

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055704	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Angels Nursing Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 415 S Union Avenue Los Angeles, CA 90017	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observation, interview, and record review, the facility failed to maintain accountability for 17 Percocet (an opioid pain medication used to relieve severe pain) tablets, schedule II Medications (drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence) for one of three sampled residents (Resident 1).</p> <p>This failure had the potential to result in a drug diversion (when a medication is taken for use by someone other than whom it is prescribed), opioid abuse (excessive use of a drug in a way that is detrimental to self, society, or both), and accidental overdose (unintentional intake or administration of a substance in doses higher than what is considered safe or recommended) for Resident 1 and or other residents.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s admission Record, the admission Record indicated the facility admitted Resident 1 on 3/18/2025 with diagnoses including muscle weakness and spina bifida (a condition that affects the spine).</p> <p>During a review of Resident 1 ' s History and Physical Examination dated 3/19/2025, the History and Physical Examination indicated Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1 ' s Medication Administration Record (MAR) dated for 5/1/2025 to 5/31/2025, the MAR indicated an order for the resident to receive Percocet 10-325 milligrams (mg, a unit of measurement) one tablet by mouth every six hours as needed for severe pain. The MAR indicated the order was discontinued on 5/31/2025 at 3:59 pm. The inventory account indicated 17 Percocet tablets were not administered at the time of discontinuation and were unaccounted for.</p> <p>During a review of the facility ' s pharmacy Manifest form (document that records) dated 5/20/2025 indicated the facility ' s contracted pharmacy delivered 24 tablets of Percocet prescribed for Resident 1 on 5/20/2024.</p> <p>During a review of Resident 1 ' s Skilled Nursing Pharmacy Antibiotic or Controlled Drug Record between 5/20/2025 to 5/28/2025, the Skilled Nursing Pharmacy Antibiotic or Controlled Drug Record indicated the last Percocet administered to Resident 1 was on 5/28/2025 at 6:45pm.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility ' s Narcotic Inventory list (a detailed document used to track the movement and management of drugs like opioids) dated 5/1/2025 to 5/31/2025 and 6/1/2025 to 6/4/2025, indicated the list was signed by outgoing (off duty) and incoming (on duty) nurses and did not indicate any discrepancies at each change of shift. The Narcotic Inventory sheet indicated Countable drugs are to be counted at each change of shift. The Last person whose name appears on the inventory sheet is responsible for the drugs.</p> <p>During a review of Resident 1 ' s MAR dated 6/4/2025 indicated seven Percocet 10-325 (medication dose) milligrams (mg-unit of measure) tablets were administered after 5/28/2025 at 18:45pm as follow:</p> <p>&middot;</p> <p>5/29/2025 at 5:00am and 7:30pm</p> <p>&middot;</p> <p>5/30/2025 at 2:00am, 8:14am and7:30pm</p> <p>&middot;</p> <p>5/31/2025 at 2:14am and 11:30 am.</p> <p>During an observation and interview on 6/4/2025 at 8:39 am, with Resident 1 inside Resident 1 ' s room, Resident 1 was awake and was well groomed. Resident 1 stated he (Resident 1) would receive the medications timely, and he (Resident 1) did not have any concerns.</p> <p>During a telephone interview on 6/4/2025 at 8:59am, with Licensed Vocational Nurse (LVN2), LVN 2 stated she (LVN2) carried out (completed) an order issued by Resident 1 ' s physician to discontinue Percocet for Resident1. LVN2 stated she (LVN2) informed LVN 3 (Resident 1 ' s medication nurse) of the discontinued Percocet order and they (LVN2 and LVN3) removed the skilled Nursing Pharmacy controlled drug record sheet wrapped it around the remaining Percocet medication ' s bubble pack (a type of packaging used to organize and dispense medications) and placed it at the back of the Narcotic box inside Med Cart 1. LVN2 indicated she did not carry out an inventory check of the remaining Percocet with LVN3 and was unable to state the number of Percocet medications left in the bubble pack.</p> <p>During a telephone interview on 6/4/2025 at 11:12 am, LVN 3 indicated she (LVN3) began her work shift on 5/31/2025 at 6:45am - 7:00pm and left work at approximately 8:30pm, LVN3 indicated she did not carry out an inventory check of the discontinued Percocet ' s with LVN2, LVN3 indicated the process for handling discontinued medication is to remove the medication from the med Cart, perform an inventory of remaining narcotic and to place the narcotics in a locked cabinet, LVN3 indicated she endorsed the Medication Cart 1 (Med Cart 1, a mobile storage unit used in healthcare settings to hold and transport medications) key to LVN4 at the end of her shift at 7 pm. LVN3 stated she (LVN3) did not remember carrying out an off duty narcotic inventory count with LVN4 on 6/1/2025 at the end of her shift at 7 pm.</p> <p>During a review of Cart 1 ' s Narcotic Inventory sheet dated 5/2025 indicated LVN3 signed off on the Narcotic inventory sheet on 5/31/2025 with on duty LVN4. The Narcotic Inventory sheet indicated there were no discrepancies were reported.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a telephone interview on 6/4/2025 at 11:42am with LVN4, LVN 4 stated she (LVN4) began her work shift on 5/31/2025 7pm to 6/1/2025 7 am, LVN4 stated she (LVN4) carried out a narcotic inventory count with LVN3 at the beginning of her shift on 5/31/2025 at 7pm. LVN4 stated there were no narcotic discrepancies. LVN4 stated she (LVN4) noticed there was a bubble pack of Percocet wrapped in a narcotic count sheet during the narcotic count. LVN4 stated she (LVN4) asked LVN3 about the Percocet tablet. LVN 4 stated LVN3 stated the Percocet medication had been discontinued. LVN4 stated on 6/1/2025 LVN6 arrived late for the 7am-3pm shift. LVN4 stated she (LVN4) left the Med Cart 1 key inside a drawer at the nursing station and clocked out at 7:13 am. LVN4 stated she (LVN4) did not do a narcotic inventory with LVN6. LVN4 stated she (LVN4) left the facility and assumed the incoming desk nurse Registered Nurse (RN1) who was also late for his shift would carry out the narcotic count with LVN6.</p> <p>During a telephone interview on 6/4/2025 at 12:40pm with RN, RN1 stated on 6/1/2025 he (RN1) worked the 7am to 3pm shift. RN1 stated he (RN1) arrived at work between 7:20 and 7:30am. RN1 stated when he (RN1) arrived at the facility LVN6 was on Med Cart 1 passing medications. RN1 stated LVN6 completed her (LVN6) shift and left at the end of her shift at 3 pm. RN1 stated LVN6 did not report any concerns and/or narcotic discrepancies to RN1.</p> <p>During a telephone interview on 6/4/2025 at 12:24pm with LVN6, LVN6 stated she (LVN6) arrived at the facility on 6/1/2024 at 7:07am for her 7am-3pm work shift. LVN6 stated she (LVN6) asked the charge nurses (LVN3 and LVN5) about her work assignment, and they (LVN3 and LVN5) told LVN6 she (LVN6) was assigned to Med Cart 1. LVN6 stated LVN3 had the key to Med Cart 1 and proceeded to carry out a narcotic count with LVN6. LVN 6 stated there were no discrepancies and LVN3 gave LVN6 the Med Cart 1 key after the Narcotic inventory count. LVN6 stated there was no narcotic sheet wrapped with discontinued bubble pack during the Narcotic Inventory count with LVN3.</p> <p>During a follow-up telephone interview on 6/5/2025 at 10:32 am with LVN3, LVN3 stated on the morning of 6/1/2025 she (LVN3) carried out a narcotic count with LVN 6 and handed over Med Cart 1 key to LVN6. LVN3 stated she (LVN3) did not mention to LVN6 that there was a narcotic sheet wrapped with discontinued Percocet bubble pack in the narcotic box. LVN3 stated she (LVN3) did not check if the Narcotic count sheet wrapped in discontinued Percocet Bubble Pack was still in the narcotic box.</p> <p>During an interview on 6/5/2025 at 12:15 pm Director of Nursing (DON), the DON stated a Licensed Nurse (in general) should only hand it (Medication Cart keys) over to another licensed nurse and/or supervisor when going on break or leaving the facility. The DON stated Medication Cart keys should never leave be left in a drawer unattended, because drawers were not secure and were accessible to anyone. The DON stated an unattended med cart key gave unaccounted access to all medications in the Medication Cart including narcotics. The DON stated an unauthorized person with access key could take narcotics lead to diversion, drug abuse and/or drug overdose.</p> <p>During a review of facility Policy and Procedure (P&P) titled Medication Storage in the facility dated 1/2025, the P&P indicated Schedule II-V medications and other medications subject to abuse are stored in a separate area under double lock. Medications nurse on duty maintains possession of the key to controlled medications storage areas. At each shift changed, a physical inventory of all controlled medications, including the emergency supply is conducted by tow licensed nurses and is documented on the controlled medications accountability record. Any discrepancy in controlled substance medication count is reported to the director of nursing immediately. Current controlled medication accountability records are kept at nursing station. When completed, accountability records are kept on file for 1 year at the facility.</p> <p>(continued on next page)</p>		

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