STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055758	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottage Crest Post Acute	12350 Rosecrans Norwalk, CA 90650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was not verbally abused (using words to name call, bully, demean, frighten, intimidate, or control another person) by certified nursing assistant (CNA 1). This deficient practice caused Resident 1 to feel offended and cry hysterically (to cry in an uncontrolled state of anger, excitement, or panic) when CNA 1 re-entered Resident 1's room. Findings: During a review of Resident 1's Admission Assessment, the Admission Assessment indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of primary lateral sclerosis (a progressive neuromuscular (nerves and muscles) condition that causes worsening muscle weakness and/or stiffness), generalized anxiety disorder (a mental health condition that causes people to experience excessive and persistent worry about everyday things), and encounter for palliative care (specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness). During a review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool) dated 8/21/2024, the MDS indicated Resident 1 was moderately cognitively (a person's ability to think, learn, remember, use judgement, and make decisions) impaired. The MDS indicated Resident 1 was dependent (helper does all the effort) for all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's untitled care plan dated 8/21/2024, the care plan indicated Resident 1 communicated by trying to verbalize with low sounds, spelling out words as able, some pointing and gesturing. The goals for Resident 1 included Resident 1 being able to express self, utilize a communication board (a tool that helps people with limited language skills express themselves), and verbalize as able. Interventions included approaching Resident 1 calmly, listen carefully, ask yes or no questions, be patient, use the communication board, and ask open ended questions and wait for Resident 1's response. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Change of Condition Evaluation dated 10/7/2024, the evaluation indicated the director of staff development (DSD) received a report from licensed vocational nurse (LVN 1) informing her that Resident 1 was emotionally distraught. The assessment indicated LVN 1 assessed Resident 1 and discovered that Resident 1 was upset because she saw CNA 1 walk into her room. The evaluation indicated LVN 1 conducted a more comprehensive review and discovered Resident 1 stated CNA 1 told her she smelled and that upset Resident 1. During a review of Resident 1's Psychotherapy (the treatment of mental conditions by verbal communication and interaction): Diagnostic (methods to identify diseases, injuries, or disabilities) Interview note dated 10/8/2024, the note indicated Resident 1 had multiple health concerns that affect her ability to deal with stress and anxiety. During a review of Resident 1's Physician's Progress Notes dated 10/9/2024, the progress note indicated Resident 1 was a hospice patient (end of life care). During an interview on 10/9/2024 at 2 p.m., Resident 1 was able to answer yes or no questions and spell words out. Resident 1 spelled out 'CNA 1 was rough', Resident 1 spelled out 'CNA 1 told me you smell', Resident 1 spelled out, 'CNA 1 was controlling', and 'CNA 1 was not patient'. Resident 1 shook her head yes to the question do staff need to be patient and explain what they are going to do? Resident 1 shook her head yes when asked if she was crying when CNA 1 entered her room on 10/7/2024 and when asked why? she spelled out that CNA 1 was bad. During an interview on 10/10/2024 at 1:21 p.m., LVN 1 stated she was in Resident 1's room with her on 10/7/2024 when CNA 1 walked into the room to answer the call light for Resident 1's room mate and as soon as Resident 1 saw CNA 1 walk into the room she began crying hysterically so LVN 1 asked CNA 1 to exit the room and began interviewing Resident 1. Resident 1 informed LVN 1 that CNA 1 told her something hurtful which was you smell. Resident 1 informed LVN 1 that was not the first time CNA 1 told her something hurtful. LVN 1 stated that once she informed Resident 1 that the facility would change the assignment and they would get her another CNA, she mellowed out a bit and seemed her normal self. LVN 1 stated it was very surprising to see Resident 1 crying like that and it was uncharacteristic for her. LVN 1 felt something was wrong by Resident 1's reaction to CNA 1 and that prompted her to inform the DSD what was going on. LVN 1 stated it was not respectful to tell a resident they smell, and it could hurt their feelings. LVN 1 stated the facility was the resident's home and they should feel comfortable in their home. During an interview on 10/11/2024 at 11:43 a.m., registered nurse supervisor (RN 1) stated verbal abuse was anything that was said by mouth that could hurt a resident mentally and emotionally and that if you told a resident You smelled it was considered verbal abuse if that was the resident's perception especially if the resident cried. RN 1 stated staff had to approach Resident 1 more delicately and be more patient with her due to her difficulty expressing herself. During a review of the facility's policy and procedure (P/P) titled Abuse, Neglect, and Exploitation, dated 10/2022, the P/P indicated the facility was to prevent and prohibit abuse. The P/P indicated verbal abuse was the use of oral, written or gestured communication or sounds that willfully includes disparaging (expressing the opinion that something is of little worth) and derogatory (showing a critical or disrespectful attitude) terms to residents, or within hearing distance regardless of their age, ability to comprehend, or disability.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on observation and interview, the facility failed to create a person-centered care plan for diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) for one of three sampled residents (Resident 2). This deficient practice had the potential for Resident 2 to have episodes of hypoglycemia (occurs when your blood sugar level drops too low for your body to function normally) and/ or hyperglycemia (elevated blood sugar) related to her diagnosis of diabetes. Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes, malignant neoplasm of the breast (breast cancer), secondary malignant neneoplasm (cancer spread to the bone), and immunodeficiency (a state in which the immune system's ability to fight infectious diseases and cancer is compromised or entirely absent). During a review of Resident 2 ' s History and Physical (H&P) report dated 8/13/2024, the H&P indicated Resident 1 was admitted from the general acute hospital (GACH) due to hypoglycemia and acute kidney failure (a sudden decline in kidney function). The Plan of care for diabetes was to monitor blood sugar (using a device to check level of blood-sugar) daily. During a review of Resident 2 ' s Physician ' s Order Summary, the Order Summary indicated an order was placed 8/14/2024 for blood sugar check before meals, and to notify the physician if the blood sugar level is less than 70 and more than 250. The Order Summary indicated Resident 2 did not have any orders for blood sugar monitoring prior to this order. The Order Summary indicated, on 8/9/2024 an order was placed for Insulin Glargine (long-acting insulin) 24 units subcutaneously (applied under the skin) at bedtime for Diabetes. On 8/13/2024 the order for Insulin Glargine was changed to 21 units subcutaneously at bedtime for diabetes and hold if blood sugar was less than 100. During a review of Resident 2 ' s Care plan titled Diabetes Mellitus, at risk for hypo/hyperglycemia, the care plan was not initiated until 8/25/2024 (16 days after Resident 1's admission on 8/9/2024). The care plan goal was for Resident 2 not to have complications related to diabetes, with goals including diabetes medication as ordered by the doctor and fasting serum blood sugar (measures the amount of sugar in the blood after you haven't eaten or drank anything for at least 8 hours.) as ordered by the doctor. The care plan did not include what kind of diabetic medication the resident was taking or the frequency of Resident 2 ' s blood sugar monitoring. During a review of Resident 2 ' s minimum data set (MDS - a federally mandated resident assessment tool) dated 9/20/2024, the MDS indicated Resident 2 had moderate cognitive (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) impairment and was receiving insulin injections. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/11/2024 at 9:14 a.m., the director of staff development (DSD) stated she reviewed Resident 2 ' s care plan and the careplan did not indicate Resident 2 was on insulin or any other type of diabetic medications she was taking and there should be a specific care plan for the type of medication Resident 2 was on. The DSD stated it was important to have a resident specific care plan indicating the specific medications because each different medication can have different side effects. The DSD stated the care plan for Resident 2 did not indicate the frequency of blood sugar monitoring. The DSD stated the importance of a resident-centered care plan was the care plan gives the basis for everyone involved in the resident ' s care and ensured consistent care for all care givers. During a review of the facility ' s policy and procedure (P/P) titled Comprehensive Care Plans dated 12/19/2022, the P/P indicated the comprehensive care plan was to describe, at a minimum, the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being. The Comprehensive Care Plan was to contain resident specific interventions that represent the resident ' s need

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on interview and record review the facility failed to monitor the blood sugar levels for one of three sampled residents (Resident 2) who had type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and was receiving insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication). This deficient practice had the potential to cause hypoglycemia (occurs when your blood sugar level drops too low for your body to function normally). Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility 8/9/2024 with diagnoses of type 2 diabetes, malignant neoplasm of the breast (breast cancer), secondary malignant neoplasm of the bone (breast cancer spread to the bone), and immunodeficiency (a state in which the immune system's ability to fight infectious diseases and cancer is compromised or entirely absent). During a review of Resident 2 ' s History and Physical (H&P) report dated 8/13/2024, the H&P indicated Resident 1 was admitted from the general acute hospital (GACH) due to hypoglycemia and acute kidney failure (a sudden decline in kidney function). The Plan of care for diabetes was to monitor blood sugar daily. During a review of Resident 2 ' s Change of Condition (COC) assessment dated [DATE], the COC indicated Resident 1 was feeling clammy (pale, cool, moist skin) and more tired than usual. The COC indicated Resident 1's blood sugar was checked (there was no Physician ' s order for routine blood sugar monitoring), Resident 2 was found to have an episode of hypoglycemia with a blood sugar of 58 (reference range for blood sugar is 70 milligrams [mg a unit of measure of mass] / deciliter [dl a unit of measure of volume] - 100 mg/dl) . The COC indicated Resident 2 was given orange juice with four packets of sugar. New orders were placed in response to the hypoglycemic episode: 1. Decrease the dose of insulin Lantus to 21 units at bedtime and 2. Ensure Resident 2 eats breakfast prior to giving her medication Glipizide (a medication used to control blood surgar levels) and the medication time for Glipizide was changed to 9 a.m. During a review of Resident 2 ' s Physician ' s Order Summary, the Order Summary indicated an order was placed 8/14/2024 for blood sugar check before meals, and notify physciian if blood sugar levels are less than 70 and more than 250. The Order Summary indicated Resident 2 did not have any orders for blood sugar monitoring prior to this order . The Order Summary indicated, on 8/9/2024 an order was placed for Insulin Glargine (long-acting insulin) 24 units subcutaneously (applied under the skin) at bedtime for Diabetes. On 8/13/2024 the order for Insulin Glargine was changed to 21 units subcutaneously at bedtime for diabetes and hold if blood sugar was less than 100. During a review of Resident 2 ' s minimum data set (MDS - a federally mandated resident assessment tool) dated 9/20/2024, the MDS indicated Resident 2 had moderate cognitive (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) impairment and was receiving insulin injections. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/11/2024 at 9:14 a.m., the director of staff development (DSD) stated Resident 2 should have had an order upon admission for blood sugar checks because she was on a long-acting insulin (Lantus), and they needed to hold the medication if the blood sugar was below 110. The DSD stated she reviewed Resident 2 ' s physicians orders and Resident 2 did not have blood sugar checks ordered upon admission, the order for blood sugar monitoring was placed on 8/14/2024 after Resident 2 ' s episode of hypoglycemia. The DSD stated the risk of administering insulin without checking the blood sugar was that the resident could get hypoglycemia. The DSD stated she reviewed Resident 2 ' s chief complaint from her stay at the general acute hospital (GACH) on 8/8/2024 prior to her admission to the facility and the chief complaint was hypoglycemia, the DSD stated Resident 1's blood sugars should have been monitored closely upon Resident 2's admission to the facility. The DSD stated Resident 2 was at risk for hypoglycemia due to the medications she was taking and her diagnosis of DM. The DSD stated the admitting nurse should have followed up with the physician regarding blood sugar monitoring orders for the diabetic resident. During an interview on 10/11/2024 at 11:43 a.m., registered nurse (RN 1) stated nurses were not to give insulin prior to checking the blood sugar, even if it was a long- acting insulin and there should be a physician ' s order to check blood sugar. During a review of the facility ' s policy and procedure (P/P) titled Nursing Care of Resident with Diabetes Mellitus dated 12/19/2022, the P/P indicated the physician would order the frequency of glucose (blood sugar) monitoring. The P/P indicated residents who had poorly controlled blood sugar or those taking insulin may require more frequent monitoring.