 on 12/13/2022. Resident 61's admitting diagnoses included symptoms and signs involving the musculoskeletal system, reduced mobility, and difficulty or inability to move his right side following a stroke (interruption of blood flow to the brain).</p> <p>A review of Resident 61's H&P, dated 2/8/2024, indicated Resident 61 had the capacity to understand and make decisions.</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>A review of Resident 61's MDS, dated [DATE], indicated Resident 61 had mild cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 61 required partial to maximal assistance from staff for assistance with ADLs. The MDS indicated Resident 61 required substantial assistance from staff with repositioning while in and out of bed (rolling from side to side, transferring from bed to chair and vice versa, and transitioning from a lying to sitting position and vice versa, etc.).</p> <p>A review of Resident 61's current physician orders, dated 5/14/2024, indicated Resident 61 was receiving Gabapentin (medication to treat nerve pain) by mouth three times a day for neuropathy (nerve pain). Further review of Resident 61's orders indicated that Resident 61 did not have any pain medication ordered for breakthrough pain (a sudden increase in pain that may occur in those who already have chronic pain from arthritis or other conditions).</p> <p>A review of Resident 61's care plan, dated 11/20/2023, indicated Resident 61 had the potential to experience pain due to his diagnoses of a stroke with subsequent right sided weakness, and neuropathy. The care plan indicated Resident 61's goals of care included verbalizing adequate relief of pain or ability to cope with incompletely relieved pain. The staff's interventions indicated to achieve this goal, staff were to anticipate the resident's need for pain relief and respond immediately to any complaint of pain.</p> <p>A review of Resident 61's care plan, dated 5/30/2023 and revised 8/10/2023, indicated Resident 61 had neuropathy and was at risk for pain. The care plan indicated Resident 61's goal of care was Resident 61 voicing a level of comfort. The staff's interventions indicated staff were to administer meds as ordered, including Gabapentin capsule 100 mg.</p> <p>A review of Resident 61's MAR, dated 5/2024, indicated Resident 61 did not receive his 6:00 p.m. dose of Gabapentin, as ordered, on 5/13/2024.</p> <p>During a concurrent interview and record review, on 5/14/2024 at 2:51 p.m., with LVN 4, LVN 4 reviewed Resident 61's current physician orders, progress notes, and MAR dated 5/2024. LVN 4 stated Resident 61 did not have any medication ordered for potential breakthrough pain. LVN 4 stated that if Resident 61 experienced breakthrough pain, staff would need to contact the physician for orders. LVN 4 stated the physicians usually responded quickly but it was not a guarantee. LVN 4 then stated Resident 61 had routinely scheduled Gabapentin ordered for his neuropathy and following a review of Resident 61's MAR dated 5/2024, LVN 4 stated Resident 61 did not receive his 6:00 p.m. dose of Gabapentin on 5/13/2024. LVN 4 reviewed Resident 61's progress notes and stated there was no documentation indicating why the medications was not administered. LVN 4 stated that not having pain medication ordered for breakthrough pain, and not administering Resident 61's Gabapentin as ordered, could cause unnecessary pain for Resident 61.</p> <p>During an interview on 5/16/2024 at 10:54 a.m., with the Director of Nursing (DON), the DON stated that if a resident's care plan indicated for staff to respond immediately to any complaints of pain, then immediately meant promptly or right away. The DON stated that when a staff was notified of a resident's complaint of pain, the staff should stop what they were doing and notify a charge nurse. The DON stated a licensed nurse should assess the resident's pain and perform an intervention, including administration of pain medication. The DON stated that delayed administration of pain medication could cause discomfort for the resident.</p>		

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

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943</p> <p>Based on observation, interview, and record review, the facility failed to provide sufficient nursing staff to:</p> <ol style="list-style-type: none"> 1. Provide range of motion ([ROM] full movement potential of a joint [where two bones meet]) exercises, apply splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion), and perform ambulation (the act of walking) to 43 residents requiring a Restorative Nursing Assistant (RNA, nursing aide program that helps residents to maintain their function and joint mobility) program, including five of seven sampled residents (Resident 8, 27, 49, 61, and 63) with limited mobility (ability to move). <p>This deficient practice had the potential for the 43 residents on RNA services, including Resident 8, 27, 49, 61, and 63, to experience a decline in range of motion and mobility, which could affect the residents' overall function. Cross reference F688.</p> <ol style="list-style-type: none"> 2. Provide assistance to one of two sampled residents (Resident 61), to accommodate his preference for getting out of bed at least once a day to sit in his wheelchair. <p>This deficient practice had the potential to cause avoidable psychosocial distress and frustration for Resident 61 from an inability to participate in his preferred activity.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of the Order Listing Report, dated 5/13/2024, for residents with physician orders for RNA, indicated 43 residents had physician orders for RNA. <p>A review of the facility's sign in sheet for 5/2024, indicated there was no RNA on 5/1/2024, 5/4/2024, 5/5/2024, 5/6/2024, 5/9/2024, 5/10/2024, and 5/15/2024.</p> <p>During an interview on 5/13/2024 at 12:15 p.m. with the Director of Rehabilitation (DOR), the DOR stated the facility had two Restorative Nursing Aide staff, RNA 1 and RNA 2. The DOR stated the Director of Staff Development (DSD) oversaw the RNA program.</p> <p>During an interview on 5/13/2024 at 1:16 p.m. with RNA 1, RNA 1 stated she was the only RNA staff present in the facility today (5/13/2024). RNA 1 stated RNA 2 had been on leave for the past three weeks and no other staff assisted with RNA services. RNA 1 stated another staff (RNA 3) was currently being trained but was not independent to provide RNA services. RNA 1 stated residents on RNA program were divided by nursing stations - one RNA for Rooms 1 to 17 and another RNA for Rooms 18 to 30. RNA 1 stated she tried to provide RNA services to as many residents as possible during the workday. RNA 1 stated duties included applying splints, assisting with ambulation, assist with feeding, providing ROM exercises, helping the other nurses, and obtaining weights for newly admitted residents, resident requiring weekly weights, residents on dialysis (process of filtering blood), and monthly weights on all other residents. RNA 1 stated the RNA staff schedule included working four days and being off two days.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 5/14/2024 at 3:40 pm. with RNA 1, RNA 1 stated she was the only RNA staff present today (5/14/2024). RNA 1 stated she was unable to see all residents with physician orders for RNA on the same day. RNA 1 stated she had to provide RNA services to half of the residents one day and then provide RNA to the other half of the residents the next day.</p> <p>During an interview on 5/15/2024 at 1:25 p.m. with the DSD, DSD stated RNA 1 was not present at the facility (5/15/2024) since it was RNA 1's scheduled day off.</p> <p>a. A review of Resident 8's Admission Record, indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including hemiplegia or hemiparesis (weakness or inability to move one side of the body) affecting the left non-dominant (used less often) side, dementia (decline in mental ability severe enough to interfere with daily life), contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness) to both knees, and muscle weakness.</p> <p>A review of Resident 8's Order Summary Report which included physician orders, dated 2/21/2024, indicated RNA program to apply the left elbow extension splint for two hours per day, five day per week.</p> <p>A review of Resident 8's RNA Task Schedule (record of nursing assistant tasks) for 5/2024, indicated to apply the left elbow extension splint for two hours per day, five days per week was blank on 5/1/2024, 5/6/2024, 5/9/2024, 5/10/2024, and 5/15/2024.</p> <p>During a concurrent interview and record review on 5/16/2024 at 11:13 a.m. with the DSD and DOR, Resident 8's physician orders for RNA, dated 2/21/2024, and the RNA Task Schedule for 5/2024 was reviewed. The DSD stated reviewed Resident 8's RNA Task Schedule for 5/2024 and stated the splint was not applied to Resident 8's left elbow five times per week in accordance with the physician orders. The DSD stated Resident 8 did not receive RNA services five times per week in 5/2024 since there was only one RNA staff working.</p> <p>During an interview on 5/16/2024 at 12:45 p.m. with the DSD, the DSD stated the facility did not have adequate staff to provide RNA services during 5/2024 since RNA 2 had been on leave for the past three weeks.</p> <p>b. A review of Resident 27's Admission Record, indicated Resident 27 was initially admitted to the facility on [DATE] and readmitted Resident 27 on 3/30/2023. The Admission Record indicated Resident 27's diagnoses included Parkinson's disease (brain disorder that causes unintended or uncontrollable movements and difficulty with balance and coordination), contractures on both knees, and muscle weakness.</p> <p>A review of Resident 27's physician orders, dated 3/4/2024, indicated for the RNA to provide PROM exercises to both legs, four times per week as tolerated. Another physician order, dated 3/5/2024, indicated to for RNA to provide Resident 27 with PROM exercises to both arms at all joints, four times per week as tolerated.</p> <p>A review of Resident 27's RNA Task Schedule for 5/2024, indicated to perform PROM to both arm and both legs was blank for 5/1/2024, 5/5/2024, 5/6/2024, 5/10/2024, and 5/15/2024.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a concurrent interview and record review on 5/16/2024 at 11:59 a.m. with the DOR and DSD, Resident 27's physician orders for RNA, dated 3/4/2024 and 3/5/2024, and RNA Task Schedule for 5/2024 was reviewed. The DSD stated Resident 27 did not receive RNA for PROM to both arms and both legs four times per week in accordance with the physician orders during 5/2024 since there was only one RNA staff working.</p> <p>During an interview on 5/16/2024 at 12:45 p.m. with the DSD, the DSD stated the facility did not have adequate staff to provide RNA services during 5/2024 since RNA 2 had been on leave for the past three weeks.</p> <p>c. A review of Resident 49's Admission Record, indicated Resident 49 was admitted to the facility on [DATE] with diagnoses including fracture (break in the bone) of the right femur hip bone), presence of a right artificial hip joint, dementia, and contracture of the right elbow, both knees, and right hip. The Admission Record also indicated Resident 49 was admitted to palliative care (specialized medical care that focuses on providing patients relief from pain and other symptoms of a serious illness) on 2/28/2024.</p> <p>A review of Resident 49's physician orders, dated 3/1/2024, indicated for the RNA to provide gentle PROM exercises to both legs and both arms, five times per week as tolerated.</p> <p>A review of Resident 49's RNA Task Schedule for 5/2024, indicated to provide PROM to both arms and both legs was blank for 5/1/2024, 5/6/2024, 5/10/2024, and 5/15/2024.</p> <p>During a concurrent interview and record review on 5/16/2024 at 12:19 p.m. with the DOR and DSD, Resident 49's physician orders, dated 3/1/2024, and RNA Task Schedule for 5/2024 was reviewed. The DSD stated Resident 49 did not receive RNA for PROM to arms and both legs, five per week in accordance with the physician orders during 5/2024 since there was only one RNA staff working.</p> <p>During an interview on 5/16/2024 at 12:45 p.m. with the DSD, the DSD stated the facility did not have adequate staff to provide RNA services during 5/2024 since RNA 2 had been on leave for the past three weeks.</p> <p>d. A review of Resident 61's Admission Record, indicated Resident 61 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant (used more often) side, dysphagia (difficulty swallowing) following a cerebral infarction, history of falling, and reduced mobility.</p> <p>A review of Resident 61's physician orders, dated 2/8/2024, indicated for RNA to perform active assistive range of motion (AAROM, use of muscles surrounding the joint to perform the exercise but required some help from a person or equipment) to the left leg and PROM to the right leg, five times per week or as tolerated, to maintain current level of function. Another physician order, dated 3/8/2024, indicated for RNA to provide Resident 61 with AAROM exercises to both arms, five times per week or as tolerated.</p> <p>A review of Resident 61's RNA Documentation Survey Report for 5/2025, indicated to provide AAROM exercises to both arms and the left leg and PROM exercises to the right leg was blank for 5/1/2024, 5/6/2024, 5/9/2024, 5/10/2024, and 5/15/2024.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a concurrent observation and interview on 5/13/2024 at 11:33 a.m. in the bedroom, Resident 61 stated he had a stroke (cerebral infarction) affecting the right side of the body. Resident 61's fingers on the right hand remained straight and unable to bend. Resident 61 stated a nurse (unknown) came once to assist with exercises on both hands but did not provide exercises to both legs. Resident 61 stated the nurse came once and had not returned in the past three to four weeks.</p> <p>During a concurrent interview and record review on 5/16/2024 at 12:40 p.m. with the DOR and DSD, Resident 61's physician orders, dated 2/8/2024 and 3/8/2024, and the RNA Documentation Survey Report for 5/2024 was reviewed. The DSD stated Resident 61 did not receive RNA for AAROM to both arms and the left leg and PROM to the right leg, five per week in accordance with the physician orders during 5/2024 since there was only one RNA staff working.</p> <p>During an interview on 5/16/2024 at 12:45 p.m. with the DSD, the DSD stated the facility did not have adequate staff to provide RNA services during 5/2024 since RNA 2 had been on leave for the past three weeks.</p> <p>e. A review of Resident 65's Admission Record, indicated Resident 65 was admitted to the facility on [DATE] and readmitted Resident 65 on 9/6/2023 with diagnoses including muscle weakness, encephalopathy (disease that affects the brain, causing changes in its function), anxiety disorder (mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities), dementia, and dysphagia. The Admission Record also indicated Resident 65 was admitted to palliative care on 10/25/2023.</p> <p>A review of Resident 65's physician orders, dated 11/17/2023, indicated for the RNA to provide PROM exercises to both legs, seven times per week as tolerated. Another physician orders, dated 3/12/2024, indicated for RNA to provide PROM exercises to both arms, five times per week as tolerated.</p> <p>A review of Resident 65's RNA Documentation Survey Report for 5/2025, indicated to provide PROM to both arms, five times per week, and PROM to both legs, seven times per week, was blank on 5/1/2024, 5/4/2024, 5/5/2024, 5/6/2024, 5/9/2024, 5/10/2024, and 5/15/2024.</p> <p>During a concurrent interview and record review on 5/16/2024 at 12:45 p.m. with the DOR and DSD, Resident 65's physician orders, dated 11/17/2023 and 3/12/2024, and the RNA Documentation Survey Report for 5/2024 was reviewed. The DSD stated Resident 65 did not receive RNA for PROM to arms, five times per week, and both legs, seven times per week in accordance with the physician orders during 5/2024 since there was only one RNA staff working. The DSD stated the facility did not have adequate staff to provide RNA services during 5/2024 since RNA 2 had been on leave for the past three weeks.</p> <p>A review of the facility's undated Policy and Procedure (P&P) titled, Restorative Nursing Services, indicated residents will receive restorative nursing care as needed to help promote optimal safety and independence.</p> <p>A review of the facility's undated P&P titled Staffing, Sufficient and Competent Nursing, indicated the facility provided sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents.</p> <p>47286</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. A review of Resident 61's Admission Record indicated the facility originally admitted Resident 61 on 12/13/2022. Resident 61's admitting diagnoses included symptoms and signs involving the musculoskeletal system, reduced mobility, and difficulty or inability to move his right side following a stroke (interruption of blood flow to the brain).</p> <p>A review of Resident 61's History and Physical (H&P), dated 2/8/2024, indicated Resident 61 had the capacity to understand and make decisions.</p> <p>A review of Resident 61's Minimum Data Set (MDS), dated [DATE], indicated Resident 61 had mild cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 61 had impairments to the upper extremities on both sides of his body (shoulder, elbow, wrist, and hands), and impairments to the lower extremity on one side of his body (hip knee, ankle, and foot). The MDS indicated Resident 61 required substantial/maximal assistance from staff (staff provide more than half the effort in lifting, holding, or supporting the resident's body) to get dressed and put on footwear. The MDS indicated Resident 61 required substantial/maximal assistance from staff to roll from side to side, to transition from a lying position to a sitting position, and to transfer from the bed to a wheelchair.</p> <p>During an observation on 5/13/2024 at 11:00 a.m., in Resident 61's room, observed Resident 61 lying in bed watching TV. Resident 61's wheelchair was parked at his bedside.</p> <p>During a concurrent observation and interview, on 5/13/2024 at 11:33 a.m., in Resident 61's room, observed Resident 61 lying in bed watching television. Resident 61 stated he suffered a stroke and had difficulty with his mobility, on his own.</p> <p>During a concurrent observation and interview, on 5/14/2024 at 9:56 a.m., observed Resident 61 lying in bed watching TV. Resident 61 stated he wanted to get dressed and get up to go outside. Resident 61 stated he required a wheelchair and help from staff to get dressed and transfer to his wheelchair. Resident 61 stated when he asked staff to assist him, the certified nursing assistants (CNAs) repeatedly told him they had around ten (10) patients, and if someone called off from work, their assignment increased to 14 to 16 patients. Resident 61 stated the CNAs told him they did not have time to help him. Resident 61 stated that the last time he got out of bed was on 5/10/2024.</p> <p>During a concurrent observation and interview on 5/15/2024 at 2:06 p.m., in Resident 61's room, observed Resident 61 lying in bed and watching TV. Resident 61 stated he would like to get out of bed every day, but on average he gets out of bed twice a week. Resident 61 stated that before he can ask for assistance to get out of bed, staff tell him they are too busy or have too many patients, so he does not ask to get out of bed.</p> <p>During a concurrent observation and interview, on 5/16/2024 at 9:06 a.m., observed Resident 61 lying in bed and watching television, with his wheelchair parked next to his bed. Resident 61 stated he wanted to get out of bed but did not ask yet because he was not sure who his nurse was. Resident 61 stated he had not been offered to get out of bed that day (5/16/2024).</p> <p>During an interview on 5/16/2024 at 9:22 a.m., with the Activities Director (AD), the AD stated the facility had a patio where residents could sit outside if they wanted to. The AD stated that there were no restrictions on residents using the patio, there just needed to be staff available to supervise. The AD stated it was important for residents to do activities that they preferred.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 5/16/2024 at 11:45 a.m., with the Director of Nursing (DON), the DON stated staff should assist with transferring residents to their wheelchairs and supervise them in the patio as needed. The DON stated that sitting in a wheelchair while out on the patio was not a hazardous activity. The DON stated it was not appropriate for staff to tell the resident that they were too busy to assist him. The DON stated that if staff were busy, they should come back once their task was completed to follow up on the resident's request or identify another staff member that could assist.</p> <p>A review of the facility policy and procedure (P&P) titled Accommodation of Needs, dated 3/2021, indicated our facility's environment and staff behaviors are directed towards assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. The P&P further indicated the resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered.</p> <p>48131</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38740</p> <p>Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and preparation practices when:</p> <p>1. Nutritional supplements labeled store Frozen with manufactures instruction to use within 14 days of thawing, were not monitored for the date they were thawed to ensure expired shakes were discarded within the appropriate time frame. Four boxes containing 50 individual cartons of strawberry flavored nutrition supplements were stored in the walk-in refrigerator with no thaw date.</p> <p>This deficient practice had the potential to result in food borne illness in 24 residents who were on nutrition supplements at the facility.</p> <p>2. One plastic bag of breaded cylinder-shaped food item was stored in the walk-in freezer with no label and date. One plastic bag of previously open ham with date [DATE] and use by date of [DATE] exceeding storage period for ham stored in the reach in freezer. The ham was covered in ice crystals. One plastic bag with previously open diced stew meat with date [DATE] exceeding storage period for meat stored in the reach in freezer. The diced stew meat was covered in ice crystals and freezer burn. One large plastic container on the shelf next to the food preparation area holding dry food product (pasta) was dirty with food debris and pieces of toast.</p> <p>This deficient practice had the potential to result in expired food consumption.</p> <p>3. One staff working in the dish washing area did not wash their hands before removing the clean and sanitized dishes from the dish machine. One cook did not their wash hands and change gloves before handling resident ready to eat cooked food.</p> <p>These deficiencies had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness in 86 out of 89 residents who received food from the kitchen.</p> <p>Findings:</p> <p>1. During an observation in the kitchen on [DATE] at 9:15 a.m., there were four boxes stacked up on top of each other. Each box contained 50 individual cartons of strawberry flavored nutrition supplement stored in the walk-in refrigerator with no thaw date.</p> <p>During a concurrent interview with Dietary Aide (DA 1), DA 1 stated the nutrition supplements were delivered frozen and when thawed were good for 14 days. DA 1 stated there should be a thaw date on the supplements to monitor before they went bad.</p> <p>During a concurrent interview and review on [DATE] at 10 a.m. with the Dietary Supervisor (DS), the labels on the box were reviewed. The DS stated that the supplements had delivery dates but not thaw dates.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a concurrent observation and interview on [DATE] at 9:30 a.m., with the DS, in the kitchen, the reach in freezer was overloaded with food items, stacked on top of each other. There was one plastic bag with leftover breaded food with no date or label. The DS stated the food items were leftover sausage and removed it from the freezer. The DS stated food should be labeled and dated.</p> <p>During the same observation in the reach in freezer there was one plastic bag of previously opened ham dated [DATE] and use by date of [DATE] exceeding the storage period for ham. There were ice crystals inside the bag and on the ham. One plastic bag with previously opened diced stew meat with dated [DATE] exceeding the storage period for meat stored in the reach in freezer. The diced stew meat was covered with ice crystals and had freezer burn with dark and dried spots on the meat. The DS stated the ham, and the stewed meat should be discarded because they were old. The DS stated the freezer was overcrowded and old items were not rotated. The DS stated the facility had previously identified the need for more freezer space to organize food.</p> <p>During an observation on [DATE] at 9:35 a.m., in the food preparation area, a container for holding open bags of pasta and open bags of marshmallow had food debris and pieces of dry toast.</p> <p>During a concurrent interview the DS, the DS stated the container was dirty with food debris. The DS stated sanitation in the kitchen was very important to keep everything clean.</p> <p>A review of the facility policy and procedure (P&P) titled Procedure for Refrigerated Storage, dated 2023, indicated, food items should be arranged so that older items will be used first and dating the packages or containers will facilitate this practice. The P&P indicated leftovers will be covered, labeled, and dated, and individual packages of refrigerated or frozen food taken from the original packaging box need to be labeled and dated. The P&P indicated freezer burn may occur before that and reduce the maximum shelf life. The P&P indicated food that has been freezer burned must be discarded. The P&P indicated supplemental shakes which are taken from the frozen state and thawed in the refrigerator must be dated as soon as they are placed in the refrigerator.</p> <p>A review of the facility Freezer Storage Guidelines, dated 2018, indicated all foods which need to be kept in the freezer can be stored frozen for six months with the following exceptions: processed meats, ham length of time in the freezer is one month.</p> <p>A review of the facility P&P titled Sanitization, dated ,d+[DATE] indicated, all kitchen, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects.</p> <p>3. During an observation on [DATE] at 9:40 a.m., in the dishwashing area, DA 2 was observed rinsing soiled dishes and loading the dirty dishes in the dish machine. DA 2 had several layers of gloves on his hands. DA 2 removed the outer layer of gloves and removed the clean and sanitized dishes from the dish machine. DA 2 had a disposable apron and was moving from the dirty dishes area to the clean dishes area are without washing his hands or changing aprons.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Costa Del Sol Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1016 S. Record St. Los Angeles, CA 90023	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 9:45 a.m. with DA 2, DA 2 stated he did not wash his hands before removing the clean and sanitized dishes. DA 2 stated the handwashing sink was far from his workspace. DA 2 stated he wore multiple gloves and removed the dirty glove on top before moving to the clean dishes area. DA 2 stated it was important to remove all disposable gloves and wash the hands in the handwashing sink before touching the clean dishes because the dirty hands and gloves could contaminate the clean dishes.</p> <p>During an interview on [DATE] at 10 a.m. with the DS, the DS stated it was important to wash the hands and put on clean gloves before touching the clean and sanitized dishes to prevent cross contamination. The DS stated usually there were two people working in the dishwashing area to prevent cross contamination.</p> <p>During an observation of the lunch service on [DATE] at 12 p.m., [NAME] 1 was observed wearing gloves and performing multiple tasks. [NAME] 1 left to open the oven, pick up food and returned. [NAME] 1 was also observed assisting with taking the food temperatures on the steam table. While standing, [NAME] 1 hands were touching the counters while waiting to start serving the food. [NAME] 1 did not change his gloves or wash his hands.</p> <p>During the same observation of the lunch service on [DATE], at 12:15 p.m., [NAME] 1 was observed picking up roast turkey slices with gloved hands and serving them on the plates. [NAME] 1 was observed wearing the same gloves while performing multiple tasks since the beginning of lunch service at 12 p.m. [NAME] 1 left to grab utensils and pushed the plate warmer cart with gloved hands.</p> <p>During a subsequent interview with [NAME] 1, [NAME] 1 stated he should have changed his gloves and washed his hands when he returned from picking up the food from the oven. [NAME] 1 stated he should have used utensils to serve the food. [NAME] 1 stated dirty gloves could contaminate the food.</p> <p>A review of facility P&P titled Preventing foodborne illness-Employee Hygiene and Sanitary Practices, revised ,d+[DATE], indicated, employees must wash their hands before coming in contact with any food surfaces, after handling soiled equipment or utensils, after engaging in other activities that contaminate the hands, during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.</p> <p>A review of the facility P&P titled Preventing foodborne illness-Employee Hygiene and Sanitary Practices, revised ,d+[DATE], indicated gloves are considered single use items and must be discarded after completing the task for which they are used. The P&P indicated gloves are removed, hands are washed, and gloves are replaced between handling soiled and clean dishes. The P&P indicated the use of disposable gloves does not substitute for proper handwashing. The P&P indicated food service employees are trained in the proper use of utensils such as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>38740</p> <p>Based on observation, interview, and record review, the facility failed to ensure the trash stored in the dumpster area was maintained in a sanitary manner when:</p> <p>One of three garbage dumpsters lid was open and overfilled with cardboard boxes. The ground around the trash dumpsters was not clean and had plastic utensils, gloves, and paper around and under the dumpsters.</p> <p>This deficient practice had the potential for harborage and feeding of pests.</p> <p>Findings:</p> <p>During a concurrent observation and interview with Maintenance Staff (MS 1) on 5/14/2024 at 9:00 a.m., there was one dumpster outside of the kitchen back exit that was not covered. The dumpster was overfilled with cardboard boxes and not covered. There was trash on the ground including plastic forks, gloves, and paper. MS 1 stated the cardboard boxes should be made flat so they could fit in the dumpster and the lids could close. MS 1 stated the trash on the floor was from the neighbor who lived next door to the facility who threw their trash into the facility's trash bins and on the ground. MS 1 stated the area should be clean and the trash bin should always stay covered to prevent attracting flies and other pests.</p> <p>A review of the facility policy and procedure (P&P) titled Food-Related Garbage and Refuse Disposal, revised 2017, indicated outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter.</p> <p>A review of the facility P&P titled Sanitation, revised 2022, indicated garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters/compactors with lids or otherwise covered.</p> <p>A review of the Food and Drug Administration (FDA) Food Code 2022, dated 1/18/2023, code number 5-501.113 titled Covering receptacles, indicated receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered with tight-fitting lids or doors if kept outside the establishment. The Food Code also indicated under code number 5-501.110 titled Storing Refuse, Recyclables, and Returnable indicated refuse, recyclables, and returnable shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943</p> <p>Based on observation, interview, and record review, the facility did not provide accurate documentation for two of seven sampled residents (Resident 8 and 63) with limited mobility (ability to move) and range of motion ([ROM] full movement potential of a joint [where two bones meet]).</p> <p>a. Resident 8's clinical record for Restorative Nursing Aide (RNA, certified nursing aide program that helps residents to maintain their function and joint mobility) tasks did not indicate both knee splints (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion) were applied from 11/2023 to 2/2024.</p> <p>b. Resident 63's clinical record for RNA tasks did not include passive range of motion (PROM, movement of joint through the ROM with no effort from the person) exercises to both legs from 12/16/2023 to 2/13/2024.</p> <p>These deficient practices provided inaccurate records of the RNA services provided to Resident 8 and 63.</p> <p>Findings:</p> <p>a. A review of Resident 8's Admission Record, indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including hemiplegia or hemiparesis (weakness or inability to move one side of the body) affecting the left non-dominant (used less often) side, dementia (decline in mental ability severe enough to interfere with daily life), contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness) to both knees, and muscle weakness.</p> <p>A review of Resident 8's Minimum Data Set ([MDS] a comprehensive assessment and care planning tool), dated 2/29/2024, indicated Resident 8 had clear speech, had difficulty communicating some words, usually understood others, and had severely impaired cognition (ability to think, understand, learn, and remember).</p> <p>A review of Resident 8's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Discharge Summary, dated 10/31/2023, indicated recommendations for the RNA to provide PROM exercises to both legs followed by the application of both knee extension splints.</p> <p>A review of Resident 8's physician orders, dated 10/31/2023, indicated for the RNA to provide PROM exercise to both legs followed by the application of both knee extension splints with skin checks for two-and-a half (2.5) hours a day, seven days a week as tolerated.</p> <p>A review of Resident 8's RNA Task Schedule (record of nursing assistant tasks) for 11/2023, 12/2023, 1/2024, and 2/2024, indicated for RNA to provide Resident 8 with PROM to both legs but did not indicate the RNA applied both knee splints.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 8's RNA Weekly Summary, dated 11/29/2023, 12/4/2023, 12/23/2023, 12/25/2023, 12/30/2023, 1/14/2024, 1/20/2024, and 2/27/2024, indicated the RNA performed PROM to both of Resident 8's legs and applied both knee extension splints.</p> <p>During a concurrent interview and record review on 5/16/2024 at 11:13 a.m. with the Director of Rehabilitation (DOR) and Director of Staff Development (DSD), Resident 8's PT Discharge Summary, physician orders, RNA Task Schedule from 11/2023 to 2/2024, and RNA Weekly Summary from 11/29/2023 to 2/24/2024 were reviewed. The DOR stated Resident 8 had physician orders, dated 10/31/2023, for the RNA to provide PROM to both legs and apply both knee extension splints for 2.5 hours, seven days per week. The DSD reviewed the RNA Weekly Summary from 11/29/2023 to 2/27/2024 and stated the RNA staff applied both knee extension splints. The DOR stated the RNA Task Schedule from 11/2023 to 2/2024 did not include the application of both knee splints since it was inputted into the electronic documentation system as an instruction. The DOR and the DSD stated Resident 8's RNA Task Schedule for 11/2023 to 2/2024 had documentation errors since the application of both knee splints should have been included as a separate RNA task instead of an instruction.</p> <p>b. A review of Resident 63's Admission Record, indicated Resident 63 was admitted to the facility on [DATE] and readmitted Resident 63 on 12/12/2023. The Admission Record indicated Resident 63 had diagnoses including muscle weakness, history of falling, and contracture (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness) to both elbows, both hands, both hips, and both knees.</p> <p>A review of Resident 63's MDS, dated [DATE], the MDS indicated Resident 63 had clear speech, had difficulty communicating some words, usually understood others, and had severely impaired cognition.</p> <p>A review of Resident 63's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Discharge Summary, dated 12/16/2023, indicated recommendations for the RNA to provide PROM to both legs.</p> <p>A review of Resident 63's physician orders, dated 12/16/2023, indicated for RNA to provide PROM exercises to both legs, five times per week.</p> <p>A review of Resident 63's Documentation Survey Report (record of nursing assistant tasks) for 12/2023, 1/2024, and 2/2024, did not indicate the RNA provided PROM exercises to both legs.</p> <p>A review of Resident 63's RNA Weekly Summary, dated 12/26/2023, 1/2/2024, 1/9/2024, 1/17/2024, 1/31/2024, and 2/7/2024, indicated the RNA provided PROM to both of Resident 63's legs.</p> <p>During an observation on 5/14/2024 at 12:39 p.m., in Resident 63's room, with Physical Therapist 1 (PT 1) and Occupational Therapist 1 (OT 1), Resident 63 was observed awake and lying in bed. Both of Resident 63's hips and knees were bent toward Resident 63's torso (part of the body that includes the chest and abdomen).</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 5/16/2024 at 12:29 p.m. with the Director of Rehabilitation (DOR) and Director of Staff Development (DSD), Resident 63's PT Discharge Summary, physician orders, RNA Task Schedule from 12/2023 to 2/2024, and RNA Weekly Summary from 12/26/2023 to 2/7/2024 were reviewed. The DOR and DSD reviewed the physician orders, dated 12/16/2023, for RNA to provide Resident 65 with PROM to both legs, five times per week. The DSD and DOR stated the RNA task to provide Resident 65 with PROM to both legs was not created in the electronic documentation system. The DSD reviewed Resident 65's RNA Weekly Summary from 12/26/2023 to 2/7/2024 and stated PROM was provided. The DOR and DSD stated Resident 65's RNA Task Schedule from 12/2023 to 2/2024 had documentation errors since the RNA task to perform PROM to both legs was not included.</p> <p>A review of the facility's undated policy and procedure (P&P) titled, Documentation, indicated nursing personnel will maintain complete and accurate documentation. The P&P indicated documentation entries will be factual and specific.</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>47286</p> <p>Based on interview and record review, the facility failed to follow their policy when discussing binding arbitration agreements (a form of alternative dispute resolution in which both parties agree to have their case heard by a neutral party instead of a judge and jury) with three of three sampled residents and/or their responsible parties (Resident 73, 80, and 241).</p> <p>This deficient practice increased the risk that Resident 73, Resident 80, and Resident 241 and/or their responsible parties unknowingly forfeited their right to resolve any disputes with the facility in court, alongside a judge and/or jury.</p> <p>Findings:</p> <p>1. A review of Resident 73's Admission Record indicated the facility originally admitted Resident 73 on 1/27/2024. Resident 73's admission record indicated the resident had a responsible party (RP) making decisions on her behalf.</p> <p>A review of the facility document titled Arbitration Agreement, dated 1/20/2022, indicated Resident 73's RP (RP 1) signed the binding arbitration agreement on 3/5/2024, indicating Resident 73 no longer had the right to a jury or court trial in the event of medical malpractice (when a healthcare professional neglects to provide appropriate treatment, take appropriate action, or gives substandard treatment that causes harm, injury, or death to a person) or any other claim.</p> <p>During an interview on 5/15/2024 at 11:06 a.m., with RP 1, RP 1 stated he did not recall discussing binding arbitration agreements with the facility, and stated he did not know what it meant to enter into a binding arbitration agreement.</p> <p>2. A review of Resident 80's Admission Record indicated the facility originally admitted Resident 80 on 2/22/2024. Resident 80's admission record indicated he had an RP making decisions on his behalf.</p> <p>A review of the facility document titled Arbitration Agreement, dated 1/20/2022, indicated Resident 80's RP (RP 2) signed the binding arbitration agreement on 3/7/2024, indicating Resident 73 no longer had the right to a jury or court trial in the event of medical malpractice or any other claim.</p> <p>3. A review of Resident 241's Admission Record indicated the facility originally admitted Resident 241 on 5/4/2024. Resident 241's Admission Record indicated Resident 241 was self-responsible.</p> <p>A review of the facility document titled Arbitration Agreement, dated 1/20/2022, indicated Resident 241 signed the binding arbitration agreement on 5/7/2024, indicating Resident 241 no longer had the right to a jury or court trial in the event of medical malpractice or any other claim.</p> <p>(continued on next page)</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/15/2024 at 11:39 a.m., with Resident 241, Resident 241 stated he had resided facility for less than two weeks. Resident 241 stated he did not recall entering into a binding arbitration agreement with the facility and stated, What is that? Can you tell me more?. Resident 241 stated he signed his own paperwork upon admission and stated that a binding arbitration was not explained to him prior to signing the agreement.</p> <p>During a concurrent interview and record review, on 5/15/2024 at 12:40 p.m., with the Admissions Coordinator (AC), the AC reviewed the facility policy and procedure (P&P) titled Binding Arbitration Agreements, dated 11/2023. The AC stated she did not document the Residents'/RPs' verbal acknowledgement of understanding what a binding arbitration agreement was prior to having them sign the document.</p> <p>During an interview on 5/15/2024 at 12:49 p.m., with the AC, the AC stated that she was trained on how to explain binding arbitration agreements, and stated the training curriculum was based on the facility policy and procedure titled Binding Arbitration Agreements, dated 11/2023.</p> <p>A review of the facility P&P titled Binding Arbitration Agreements, dated 11/2023, indicated residents (or representatives) are informed of the nature and implications of any proposed binding arbitration agreements so as to make informed decisions on whether to enter into such agreements. The P&P indicated the terms and conditions of a binding arbitration agreement are explained to the resident (or representative) in a way that ensures his or her understanding of the agreement and after the terms and conditions of a binding arbitration agreement are explained, the resident or representative must acknowledge that he or she understands the agreement before being asked to sign the document. The P&P further indicated a signature alone is not sufficient to acknowledgement of understanding and the resident (or representative) must verbally acknowledge understanding, and the verbal acknowledgement documented by the staff member who explains the agreement.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286</p> <p>Based on observation, interview, and record review, the facility did not maintain infection control measures when:</p> <ol style="list-style-type: none"> Staff did not ensure enhanced barrier precautions (EBPs, an infection control intervention used to reduce transmission of multidrug-resistant organisms [MDROs, organisms resistant to at least one or more classes of antimicrobial agents]) were implemented for one of 18 sampled residents (Resident 27). <p>This deficient practice increased the risk for spread of MDROs to vulnerable facility residents, and the potential incidence of preventable infection.</p> <ol style="list-style-type: none"> Clean one of one vinyl (type of plastic material) gait belt (assistive device used for lifting, transferring, and walking patients who have limited mobility issues) and front-wheeled walker (FWW, an assistive device with two front wheels used for stability when walking) after ambulation (the act of walking) with Resident 69. Clean cloth gait belts in accordance with the manufacturer's recommendations for bleach sanitizing wipes (pre-moistened towelettes that contain a sanitizing or disinfecting formula that kill or reduce germs on surfaces). <p>These deficient practices placed Resident 69, and other residents at risk for cross-contamination or contact with infectious agents.</p> <p>Findings:</p> <ol style="list-style-type: none"> A review of Resident 27's Admission Record indicated the facility originally admitted Resident 27 on 8/5/2021, and most recently readmitted Resident 27 on 3/30/2023. Resident 27's admitting diagnoses included gastrostomy status (the creation of an artificial external opening into the stomach for nutritional support), protein-calorie malnutrition (the state of inadequate intake of food [as a source of protein, calories, and other essential nutrients]), muscle wasting and atrophy (decrease in size of muscle tissue), dysphagia (difficulty or discomfort in swallowing). <p>A review of Resident 27's active physician orders, dated 4/23/24, indicated Resident 27 was on enhanced barrier precautions (EBP).</p> <p>A review of Resident 27's active physician orders, dated 5/13/24, indicated Resident 27 was receiving liquid nutrition through a gastrostomy tube (a flexible tube inserted into the abdomen for administration of nutrition and medications).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 27's care plan, dated 5/13/24, indicated Resident 27 required EBP during high-contact resident care activities due to the presence of: feeding tubes [gastrostomy tube]. The goals of Resident 27's care included [EBP] will be appropriately utilized to reduce the risk of transmission of multidrug-resistant organisms and enhanced barrier precautions will be followed during high contact resident care activities. Interventions to achieve these goals required staff to utilize PPE [personal protective equipment] (gown and gloves .) during high contact resident care activities.</p> <p>During an observation on 5/13/2024 at 9:42 a.m., outside of Resident 27's room, signage was observed indicating Resident 27 was on EBP. Personal protective equipment (PPE, protective garments or equipment designed to protect the wearer's body from infection) was observed outside of or near Resident 27's room for staff use.</p> <p>During a concurrent observation and interview, on 5/13/2024 at 10:16 a.m., inside Resident 27's room, with Licensed Vocational Nurse (LVN) 1, LVN 1 performed hand hygiene prior to entering Resident 27's room and did not put on PPE. LVN 1 then touched Resident 27's gastrostomy tube to check it for complications. LVN 1 stated Resident 27 was on EBP, and stated she should have been wearing a gown and gloves while providing care to the gastrostomy tube.</p> <p>During an interview, on 5/16/2024 at 9:27 a.m., with the Infection Preventionist Nurse (IPN), the IPN stated EBP was used to prevent spread of MDROs. The IPN stated that EBP required staff to wear a gown and gloves while performing high contact activities such as handling indwelling medical devices, which included gastrostomy tubes. The IPN stated the purpose of implementing EBP was infection prevention and stated that not implementing EBP could increase the risk for spread of infection in the facility.</p> <p>A review of the facility policy and procedure (P&P) titled Isolation - Transmission-Based Precautions & Enhanced Barrier Precautions, dated 9/2022, indicated Enhanced Barrier Precautions are indicated for residents with .: wounds and/or indwelling medical devices. The P&P further indicated that staff were required to wear gowns and gloves while performing .high-contact tasks .such as: device care .feeding tube. Based on observation, interview, and record review, the facility did not maintain infection control measures when:</p> <p>36943</p> <p>2. A review of Resident 69's Admission Record, indicated Resident 69 was admitted to the facility on [DATE] and readmitted Resident 69 on 11/21/2023. Resident 69's diagnoses included end stage renal (kidney) disease (progressive loss of kidney function), dependence on renal dialysis (process of filtering blood), and muscle weakness.</p> <p>A review of Resident 69's physician orders, dated 4/11/2024, indicated Restorative Nursing Aide (RNA, certified nursing aide program that helps residents to maintain their function and joint mobility) to provide ambulation using the FWW on non-dialysis days, three times per week as tolerated.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Costa Del Sol Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 5/14/2024 at 1:21 p.m. with Restorative Nursing Aide 1 (RNA 1), Resident 69 was observed alert, awake, and sitting up in the wheelchair. RNA 1 placed a vinyl gait belt around Resident 69's waist and placed a FWW in front of Resident 69. Resident 69 stood using the FWW and walked down the hallways throughout the entire facility. RNA 1 assisted Resident 69 to sit back into the wheelchair and removed the vinyl gait belt from Resident 69's waist. RNA 1 folded up the FWW and placed the walker against a wall near a weighing scale. RNA 1 fastened the vinyl gait belt around RNA 1's own waist and wheeled Resident 69 back to the bedroom. RNA 1 did not clean the FWW and the vinyl gait belt after use with Resident 69.</p> <p>During an interview on 5/14/2024 at 3:40 p.m. with RNA 1, RNA 1 stated the vinyl gait belt should be cleaned with bleach sanitizing wipes after every resident. RNA 1 stated she did not clean the vinyl gait belt after use with Resident 69 since Resident 69 was eager to return to the bedroom.</p> <p>During an interview on 5/15/2025 at 12:52 p.m. with the IPN, the IPN stated reusable equipment was supposed to be cleaned with the bleach sanitizing wipes before and after each resident use. The IPN stated it was important to disinfect surfaces in-between residents to prevent the spread of contamination (presence of unwanted substances) between residents.</p> <p>A review of the facility's P&P titled, Cleaning and Disinfecting Non-Critical Resident-Care and Multi-use Items, revised June 2011, indicated reusable items are cleaned and disinfected or sterilized between residents.</p> <p>3. During an observation on 5/13/2024 at 12:29 p.m., Certified Nursing Assistant 1 (CNA 1) wore a cloth gait belt around CNA 1's waist.</p> <p>During an observation on 5/13/2024 at 12:57 p.m., CNA 2 wore a cloth gait belt around CNA 2's waist.</p> <p>During an observation on 5/13/2024 at 1:14 p.m., CNA 3 wore a cloth gait belt across the chest like a seatbelt.</p> <p>During an observation on 5/13/2024 at 1:16 p.m., CNA 4 wore a cloth gait belt around CNA 4's hips.</p> <p>During an observation on 5/14/2024 at 9:08 a.m., CNA 2 wore a cloth gait belt around CNA 2's waist.</p> <p>During an observation on 5/14/2024 at 9:52 a.m., CNA 6 wore a cloth gait belt around CNA 6's waist.</p> <p>During an observation on 5/14/2024 at 12:33 p.m. CNA 1 wore a cloth gait belt around CNA 1's waist.</p> <p>During a concurrent observation and interview on 5/15/2024 at 12:30 p.m. with CNA 7, CNA 7 wore a cloth gait belt around CNA 7's waist. CNA 7 stated the gait belts were used multiple times per day to transfer residents from the bed to wheelchair.</p> <p>During an observation on 5/15/2024 at 12:40 p.m., CNA 8 wore a cloth gait belt around CNA 8's waist.</p> <p>(continued on next page)</p>		

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

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 5/15/2024 at 12:41 p.m. with CNA 2 and CNA 9, CNA 2 wore a cloth gait belt around CNA 2's waist and CNA 9 wore a vinyl gait belt around CNA 9's waist. CNA 9 stated the vinyl gait belt was cleaned using the bleach sanitizing wipes before and after use with a resident. CNA 2 stated the cloth gait belt was washed at home each day and used the bleach sanitizing wipes in-between use with residents.</p> <p>A review of the (undated) bleach sanitizing wipes' manufacturer recommendations, indicated the premoistened wipes can be used to clean, deodorize and disinfect hard, non-porous (water, air, or other fluids are unable to go through the material) healthcare and environmental surfaces. The manufacturer recommendation also indicated it was a violation of Federal Law to use the product in a manner inconsistent with its labeling.</p> <p>During an concurrent interview and review of the bleach sanitizing wipes' manufacturer recommendations on 5/15/2024 at 12:52 p.m. with the IPN, the IPN stated the manufacturer recommendations for the bleach sanitizing wipes indicated the wipes were for use on non-porous surfaces. The IPN stated the cloth gait belts were porous and should be washed. The IPN stated using the bleach sanitizing wipes on the cloth gait belts was ineffective since cloth gait belts were porous. The IPN stated it was important to disinfect surfaces in-between residents to prevent the spread of contamination (presence of unwanted substances) between residents.</p> <p>A review of an article entitled Rehabilitation Services published on October 3, 2014 by the Association for Professionals in Infection Control and Epidemiology, page 10 of the article indicated shared equipment must be cleaned and disinfected between each use. The article further states that gait belts should not be worn around the waist of staff or (if cloth) used on multiple patients due to the inability to clean the gait belt between patients.</p>