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	06/11/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure two of 18 sampled resident (Resident 7 and Resident 44) were offered an advance directive (a legal document that specifies what actions should be taken for your health if you are no longer able to make decisions for yourself) and provided information regarding the advance directive. This failure had the potential to violate the residents' and/or the representatives' right to be fully informed of the option to formulate their advance directives and had the potential to cause conflict with the residents' wishes regarding health care. Findings: 1. During a review of Resident 7 Admission Record, the admission record indicated Resident 7 was originally admitted to the facility on [DATE] and readmitted to the facility o 4/27/2023 with diagnoses of but not limited to chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs), diabetes (a group of diseases that affect how the body uses blood sugar), chronic kidney disease (a gradual loss of kidney function that occurs over a period of months to years, or abnormal kidney structure) and cardiomyopathy (diseases of the heart muscles). During a review of Resident 7's History and Physical (H&P), dated 7/10/2018, the H&P indicated, Resident 7 had the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set (MDS- a standardized assessment and screening tool), dated 5/17/2024, the MDS indicated, Resident 7 needed set-up or clean up assistance from nursing staff with eating. The MDS indicated Resident 7 needed partial to moderate assistance from nursing staff with oral hygiene. The MDS indicated Resident 7 needed substantial or maximal assistance from nursing staff with dressing and putting on and taking off shoes. The MDS indicated resident 7 was independent with toilet hygiene, showering, changing positions from left to right, sitting to standing, transferring from the chair to the bed. The MDS indicated Resident 7 did not attempt to walk due to medical condition or safety concerns. The MDS indicated Resident 7 did not have an Advance Directive (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	06/11/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 7's Advance Health Care Directive, dated 8/24/2014, the Advance Health Care Directive indicated Resident 7 did not have two witnessed signatures on the Advance Health Care Directive as required by law. During a concurrent interview and record review on 6/7/2024 at 1:48 pm with the Social Services Director (SSD 1), Resident 7's Advance Healthcare Directive, dated 8/24/2024 was reviewed. The Advance Health Care Directive indicated on 8/24/2024 there were no documented signatures to show the Advance Health Care Directive had two witnesses' sign. The SSD 1 stated the Advance Health Care Directive it is not completed. The SSD 1 stated the Advance Health Care Directive needs to be signed by two witnesses. During a concurrent interview and record review on 6/11/2024 at 3:42 pm with the Director of Nursing (DON), Resident 7's Advance Health Care Directive, dated 8/24/2024 was reviewed. The DON agreed Resident 7's Advance Health Care Directive is not complete because it needs to have two witnesses' sign. The DON stated staff will not be able to adhere to the Advance Health Care Directive and Resident 7's rights and wishes will not be addressed and carried out if the Advanced Health Care Directive is not signed by two witnesses. 2. During a review of resident 44's Admission Record, the admission Record indicated Resident 44 was admitted to the facility on [DATE] with diagnoses of but not limited to end stage renal disease (occurs when the gradual loss of kidney function reaches an advanced state and require external support to meet the daily requirements of life), heart failure (the heart cannot pump enough blood to the body), hypertension (high blood pressure), and diabetes. During a review of Resident 44's H&P dated 3/22/2023, the H&P indicated, Resident 44 had the capacity to understand and make decisions. During a review of Resident 44's MDS, dated [DATE], the MDS indicated Resident 44 needed set up or clean up assistance from nursing staff with eating, oral hygiene, personal hygiene. The MDS indicated Resident 44 needed supervision and touching assistance from nursing staff with toileting, dressing and putting on and taking off shoes, changing positions from left to right, sitting to lying, sitting to standing, transferring to chair, transferring to the bed, transferring to the toilet, transferring to the shower, and walking. The MDS indicated Resident 44 did not have an advance directive. During an interview on 06/07/2024 at 2:00 pm with SSD 1, SSD 1 stated Resident 44 was offered an advanced directive today (6/7/2024) and does not remember offering Resident 44 an advance directive upon admission and quarterly. The SSD 1 stated advanced directives are important so the resident's healthcare wishes can be carried out appropriately. During an interview on 6/11/2024 at 3:55 pm with the DON, the DON stated Resident 44 does not have an advance directive and there is no documentation in Resident 44's chart that indicates an advance directive was offered. During a review of the facility's and procedure (P&P) titled, Residents' Rights Regarding Treatment and Advance Directives, dated 12/19/2022, the P&P indicated, On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident, if cognitively able to, would like to formulate an advance directive.

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	06/11/2024

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure one of 18 sampled residents (Resident 7)'s documentation of a significant change of condition (COC-documentation of a resident's sudden change from baseline) was done when Resident 7 was transferred to the hospital. This failure had the potential to result in resident 7 not receiving the appropriate care and necessary treatment. Findings: During a review of Resident 7 Admission Record, the admission Record indicated Resident 7 was originally admitted to the facility on [DATE] and readmitted to the facility o 4/27/2023 with diagnoses of but not limited to chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs), diabetes (a group of diseases that affect how the body uses blood sugar), chronic kidney disease (a gradual loss of kidney function that occurs over a period of months to years, or abnormal kidney structure) and cardiomyopathy (diseases of the heart muscles). During a review of Resident 7's History and Physical (H&P), dated 7/10/2018, the H&P indicated, Resident 7 had the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set (MDS- a standardized assessment and screening tool), dated 5/17/2024, the MDS indicated, Resident 7 needed set-up or clean up assistance from nursing staff with eating. The MDS indicated Resident 7 needed partial to moderate assistance from nursing staff with oral hygiene. The MDS indicated Resident 7 needed substantial or maximal assistance from nursing staff with dressing and putting on and taking off shoes. The MDS indicated resident 7 was independent with toilet hygiene, showering, changing positions from left to right, sitting to standing, transferring from the chair to the bed. The MDS indicated Resident 7 did not attempt to walk due to medical condition or safety concerns. During an interview on 6/07/2024 at 2:25 pm with Licensed Vocational Nurse (LVN 3), LVN 3 stated Resident 3 was hospitalized on [DATE] for left lower extremity edema. LVN 3 stated no change of condition was documented. LVN 3 stated Resident 7 should have a completed COC documented in the chart. LVN 3 stated when Resident 7 was transferred to the hospital a COC needed to be completed. During an concurrent interview and record review on 6/10/2024 at 11:34 am with Registered Nurse Supervisor (RNS 1), resident 7's medical chart was reviewed, RNS 1 stated Resident 7 was hospitalized on [DATE] for abnormal vital signs and no COC was done. RNS 1 stated on 5/10/2024 Resident 7 was transferred to the hospital on 5/10/2024 for left lower extremity edema and no COC was done. The RNS 1 stated a COC indicates a change of condition. RNS 1 stated for any acute change in the resident's health condition a COC needs to be done to monitor the change in condition, if a COC is not done, the change of condition can go unmonitored and the resident's condition can worsen if there is no monitoring. (continued on next page)

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	06/11/2024

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/2024 at 3:47 pm with the Director of Nursing (DON), the DON stated Resident 7 does not have a COC documented in the chart for being transferred to the hospital. The DON stated the COC can indicate a new physician order, and what was done for resident. The DON stated the COC indicates the family and the doctor were notified about the change of condition. The DON stated if the COC is not done the staff are not able to monitor the residents' change of condition and the change of condition can go unmonitored. During a review of the facility's policy and procedure titled, Job Description Registered Nurse, 12/19/2022, the P&P indicated, Notify the resident's attending physician and next -of-kin when there is a change in the resident's condition. During a review of the facility's policy and procedure titled, Licensed Vocational Nurse, dated 2003, the P&P indicated, Notify the resident's attending physician and next -of-kin when there is a change in the resident's condition.

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	06/11/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to a. Ensure one of 18 sampled residents (Resident 7)'s assessment entries on the Minimum Data Set (MDS- an assessment and care screening tool) related to the section in the MDS called Swallowing/Nutrition Status was accurately documented to reflect Resident 7's nutritional approaches. b. To conduct an accurate fall assessment for one of three sampled residents (Resident 36). This failure had the potential to result in a negative effect on Resident 7 and Resident 36's plan of care and delivery of necessary services, care and treatment. Findings: a. During a review of Resident 7 Admission Record, the admission record indicated Resident 7 was originally admitted to the facility on [DATE] and readmitted to the facility o 4/27/2023 with diagnoses of but not limited to chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs), diabetes (a group of diseases that affect how the body uses blood sugar), chronic kidney disease (a gradual loss of kidney function that occurs over a period of months to years, or abnormal kidney structure) and cardiomyopathy (diseases of the heart muscles). During a review of Resident 7's History and Physical (H&P), dated 7/10/2018, the H&P indicated, Resident 7 had the capacity to understand and make decisions. During a review of Resident 7's MDS, dated [DATE], the MDS indicated, Resident 7 needed set-up or clean up assistance from nursing staff with eating. The MDS indicated Resident 7 needed partial to moderate assistance from nursing staff with oral hygiene. The MDS indicated Resident 7 needed substantial or maximal assistance from nursing staff with dressing and putting on and taking off shoes. The MDS indicated resident 7 was independent with toilet hygiene, showering, changing positions from left to right, sitting to standing, transferring from the chair to the bed. The MDS indicated Resident 7 did not attempt to walk due to medical condition or safety concerns. The MDS indicated Resident 7 received intravenous feedings and tube feedings. During a review of Resident 7's Order Summary Report, the order summary report indicated, Resident 7 had a physician order, dated 5/14/2024, for a Consistent Carbohydrate Diet (a nutritional approach that focuses on regulating carbohydrate intake throughout the day), mechanical soft texture (foods that are soft, easy to chew and swallow), thin consistency (substances that are non-restrictive and flow easily), renal diet (low protein, sodium, potassium and phosphorus). During an interview on 6/06/2024 at 12:21 pm, with Certified Nursing Assistant (CNA 5), CNA 5 stated Resident 7 was not receiving tube feeding (a feeding tube is used to supply nutrients and fluids to the body if a person cannot chew or swallow). (continued on next page)

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	06/11/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/10/2024 at 11:47 am with RNS 1, Resident 7's MDS, dated [DATE], was reviewed, the MDS indicated Resident 7 was getting parenteral nutrition (a way for a person to receive nutrients by bypassing the digestive system and goes directly to the bloodstream) and enteral nutrition (a way of providing nutrition in liquid or formula form through a tube in the stomach or intestine). RNS 1 stated Resident 7 did not have enteral nutrition and did not have a feeding tube. RNS 1 stated Resident 7 did not have any intravenous feedings while at the facility. During a concurrent interview on 6/10/2024 at 1:57 pm with the MDS coordinator, of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7 was receiving parenteral and enteral nutrition. The MDS coordinator stated there was a coding error and a coding error can be changed MDS stated Resident 7 is not receiving parenteral or enteral nutrition. The MDS coordinator stated he would not have coded Resident 7 as having parental nutrition or enteral nutrition based on the Resident 7's medical chart. The MDS coordinator agreed Resident 7's information had to be accurate in order for the resident to receive the best quality of care. During an interview on 6/11/2024 at 3:51 pm with the Director of Nursing (DON), the DON stated Resident 7 is not receiving parenteral or enteral nutrition and has never received parental or enteral nutrition. The DON stated this is a coding error and information needs to be documented accurately. DON stated it is important to document the resident's information accurately because the information on the MDS is turned in to the Center for Medicare and Medicaid Services (CMS). b. During a review of Resident 36's Face Sheet Admission Record, the admission record indicated Resident 36 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including seizures (uncontrolled electrical disturbances in the brain that causes changes in movements and consciousness), epilepsy (a disorder of the brain that is caused by repeated seizures), spondylosis (a small crack in the lower spine that causes back pain), and traumatic brain injury (TBI: a serious medical issue caused by a blow to the head). During a review of Resident 36's Minimum Data Set [(MDS) a standardized assessment and care screening tool], dated 4/20/2024, the MDS indicated Resident 36's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were intact. The MDS indicated Resident 36 required moderate assistance for bathing and required supervision for all other activities of daily living (dressing, transferring, ambulating) except for eating and oral hygiene. The MDS indicated Resident 36 did not have any impairments on both the upper and lower extremities (arms and legs) and did not use assistive devices (wheelchair, walker). During a review of Resident 36's untitled Care Plan (CP: document the patient's needs, wants, and nursing interventions planned to meet the needs), the care plan indicated Resident 36 is at risk for falls related to (r/t) gait/balance problems, seizures initiated on 6/6/2024. During a review of the Change of Condition (COC: document initiated when there is a sudden change from the resident's baseline), the COC indicated on 6/4/2024, Resident 36 had a witnessed fall at 10:30a.m. Resident was transferred by wheelchair back to room by the physical therapist 1 (PT 1) . Resident 36 stated when he got up, he felt dizzy and fell . Resident 36 refused to go the hospital, a head to toe assessment was done, and no changes were noted, and neurological checks were initiated. During a review of the fall risk assessment, the document stated as follows: (continued on next page)

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	06/11/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/16/24 at 8:53p.m.: Fall score nine (9), alert and oriented, no falls in the past (3) months, requires use of assistive devices, takes three (3) or more medications currently, has three (3) or more predisposing diseases. 5/5/2024 at 9:58p.m.: Fall score eight (8), alert and oriented, no falls in past three (3) months, gait/balance is normal, takes three (3) or more medications currently, has three (3) or more predisposing diseases. 6/1/2024 at 5:40p.m.: fall risk: Fall score eight (8), alert and oriented, no falls in past three (3) months, gait/balance is normal, takes three (3) or more medications currently, has three (3) or more predisposing diseases. 6/4/2024 at 11:28a.m. fall risk: Fall score: six (6), alert and oriented, no falls in past three (3) months, ambulatory, balance problem while standing, balance problem, has one to two (1-2) medications currently taking and has one to two (1-2) predisposing diseases. Noted a hand written signature and date documented on the fall risk evaluation. The original document received did not reflect a signature and date. During a review of Resident 36's physical therapy (PT) evaluation and plan of treatment, the evaluation and treatment indicated the following: 4/18/2024: Resident 36 feels unsteady when walking and worries about falling. Resident 36's right and left lower extremities (hips and legs) are impaired and the general right and left lower extremity strength indicated the hip, knee, and ankle were impaired. Resident 36 exhibits inadequate hip and trunk extension which are associated with the underlying causes of lack of/impaired coordination, muscle weakness and reduced functional activity tolerance. Due to documented physical impairments and associated functional deficits, Resident 36 is at risk for falls with the decreased level of mobility. 5/7/2024: Resident 36 presents with bilateral (both sides) muscle weakness, decreased activity tolerance, safety awareness, balance deficits in sitting and standing which impairs Resident 36's functional mobility performance and increased the risks for falls. Due to documented physical impairments and associated functional deficits, Resident 36 is at risk for decrease in level of mobility, decreased participation with functional tasks and falls. 6/3/2024: Resident 36 presented with complaint of generalized weakness and difficulty with prolonged walking, decreased mobility and tolerance, balance deficit, difficulty walking, and decreased bilateral extremity strength. Due to documented physical impairments and associated functional deficits, Resident 36 is at risk for falls. During a review of Resident 36's occupational therapy (OT) evaluation and plan of treatment indicated the following: 4/17/2024: Resident 36 had decreased coordination, balance, activity tolerance, and safety awareness. Due to documented physical impairments and associated functional deficits, Resident 36 is at risk for falls and further decline in function. (continued on next page)

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	06/11/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/7/2024: Resident 36 had decreased strength, decreased coordination, and impaired balance. Due to documented physical impairments and associated functional deficits, Resident 36 is at risk for falls and further decline in function and immobility. 6/4/2024: Resident 36 had decreased strength, coordination, and impaired balance. Due to documented physical impairments and associated functional deficits, Resident 36 is at risk for falls, further decline in function and immobility. During a concurrent interview and record review of the COC on 6/4/2024 at 2:21p.m. with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated she was informed about Resident 36's fall from the receptionist (RCT) as she is the one that witnessed the fall. LVN 3 stated she did a head-to-toe assessment, neurological checks, assessed for pain, and Resident 36 did complain of head and shoulder pain and notified the doctor, however Resident 36 refused to go to the hospital and to continue monitoring the resident. During a concurrent interview and record review of the risk management for falls on 6/4/2024 at 2:29p.m. with LVN 3, LVN 3 stated the risk management for falls document is initiated and documented when there is an incident and is done additional to the fall risk assessment. LVN 3 stated residents are monitored for falls to see for any changes in the level of consciousness and pain, and if the resident was never checked, they can decline and have possible injuries. LVN 3 stated she reminds Resident 36 to get up slowly and to wear proper foot wear. LVN 3 stated Resident 36 ambulates without assistance and is out and about. During an interview on 6/4/2024 at 2:35p.m. with RCT, RCT stated Resident 36 was standing in the front of her and was making moaning noise. RCT stated when she looked, Resident 36 fell backwards, requested for assistance, two consultants came out to direct the resident to not move and to continue laying down, and the two consultants and the PT assessed the resident, got a wheelchair and took him into this room. RCT stated Resident 36's eyes were following and did not notice any bleeding. RCT stated Resident 36 likes to come out to the front of the facility to look out the window and is stable when ambulating. During a concurrent interview and record review of the fall risk document and PT/OT notes on 6/11/2024 at 5:49p.m. with Director of Nursing (DON), DON stated Resident 36 fell on [DATE]. DON stated the fall risk assessment determines whether a resident is a fall risk or not. The DON stated she is not sure why it states uses assistive device on the fall risk dated 4/16/2024. The DON stated Resident 36 is a fall risk according to the PT/OT notes and any significant changes will be communicated in the meetings. (continued on next page)

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	06/11/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of the fall risk document and PT/OT notes on 6/11/2024 at 6:01p.m. he DON stated if a resident had a score of 10 and above, they would be at risk for falls, but since Resident 36 fall score was a nine (9), although he is a fall risk did not indicate he was a fall risk. The DON stated however the PT/OT notes states otherwise and no one mentioned to her that he was a fall risk. The DON stated the fall risk assessment for 5/5/2024 and 6/1/2024 are not correct as it is documented as Resident 36's gait is normal, but he is unsteady. The DON stated the documentation is not correct because the nurses did not do a thorough assessment on the resident and although Resident 36 is observed walking, he is not steady 100% and has unsteadiness. The DON stated Resident 36 needed an at risk for fall care plan and did not have a care plan until it was initiated on 6/6/2024. The DON stated LVN 3 is the one that documented the fall risk assessment for 6/4/2024 but did not sign it on the computer. The DON stated everything has to be signed for the document to be considered complete and thus indicated the fall assessment for 6/4/2024 was not completed. The DON stated the fall assessment is also not correct as Resident 36 takes three (3) or more medications currently and has three (3) or more predisposing diseases and it is documented as Resident 36 taking one to two (1-2) medications and has one to two (1-2) predisposing diseases. DON stated without an accurate fall assessment, more falls would occur and would need to re-educate the licensed nurses. During a review of the facility's policy and procedure titled, Medicare/MDS Coordinator Job Description, undated, the P&P indicated, Ensures the exchange and use of essential information necessary for quality resident care . Ensures all documentation is maintained as required by Federal and State regulations and Company policy. During a review of the facility's P&P titled, Fall Prevention Program, revised 12/28/2023, the P&P indicated each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. 46415

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	06/11/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on interview and record review, the facility failed to follow through and accurately assess with the Preadmission Screening and Resident Review (PASARR- a comprehensive evaluation that ensures people who have been diagnosed with serious mental illness, intellectual, and/or developmental disabilities are able to live in the most independent settings while receiving the recommended care and interventions to improve their quality of life) level I and level II evaluation for four of four sampled residents (Resident 22, Resident 6, and Resident 1) to determine the facility's ability to provide the special need of the residents. This deficient practice placed Resident 22, Resident 6, and Resident 1 at risk of not receiving the necessary care and services they need. Findings: A. During a review of Resident 22's Admission Record, the Admission Record indicated, Resident 22 was admitted to the facility on [DATE] with diagnosis including anxiety disorder (persistent and excessive worry that interferes with daily activities), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks). During a review of Resident 22's History and Physical (H&P), dated 5/10/2024, the H&P indicated, Resident 22 had no capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set ([MDS]-a standardized assessment and care screening tool), dated 5/13/2024, the MDS indicated Resident 22 required dependent assistance (helper does all of the effort) from two or more staff for shower, toileting hygiene, personal hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, moderate assistance (Helper does less than half the effort) from one staff for eating, oral hygiene, and independent for roll left and right. The MDS indicated, sit to lying, lying to sitting on the side of bed, sit to stand, chair/bed to chair transfer was not attempted due to medical condition or safety concerns. The MDS Section N (medications) indicated, Resident 22 was taking antipsychotic (a group of drugs that have been used for treating a variety of mental disorders), antianxiety (A drug used to treat symptoms of anxiety, such as feelings of fear, dread, uneasiness, and muscle tightness, that may occur as a reaction to stress), and opioid (A class of drug used to reduce moderate to severe pain) medications. During a review of Resident 22's PASARR dated on 5/7/2024, the PASARR indicated Negative level I screening indicated a level II mental evaluation is not required. If the individual remains in the nursing facility longer than 30 days, the facility should resubmit a new level I screening as a resident review on the 31st day. The PASARR level I screening indicated, section LLL-serious illness: 10. Does the individual have a serious diagnosed mental disorder such as depressive disorder, anxiety disorder, symptoms of psychosis? -NO. (continued on next page)

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	06/11/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 22's Care Plan (CP), initiated 5/11/2024, the CP Focus indicated, Resident 22 received psychotropic medication (Seroquel-antipsychotic medication to treat certain mental/mood disorders) related to behavior management. The CP Interventions indicated, administer psychotropic medication as ordered by physician and monitor for side effects. During an interview on 6/6/2024, at 11:15 a.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated, Resident 22's was diagnosed with dementia, Alzheimer, anxiety disorder and was receiving medications to treat her mental illness. RNS 1 stated, PASARR was done incorrectly and should have submitted new one. B. During a review of Resident 6's Admission Record, the Admission Record indicated, Resident 6 was initially admitted to the facility on [DATE] and last admission was 4/3/2024 with diagnosis including recurrent major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia and Alzheimer's disease. During a review of Resident 6's H&P, dated 4/12/2024, the H&P indicated, Resident 6 had fluctuating capacity to understand and make decisions. During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 required maximal assistance (Helper does more than half the effort) from one staff for toilet hygiene, shower, lower body dressing, putting on/taking off footwear, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair /bed to chair transfer, toilet transfer, and moderate assistance (Helper does less than half the effort) from one staff for oral hygiene. During a review of Resident 6's PASARR level I dated on 8/10/2023, the PASARR I indicated, positive level I am screening indicates a level II mental health evaluation is required. During a review of Resident 6's PASARR level II dated on 8/10/2023 indicated unable to complete level II evaluation. The individual has no serious mental illness. During a review of Resident 6's CP initiated 3/20/2023 and revised 6/4/2024, the CP Focus indicated, Resident 6 received antianxiety medication (Ativan) related to anxiety manifested by verbalization of feeling anxious. The CP Interventions indicated, administer antianxiety medication as ordered by physician and monitor for side effects. During a review of Resident 6's Medication Administration Record (MAR), dated 6/2024, The MAR indicated, Sertraline 50mg, give one tablet at bedtime enterally (in a way that involves putting food substances or medicine into someone's digestive system) for depression manifested by verbalizing feeling depressed. During an interview on 6/6/2024, at 11:25 a.m., with RNS 1, RNS 1 stated, Resident 6 was diagnosed with Alzheimer's disease, dementia, and major depressive disorder. RNS 1 stated, Resident 6 was receiving antidepressant and antianxiety medications to treat his mental illness. RNS 1 stated, PASARR I was done correctly, but PASARR II was not done correctly. RNS 1 stated Resident 6's PASARR should have been re-evaluated and re-submitted new. (continued on next page)

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	06/11/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. During a review of Resident 1's Admission Record, the Admission Record indicated, Resident 1 was initially admitted to the facility on [DATE] and last admission was 11/25/2023 with diagnosis including Schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), mood disorder (a type of mental health condition where there is a disconnect between actual life circumstances and the person's state of mind or feeling), and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 1's H&P dated 11/26/2023, the H&P indicated, Resident 1 had no capacity to understand and make decisions. During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 required dependent assistance from two or more staff for toileting hygiene, shower/bath self, lower body dressing, putting on/taking off footwear, sit to lying, lying to sitting on side of bed, chair/bed to chair transfer, and maximal assistance from one staff for eating, oral hygiene, upper body dressing, personal hygiene, roll left and right. During a review of Resident 1's PASARR level I dated on 3/9/2023, the PASARR I indicated, Level I am screening was negative. During a review of Resident 1's PASARR Letter dated on 3/17/2023, the PASARR Letter indicated, no further evaluation required at this time. During a review of Resident 1's MAR dated from 5/1/2024 to 6/4/2024, The MAR indicated, Risperdal 1mg, give one tablet by mouth one time a day for schizophrenia manifested by thought disorder related to other schizophrenia as evidenced by jumping from topic to topic without any meaning. During an interview on 6/6/2024, at 11:35 a.m., with RNS 1, RNS 1 stated, Resident 1's was diagnosed with schizophrenia, dementia, and mood disorder. RNS 1 stated, Resident 1 was receiving Risperdal to treat her mental illness. RNS 1 stated, PASARR I was done incorrectly, and it should be positive. RNS 1 stated Resident 1's PASARR I should have been re-evaluated and re-submitted new. During an interview on 6/7/2024, at 10:30 a.m., with Social Service Director (SSD), SSD stated, she did not do follow up with PASARR. SSD stated, she believed Director of Nursing (DON) oversaw following up PASARR. During an interview on 6/7/2024 at 10:36 a.m., with DON, DON stated Resident 22,6, and 1's PASARR was not done correctly. DON stated, when a resident admitted to the facility, admitting department would check if there was PASARR I done. DON stated they should have followed up for its accuracy, but no one did. DON stated it was important to make sure PASARR was done correctly to provide appropriate services to the resident. (continued on next page)

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	06/11/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Resident Assessment-Coordination with PASARR Program, revised 12/18/2023, the P&P indicated, Policy: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level I - initial pre-screening that is completed prior to admission.

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	06/11/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to develop a baseline care plan for two of three sampled residents (Resident 25 and Resident 36) by: 1. Failing to address multiple falls and a fall with injury by initiating an at risk for fall care plan, the use of psychotropic medication (medication capable of affecting the mind, emotions, and behavior) in the care plan for Resident 25 who was on Ativan (generic name Lorazepam is used to treat anxiety) Rexulti (generic name Brexpiprazole is an antipsychotic (medication used to treat a collection of symptoms that affect your ability to tell what's real and what isn't) medication to treat major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and dementia (a group of symptoms that affects memory and thinking)-related agitation. 2. Failing to initiate an at risk for fall care plan and address Resident 36's history of seizures. These deficient practices had the potential to negatively affect the delivery of necessary care and services for Resident 25 and Resident 36. 1. During a review of Resident 25's Admission record, the admission record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (disrupted blood flow to the brain caused by issues with the blood vessels that supply it), hemiplegia (severe weakness on one side of the body) and hemiparesis (one sided weakness without complete paralysis), and dementia (a group of symptoms that affects memory and thinking) without behavioral disturbance (aggression, anxiety) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 25's Minimum Data Set [(MDS) a standardized assessment and care screening tool], dated 4/15/2024, the MDS indicated Resident 25 did not exhibit behaviors such as hallucinating, delusions, or physical (hitting, biting) and verbal (screaming at others) behaviors. The MDS indicated Resident 26 was moderately depressed. The MDS indicated Resident 25 required maximal assistance for transferring chair to bed, rolling left and right and required moderate assistance for toileting, bathing, and dressing. During a review of Resident 25's untitled Care Plan (CP: document the patient's needs, wants, and nursing interventions planned to meet the needs), the care plan indicated Resident 25 had an actual fall with no injury due to poor balance, communication, comprehension, and unsteady gate initiated 4/16/2024 with a revision date of 6/4/2024. The interventions included to continue interventions on the at-risk plan, determine and address causative factors of the fall initiated 4/16/2024, may place the bed against the wall for safety per family on 5/4/2024, and a resolved intervention of Resident 25 being on one-to-one (1:1) monitoring for safety initiated on 4/18/2024. (continued on next page)

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	06/11/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 25's untitled Care Plan, the care plan indicated Resident 25 is at risk for falls related to confusion, gait/balance problems initiated on 6/6/2024. The interventions included to place the bed against the wall for safety with floormat on the side of the bed, place call light within reach, and anticipate and meet the resident's needs initiated 6/6/2024. During a review of the Change of Condition Evaluation (COC: form initiated when a resident has a deviation from baseline, Resident 25 had falls on the following days: -4/13/2024 at 2:05p.m. -4/17/2024 at 6:17a.m. -4/18/2024 at 10:25p.m -4/27/2024 at 4:59a.m.: Resident fell on [DATE] with no pain or discoloration upon assessment. -5/4/2024 at 2:61p.m.: Resident fell on [DATE] with other behavioral symptoms. -5/24/2024 at 7:11p.m.: Resident fell on [DATE] sustained a bump to the right eyebrow after rolling off the bed. During a concurrent interview and record review on 6/6/2024 at 9:04a.m., with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated whether the fall was witnessed or not, they will monitor the resident for 72 hours and do a fall care plan. RNS 1 stated when there is a fall, the care plan is done on the day of the fall or within 24 hours to manage the situation safely. RNS 1 stated if the resident had a history for falls, they would have a goal, interventions to meet the goal, and identify the issues for the residents' safety. RNS 1 stated falls are reported to keep track of the resident, how many falls they had as if a resident had multiple falls, it may be due to new medications or physiological, so they need to know what changed or caused the fall. During an interview on 6/11/2024 at 6:14p.m. with the Director of Nursing (DON), the DON stated care plans should be updated whenever a resident falls and did not update the care plan for all the falls Resident 25 had and should have been initiated and updated. The DON stated the interventions for Resident 25's fall were revised with the last revision date of 6/4/2024, but the revision date should have been 5/4/2024. The DON stated they did not put the actual date for every fall Resident 25 had and usually do not put all the falls under the care plan and the interventions would be revised. The DON stated Resident 25's at risk for fall care plan was created on 6/6/2024 and did not have an at risk for fall care plan when Resident 25 was admitted . During a review of the Order Summary Report (Physician's Orders) date range from 4/1/2024 to 4/30/2024, the order summary report indicated the following: 1. Ativan one tablet by mouth every 12 hours (hrs) as needed for anxiety manifested by (m/b) inability to relax three (3) days on 4/12/2024 to 4/15/2024. 2. Rexulti oral tablet 0.5mg one tablet by mouth a day for agitation for seven (7) days on 4/18/2024 to 4/25/2024. (continued on next page)

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	06/11/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Lexapro (generic name escitalopram Oxalate-medication used to treat depression) Oral Tablet 10 milligrams (mg- a unit of measure for weight) by mouth one time a day for depression manifested by (m/b) low interest in ADL's on 5/15/24. During a review of Resident 25's untitled care plan, the care plan indicated Resident 25 uses psychotropic medications (Quetiapine: treat depression and bipolar disorder: mental illness characterized by extreme mood swings including extreme excitement or extreme depression) related to behavioral management and potential injury to self and others and Depakote (used to treat manic episodes related to bipolar disorder (manic depression) for dementia manifested by constantly getting up initiated on 4/16/2024 and revised on 6/4/2024. The interventions included to administer psychotropic medications as ordered, monitor for side effects, review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy, monitor adverse reactions of Quetiapine therapy (falls, lethargy, sedation) and monitor/record occurrence of for target behavioral symptoms (aggression towards staff, inappropriate response to verbal communication, violence/aggression towards staff/others etc.) and document per facility protocol initiated 4/16/2024. Depakote did not have a specific intervention to monitor for any adverse effects. During of review Resident 25's untitled Care Plan, Resident 25 did not have any care plans for the use of Ativan, Rexulti, and Lexapro. During a concurrent interview and record review of the care plan on 6/11/2024 at 5:01p.m. with DON, DON stated Resident 25 has a care plan for the use of psychotropic medications which included Quetiapine and Depakote and indicated the psychotropic medications should have its own focused care plan and the purpose of a care plan included the plan of care that is being provided to the resident and what interventions are being done for the residents diagnosis. DON stated they have to follow the care plan and if not, the resident can decline and get hurt. 2. During a review of Resident 36's Admission Record, the admission record indicated Resident 36 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including seizures (uncontrolled electrical disturbances in the brain that causes changes in movements and consciousness), epilepsy (a disorder of the brain that is caused by repeated seizures), spondylosis (a small crack in the lower spine that causes back pain), and traumatic brain injury (TBI: a serious medical issue caused by a blow to the head). During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were intact. The MDS indicated Resident 36 required moderate assistance for bathing and required supervision for all other activities of daily living (dressing, transferring, ambulating) except for eating and oral hygiene. The MDS indicated Resident 36 did not have any impairments on both the upper and lower extremities (arms and legs). During a review of Resident 36's untitled Care Plan, a CP for Resident 36's seizure disorder was initiated on 6/4/2024. The interventions included giving medications as ordered and monitoring/document the effectiveness and side effects, monitor labs and report for any sub therapeutic of toxic results, and obtain and monitor lab/diagnostic work as ordered. (continued on next page)

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	06/11/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of the care plan on 6/6/2024 at 12:39p.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated the care plan for seizures were initiated on 6/4/2024. LVN 2 stated care plans are initiated upon admission and the Registered Nurse Supervisor (RNS) or the Director of Nursing (DON) and if there are any changes, the care plan should be updated. LVN 2 stated on 5/5/2024, Resident 36 should have had a care plan for seizure as they need a plan of action since if there are no care plans, the staff would not know what to do for the resident. During a concurrent interview and record review of the care plan on 6/7/2024 at 3:27p.m with Registered Nurse Supervisor 2 (RNS 2), RNS 2 stated she was aware Resident 36 had a history of seizures upon admission on 4/16/2024. RNS 2 stated Resident 36 should have had a care plan after his first seizure episode on 5/1/2024 and there were no interventions done or any seizure precaution during the time from 5/1/2024 to 5/28/2024. During a concurrent interview and record review on 6/10/2024 at 10:06a.m. with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated Resident 36 already had a history of seizures on 4/12/2024 at admission. RNS 1 stated residents with history of seizures are on seizure precautions such as ensuring side rails are padded, bed in low position, floor mat just in case. RNS 1 stated baseline care plans are initiated between 24 to 48 hours admission. RNS 1 stated the care plan for seizure that is dated 6/4/2024 should have been initiated at admission. RNS 1 stated care plans are individualized for residents, and if they have a seizure, a measurable goal will be implemented to prevent further seizure episodes or injuries with interventions that are followed on what should be done for the resident to reach their goal. During a concurrent interview and record review on 6/10/2024 at 2:53p.m. with Minimum Data Set Coordinator (MDS), the MDS coordinator stated comprehensive care plans and the baseline care plan is done at admission. The MDS coordinator stated Resident 36 was admitted on [DATE] and was noted to have a history of seizures. The MDS coordinator stated care plans are important to ensure resident is safe and is being monitored for seizure activities and are supposed to have interventions readily available to prevent any injuries. During a concurrent interview and record review of Resident 36's medical records on 6/11/2024 at 5:21p.m. with the DON, the DON stated Resident 36 according to the progress notes was admitted on [DATE] but was sent out to the hospital for an evaluation for back pain and was readmitted to the facility on [DATE]. The DON stated Resident 36 had a diagnosis of seizure. The DON stated if a resident has a history of seizures, they need to be monitored. The DON stated Resident 36 had his first episode of seizure on 5/1/2024 and was readmitted with seizure medications. The DON stated when Resident 36 was admitted on [DATE], he should have had a seizure care plan and was not being monitored for seizures since 4/16/2024. During a review of the facility's P&P titled, Unnecessary Drugs-Without Adequate Indication for Use, revised 12/19/2022, the P&P indicated information gathered during the initial and ongoing evaluations will be incorporated into the resident's comprehensive care plan that reflects person-centered medication related goal and parameters for monitoring the resident's conditions, including the likely medication effects and potential for adverse consequences. (continued on next page)

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	06/11/2024

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Baseline Care Plan, revised 12/19/2022, the P&P indicated the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan will be developed within 48 hours of a resident's admission. A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand. The summary shall include, at a minimum, the following: the initial goals of the resident, a summary of the resident's medications and dietary instructions. Interventions shall be initiated that address the resident's current needs including: any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk and any identified needs for supervision, behavioral interventions, and assistance with activities of daily living. During a review of the facility's P&P titled, Comprehensive Care Plans revised 12/19/2022, the P&P indicated person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. The comprehensive care plan will describe, at a minimum, the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, resident specific interventions that reflect the resident's needs .the comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress .alternative interventions will be documented, as needed. Qualified staff responsible for carrying out interventions specific in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. During a review of the facility's P&P titled, Fall Prevention Program, revised 12/28/2023, the P&P indicated the nurse and/or interdisciplinary team will initiate interventions on the resident's care plan in accordance with the resident's level of risk. Indicate fall risk on care plan. When a resident experiences a fall, the facility will receive the resident's care plan and update as indicated. During a review of the facility's P&P titled, Seizure Precautions, revised 12/19/2022, the P&P indicated it is the policy of this facility to ensure a resident is protected from injury and managed in the event of a seizure according to current standards of practice. The facility will review the resident's medial history, resident or resident representative reports of prior history of or diagnosis of a seizure disorder, or conditions that could precipitate seizure activity. The facility will review the resident's medication history to ascertain if anticonvulsant medication is being administered for seizure control.

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	06/11/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on interview and record review, the facility failed to ensure and implement their policy and procedure on fall prevention for one of three sampled residents (Resident 52) by: 1. Failing to develop person-centered interventions/approaches addressing Resident 25's high risk for falls. 2. Failing to revise the fall risk care plan for multiple falls, doing a post fall assessment, and doing proper neurological checks (assessing mental status and level of consciousness). 3. Failing to identify potential risk factors of psychotropic medications (any medications that affect behavior, mood, thoughts, or perception) Resident 25 was taking. This deficient practice resulted in Resident 25 having six falls between 4/11/2024 to 5/24/2024 with a bump and bruising on the right eyebrow. During a review of Resident 25's Admission Record, the admission record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (disrupted blood flow to the brain caused by issues with the blood vessels that supply it) due to an embolism of the right middle cerebral artery (occurs when a blood clot forms in one part of the body and travels through the blood to the brain which blocks adequate oxygen and blood flow), hemiplegia (paralysis of part of total body function on one side of the body) and hemiparesis (one sided weakness without complete paralysis) following cerebral infarction (affecting left non-dominant side, Type II Diabetes (high blood sugar), metabolic encephalopathy (chemical imbalance in the blood that causes problem in the brain), muscle weakness, abnormal posture, seizures (uncontrolled electrical disturbances in the brain that causes changes in movements and consciousness), hypertension (high blood pressure), and dysphagia (difficulty swallowing). During a review of Resident 25's Minimum Data Set [(MDS) a standardized assessment and care screening tool], dated 4/15/2024, the MDS indicated Resident 25's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were mildly impaired. The MDS indicated Resident 25 did not exhibit behaviors such as hallucinations, delusions, or physical (hitting, biting) and verbal (screaming at others) behaviors. The MDS indicated Resident 25 required maximal assistance for transferring chair/bed to chair transfer, rolling left and right and required moderate assistance for toileting, bathing, and dressing. During a review of Resident 25's untitled Care Plan (CP: document the patient's needs, wants, and nursing interventions planned to meet the needs), the care plan indicated Resident 25 had an actual fall with no injury due to poor balance, communication, comprehension, and unsteady gate initiated 4/16/2024 with a revision date of 6/4/2024. The interventions included to continue interventions on the at-risk plan, determine and address causative factors of the fall initiated 4/16/2024, may place the bed against the wall for safety per family on 5/4/2024, and a resolved intervention of Resident 25 being on one-to-one (1:1) monitoring for safety initiated on 4/18/2024. (continued on next page)

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	06/11/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 25's untitled Care Plan, the care plan indicated Resident 25 is at risk for falls related to confusion, gait/balance problems initiated on 6/6/2024. The interventions included to place the bed against the wall for safety with floormat on the side of the bed, place call light within reach, and anticipate and meet the resident's needs initiated 6/6/2024. During a review of Resident 25's untitled Care Plan, the care plan indicated Resident uses antidepressant medication Lexapro (medication to treat depression) for depression manifested by low interest in activities of daily living (ADLs) initiated on 5/15/2024. The intervention states to monitor the side effects of antidepressants as it can cause disorientation, confusion, lethargy, drooling, anxiety, nervousness, and many of these effects can increase the risk for falls. During a review of the Order Summary Report (Physician Order), the order summary report indicated Resident 25 had an active order for bilateral side floor mats for safety related to risk for falls from 5/2/2024. Resident 25 had an order for 1:1 sitter that was ordered on 4/18/2024 and 4/25/2024 and was discontinued. Resident 25 had an order to place the bed against the wall for fall precaution with floor mats on the side of the bed per family on 5/4/2024 that was discontinued and restarted 6/1/2024. During a review of the Change of Condition Evaluation (COC: form initiated when a resident has sudden change from baseline), Resident 25's fall COC indicated: 4/13/2024 at 2:05p.m.: Resident fell on [DATE] in the afternoon with no or minor injury. 4/17/2024 at 6:17a.m.: Resident fell on [DATE] in the morning. 4/18/2024 at 10:25p.m.: Resident fell on [DATE] in the afternoon and is on monitoring for falls 1:1 ordered by the doctor. 4/27/2024 at 4:59a.m.: Resident fell on [DATE] in the morning. A Certified Nursing Assistant (CNA) found Resident 25 on the floor next to his bed covered with sheets. Resident 25 had no pain, no discoloration upon assessment. Resident 25 informed the CNA he was sitting on his bed and slid down and laid down on the floor. 5/4/2024 at 2:61p.m.: Resident fell on [DATE] in the morning with other behavioral symptoms. 5/24/2024 at 7:11p.m.: Resident fell on [DATE] in the afternoon. Resident 25 had an unwitnessed fall. The falling of the chair was heard and found Resident 25 on his side. Resident 25 was hoisted back into bed with the assistance of one nurse and one CNA. Resident remains in bed at the lowest position possible. Ice pack was given with pain subsiding. Resident 25 had a raised bump and mild swelling on his right eyebrow. *5/24/2024 at 7:51p.m.: Resident fell on [DATE] in the afternoon and sustained a bump to the right eyebrow after rolling off the bed. During a review of the Change of Condition Evaluation for Resident 25's Rehabilitation (Rehab) Screen by the Occupational Therapist (OT) goes as follows: (continued on next page)

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	06/11/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/15/2024 at 2:33p.m.: Resident is on monitoring for post fall on 4/13/2024. Resident was able to move upper (arms, shoulder) and lower (legs, hip) bilateral extremities with no limitation, transfer with moderate assistance using a front wheel walker (FWW) for safety. 4/19/204 at 1:41p.m.: Resident is on monitoring for post fall, able to move bilateral upper and lower extremities without limitations, no change in functional status, noted unsteadiness, required cues for safety, and balance strategies and proper body mechanics to reduce falls. 4/28/2024 at 8:18a.m.: Resident is on monitoring for post fall, able to stand and transfer with assistant, placed on 1:1 due to frequent falls for monitoring. 5/6/2024 at 3:26p.m.: Resident is on monitoring for post fall with increased weakness on bilateral upper and lower extremities and lethargic. Resident required increased assistance with transfers. Resident is on 1:1 sitter to reduce falls, nursing placed bed beside the wall and placed floor mats for safety. 5/28/2024 at 12:10p.m.: Resident is on monitoring for post fall, no new limitations for bilateral upper and lower extremities, will continue rehab services to address weakness and improve functional status. Resident will have bed at lowest position and have frequent visual checks. During a review of the progress notes for Resident 25, the progress notes indicated: 4/13/2024 at 2:53p.m.: Resident was found sitting on the floor by a CNA and was assisted back to bed after the initial assessment with no bleeding, bruising, no facial grimace, pain, or discomfort. Neurological checks are initiated, and plan of care is ongoing. At 4:01p.m., it indicated Resident 25 is on monitoring post fall and for elevated blood sugar. Resident received a onetime order of additional 10 units of Insulin Lispro (fast acting hormone that lowers blood sugar) with no significant changes. Resident is on frequent visual checks and plan of care is ongoing. At 5:56p.m., Resident has attempted to get up a few times and was reoriented back to bed. 4/14/2024 at 6:05p.m.: Resident is on monitor for post fall and elevated blood sugar. Resident has continued to get up unassisted and gets agitated when assisted back to bed. Resident was given Ativan (a sedative used for anxiety) and still continues to get up unassisted. 4/17/2024 at 6:29a.m.: Informed by CNA, Resident 25 was found sitting on the floor and was assessed from head to toe. Post fall precaution was initiated and rendered. 4/18/2024 at 8:02p.m.: A neighboring resident of Resident 25 had the call light and was yelling for help as Resident 25 was seen on the floor. Resident 25's neighbor stated Resident 25 tried getting up and pushed his wheelchair and fell to the floor. Resident was assisted back to bed and received an order for a 1:1 sitter. 4/19/2024 at 9:59a.m.: Continue 1:1 sitter due to history of dementia and recent stroke (occurs when something blocks the blood supply to part of the brain or when a blood vessel bursts in the brain) for safety. o 4/19/2024 at 4:09p.m.: Resident is being monitored post fall, continue neurological check, bed in lowest position, call light within reach, non-slip socks on resident. (continued on next page)

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	06/11/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o 4/19/2024 at 5:53p.m.: Resident found trying to get up from bed. Resident was taken to the dining room with activities director (AD). Resident continues to try to get up unassisted. Resident is reoriented to sit back down with minor agitation noted when assisted to sit down. Resident 25 remains within his room under the observation of CNA with the bed at lowest position possible and call light within reach. 4/23/2024 at 9:07a.m.: Resident transferred to hospital due to increased weakness and facial drooping with drooling on left side. 4/25/2024 at 9:37p.m.: Resident readmitted , bed kept at low level, call light within reach, remains on 1:1 monitoring due to fall risk. 4/27/2024 at 11:33a.m.: Resident is on neurological checks, bed in lowest position, monitoring post fall, 1:1 monitoring, fall safety precautions in place, call light within reach. 4/27/2024 at 10:42p.m.: Resident in bed 1:1, bed lowest possible position. 4/28/2024 at 8:18a.m.: Resident monitoring post fall, 1:1 due to frequent falls for monitoring. 4/28/2024 at 6:56p.m.: Resident is 1:1. 4/29/2024 at 4:40a.m.: Resident resting in bed, on constant visual checks, call light within reach, bed at lowest possible. 4/29/2024 at 10:20p.m.: Resident 1:1, monitoring for fall. 4/30/2024 at 1:16p.m.: Found unresponsive while sitting on his wheelchair with left side of the face drooping with excessive salivation. 5/2/2024 at 10:04p.m.: Resident readmitted , was negative for stroke, kept in low bed, call light within reach, continue to monitor. 5/4/2024 at 2:28p.m.: Resident restless and continues to get up, had fall in the morning at 9:00a.m., on monitoring for risk for falls, bed lowest position with floor mats on side, resident is now on 1:1. 5/4/2024 at 7:45p.m.: Resident on monitoring for fall, no episode of fall, educated to use call light when in need of assistance. 5/6/2024 at 2:43p.m.: Resident had fall two days ago and is now on risk for fall prevention and monitoring. Bed floor mats on both sides and bed at lowest position. 5/23/2024 at 9:57a.m.: Resident had face time with family, resident somewhat social and tired. 5/24/2024 at 7:11p.m.: Resident fell . 5/25/2024 at 2:36a.m.: Resident remains with 1:1 sitter, skull X-Ray (medical imaging used to generate images of tissues and structures inside the body) completed. (continued on next page)

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	06/11/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o 5/25/2024 at 2:46p.m.: Resident on monitoring for fall, no episodes of fall, no new orders at this time per doctor for skull x-ray, bed in lowest possible position with floor mat in place, frequent visual checks, continue with plan of care. o 5/25/2024 at 6:00p.m.: Resident observed trying to stand multiple times throughout shift and was assisted back to bed. Bed at lowest position possible and call light within reach. 5/27/2024 at 2:09p.m.: Resident on monitoring for unwitnessed post fall, resident had sitter, made few attempts to get out of bed but sitter laid resident back down. Bed at lowest position possible and call light within reach. During a review of the latest Neurological Flowsheet for 5/24/2024 at 8:12p.m., the neurological flowsheet indicated Resident 25 was assessed on 5/24/2024 at 7:11p.m., 7:26p.m., 7:41p.m., 7:56p.m., 8:11p.m., 8:41p.m., 9:11p.m., 10:10p.m., 11:11p.m., 5/5/2024 at 1:00a.m., 3:00a.m., 7:00a.m., 11:00a.m., 3:00p.m., 6:25p.m., 5/26/2024 12:00a.m. The documentation for 5/26/2024 at 12:00a.m. was under the section to do neurochecks every eight hours three times and was noted the two sections to do document neurochecks every eight hours was blank. During a review of the fall risk assessment on 4/11/2024 at 9:59p.m., the fall risk assessment indicated Resident 25 had intermittent confusion, one to two falls in the past three months, chair bound, requires use of assistive device, and has three or more predisposing medical conditions and takes more than three medications within the last seven days. Resident 25 fall score was 19. Fall risk assessment on 5/2/2024 at 10:31p.m. indicated Resident 25 had intermittent confusion, three or more falls in the past three months, chair bound, requires use of assistive device, and has three or more predisposing medical conditions and takes more than three medications within the last seven days. Resident 25 fall score was 19. Fall risk assessment on 5/4/2024 at 3:16p.m., resident was disoriented at all times, had one to two falls in the past three months, chair bound, balance problems while standing and walking, decreased muscular coordination, takes one to two medications currently and within the last seven days and has one to two predisposing medical conditions. Resident 25 fall score was 15. Fall risk assessment on 5/24/2024 at 8:10p.m., resident had intermittent confusion, three or more falls in the past three months, chair bound, jerking or unstable when making turns, requires assistive devices, has three or more predisposing medical conditions and takes more than three medications within the last seven days. Resident 25 fall score was 20. Resident 25's fall risk assessment all indicate resident is at high risk for falls. (continued on next page)

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	06/11/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/6/2024 at 9:04a.m. with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated last time Resident 25 went to the hospital was on 4/30/2024 due to left sided weakness and was readmitted on [DATE]. RNS 1 stated Resident 25 sustained a fall on 5/24/2024 that resulted in a bump and bruising to the right eyebrow after rolling off the bed according to the COC. RNS 1 stated if there was a witnessed fall, assess the resident for any injuries, pain, check if they can transfer the resident back to the bed, notify the doctor, if the fall was unwitnessed or if the resident hit their head, they should do a computed tomography (CT: scan (medical imaging that can help identify disease or injury within various regions of the body) or an X-ray but will be up to the doctors discretion. RNS 1 stated whether the fall was witnessed or not, they will monitor the resident for 72 hours and do a fall care plan. RNS 1 stated when there is a fall, the care plan is done on the day of the fall or within 24 hours to manage the situation safely. RNS 1 stated if the resident had a history for falls, they would have a goal, interventions to meet the goal, and identify the issues for the residents safety. RNS 1 stated falls are reported to keep track of the resident, how many falls they had as if a resident had multiple falls, it may be due to new medications or physiological, so they need to know what changed or caused the fall. RNS 1 stated if falls are not reported, it would be considered neglect as they can sustain internal injuries that may not be visible and can become fatal. During an interview on 6/11/2024 at 1:25p.m. with Director of Nursing (DON), the DON stated when there is a fall, rehab will do their own assessment, nursing will do a fall risk assessment and do not have an actual document for post fall assessment as it is a part of the COC. During an interview on 6/11/2024 at 6:14p.m. with DON, DON stated depending on the root cause for the fall, the resident will be placed on fall precautions. The DON stated in April, they had started a fall meeting weekly and were counting the falls based on the resident and not counting how many times a resident fell . The DON stated for Resident 25's first fall, they were monitoring him, on the second fall, they had him go to activities for redirection, and on the third fall they had placed him on a 1:1. The DON stated he was transferred to the hospital and since the resident came back with more weakness, they had discontinued the 1:1 and placed him closer to Nursing Station 2. The DON stated for the other fall incidents, the family requested to put his bed against the wall on 5/2/2024 which required a consent form. The DON stated the bed against the bed is a part of the intervention and does not have a focus care plan. The DON stated care plans should be updated, initiated, and created whenever falls occur and indicated they did not update the care plan for all the falls he had. The DON stated the interventions were revised with the last revision date of 6/4/2024 and for every fall Resident 25 had, they would just need to revise the intervention and do not usually document on the care plan all of the falls Resident 25 sustained. DON stated Resident 25 also did not have an at risk for care plan until 6/6/2024. During a review of the facility's P&P titled, Fall Prevention Program, revised 12/28/2023, the P&P indicated each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The nurse and/or interdisciplinary team will initiate interventions on the resident's are plan in accordance with the resident's level of risk. At risk protocols: the resident will be placed on the facility's Fall Prevention Program. Indicate fall risk on care plan. (continued on next page)

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	06/11/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When a resident experiences a fall, the facility will Assess the resident, Complete a post-fall assessment, Complete an incident report, Notify physician and family, Receive the resident's care plan and update as indicated, Document all assessments and actions and Obtain witness statements in the case of injury.

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	06/11/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46537 Based on interview, and record review, the facility failed to provide adequate Restorative Nursing Assistant ([RNA] -a certified nursing assistant (CNA) with specialized training in rehabilitation skills who assists the restorative team with supervised and delegated restorative programs) staff to provide range of motion ([ROM]- the amount of movement that a particular joint or series of joints can achieve in a specific direction), splint (a rigid support for restricting movement of an injured part) application, and ambulation to 28 of 54 residents on RNA program. This failure had the potential to result in 28 residents being at risk for further ROM decline and contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). Findings: A review of All Facilities Letter (AFL) dated 1/23/2018 indicated, effective July 1,2018, SB 97 (Chapter 52, Statutes 2017) requires SNFs, except those that are a distinct part of general acute care or a state- owned hospital or development center, to provide a minimum of 3.5 direct care service hours per patient day, with a minimum of 2.4 performed by certified nurse assistants. During a review of the facility's Census and Direct Care Service Hours Per patient Day (DHPPD), dated from 4/1/2023 to 4/30/2024, the DHPPD indicated as follow: a. 4/15/2024-Actual CNA DHPPD 2.24 b. 4/16/2024- Actual CNA DHPPD 2.40 c. 4/17/2024- Actual CNA DHPPD 2.40 d. 4/19/2024- Actual CNA DHPPD 2.29 e. 4/20/2024- Actual CNA DHPPD 2.06 During an interview on 6/6/2024, 3:21 p.m., with RNA 1, RNA 1 stated, there are two RNAs in the facility and they would be pulled from performing RNA duties to the floor as a CNA if there was shortage of staff. RNA 1 stated, she would have to work as CNA during the morning and work as RNA afternoon. (continued on next page)

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	06/11/2024

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 6/7/2024, at 9:34 a.m., with the Director of Staff Development (DSD), the facility's DHPPD from 4/15/2024 to 4/20/2024 was reviewed. The DHPPD indicated actual CNA direct care hours was equal or below the minimum hours of 2.4. The DSD stated, there were two RNAs, but both were unavailable for personal issues during that period. The DSD stated 28 residents had not received RNA services during that period due to unavailability of RNA staff. The DSD stated, there were three CNAs in training, but no one had a certificate yet and could not work. The DSD stated, the facility had a contract with registry (a staffing agency is a company that provides employees to work in another company on a temporary or permanent basis) but did not use registry staff. The DSD stated, the facility should have contacted the registry company. The DSD stated, 28 residents did not receive RNA service due to insufficient staffing and this would affecting residents' overall functions negatively. During an interview on 6/11/2024, at 3:38 p.m., with Director of Nursing (DON), DON stated, RNAs could pull to the floor and work as CNA because of short staffing. DON stated, residents may not receive RNA service as ordered. DON stated, she believed there was an agency that the facility contracted, but she had never utilized registry staff. DON stated, the facility should have enough staff to accommodate residents' need. During an interview on 6/11/2024, at 5:28 p.m., with the Administrator (ADM), the ADM stated, he was not aware of the staff shortage. The ADM stated, there was a contracted registry agency, but they did not use the service. The ADM stated, it was important to provide RNA service to maintain and improve residents' optimal function. During a review of the facility's policy and procedure (P&P) titled, Nursing Services and Sufficient Staff, revised 12/19/2022, the P&P indicated, Policy: It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. Policy Explanation and Compliance Guidelines; 1. The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. a. Except when waived, licensed nurses, and b. Other nursing personnel. including but not limited to nurse aides. 6. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents, needs, as identified through resident assessments, and described in the plan of care. 7. The facility is responsible for submitting timely and accurate staffing data through the CMS Payroll Based Journal (PBJ) system.

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	06/11/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to ensure that Licensed Vocational Nurses (LVN) 1, LVN 2 and LVN 5 were trained to administer medications via gastrostomy tube (g-tube - a surgically placed tube used to administer mediations or food directly into the stomach) with the appropriate technique and/or in accordance with physician's orders for three out of three sampled residents for g-tube administration (Resident 19, Resident 6 and Resident 47.) This failure had the potential to result in g-tube complications and infection for Resident 19, Resident 6 and Resident 47. Findings: a. During a review of Resident 19's Admission Record (a document containing demographic and diagnostic information), dated 6/4/2024, the admission record indicated, Resident 19 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including encounter for attention to gastrostomy. During a review of Resident 19's Order Summary Report (a list of all currently active medical orders), dated 6/5/2024, the order summary report indicated, Resident 19 had the following enteral (nutrition and medication administered directly into the stomach) feed physician's orders to be administered in addition to other medications: 1. Enteral Feed Order every shift enteral feeding: flush enteral tube with 15-30 milli liters (mL - a unit of measure of volume) water before and after medication administration and five mL water between each medication During a concurrent observation and interview on 6/4/2024 at 10:52 a.m., with LVN 1, LVN 1 prepared the following medications for Resident 19: 1. One tablet of vitamin C 500 milligram (mg-a unit of measure of weight) 2. One tablet of aspirin (a medication used to prevent and reduce the risk of blood clot) 81 mg 3. Seven and a half (7.5) mL of ferrous sulfate (a medication used to treat iron deficiency) elixir 220 mg/5 mL 4. One tablet of metoprolol tartrate (a medication used to treat high blood pressure) 25 mg 5. One tablet of furosemide (a medication for heart failure and high blood pressure) 40 mg 6. One tablet of docusate (a medication used to relieve constipation) sodium 100 mg 7. One tablet of multivitamin with minerals (continued on next page)

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	06/11/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. One tablet of oxybutynin (a medication used to treat overactive bladder) 5 mg 9. One packet of pantoprazole (a medication used to treat gastroesophageal reflux disease (GERD - a medical condition in which the stomach contents move up into the esophagus [the part of the alimentary canal that connects the throat to the stomach]) 40 mg dissolved in 7.5 mL apple juice 10. One tablet of zinc (a dietary supplement used to treat zinc deficiency and promote wound healing) 50 mg LVN 1 stated Resident 19 has a g-tube, and her medications must be crushed or in liquid form to administer. During an observation on 6/4/2024 at 10:52 a.m., LVN 1 placed each medication listed above in separate plastic bags, then crushed each medication separately using a crushing device. LVN 1 poured each powdered medication and ferrous sulfate elixir into separate plastic water cups. LVN 1 used 15 mL water to dissolve each medication in separate cups. During an observation on 6/4/2024 at 11:02 a.m., LVN 1 administered 30 mL water via push [applying pressure to force the medication down the tube into the resident's stomach] rather than gravity [allowing medication to travel down the tube naturally] into the g-tube before administering medications individually. LVN 1 placed the syringe (a tube with a nozzle and piston or bulb, fitted with a hollow needle, used to inject or withdraw fluid in and out, used for cleaning wounds or body cavities) tip in the medicine cup and pulled the syringe plunger to withdraw each medication (vitamin C, aspirin, ferrous sulfate, metoprolol tartrate, furosemide, docusate sodium, multivitamin with minerals, oxybutynin, pantoprazole, zinc) one by one and administered one by one via push into the g-tube. LVN 1 did not pour five mL water to flush syringe in between each medication per physician order. During an observation on 6/4/2024 at 11:17 a.m., LVN 1 administered 30 mL water via push into the g-tube after administering above listed medications. During an interview on 6/4/2024 at 4:33 p.m. with LVN 1, LVN 1 stated she was trained with g-tube medication administration and knew that g-tube medications were to be administered using the gravity method but she got nervous and administered medications via push. LVN 1 stated there is a risk for cross contamination when the syringe was pulled out of the g-tube and placed into the medicine cup to withdraw medicine and then placed back into the g-tube. LVN 1 stated this incorrect administration technique would cause discomfort, pain and increased the risk of infections for Resident 19. b. During a review of Resident 6's Admission Record, dated 6/7/2024, the admission record indicated, Resident 6 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including encounter for attention to gastrostomy. During a review of Resident 6's History and Physical (H&P), dated 4/12/2024, the H&P indicated Resident 6 has fluctuating capacity to understand and make decisions. During a review of Resident 6's Order Summary Report, dated 6/7/2024, timed 11:38:30, the document did not indicate any specific physician's orders for enteral feed for g-tube medication administration. (continued on next page)

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	06/11/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 6/7/2024 at 10:57 a.m., LVN 2 prepared the following medications for Resident 6: 1. One capsule of pregabalin (a medication used to treat nerve pain) 75 mg 2. One-half tablet of metoprolol tartrate 25 mg (=12.5 mg), hold if SBP less than 100 or HR less than 60 3. One tablet of memantine (a medication used to treat dementia [a medical condition characterized by impaired ability to remember, think, or make decisions about daily activities]) 10 mg 4. One tablet of amiodarone (a medication used to treat abnormal heartbeats) 200 mg 5. One tablet of meloxicam (a medication to treat inflammation and pain of joints) 7.5 mg 6. One tablet of furosemide 20 mg 7. One packet of Lokelma ([Generic name - sodium zirconium] dissolved with 45 mL water 8. One drop of brimonidine (a medication used to treat high eye pressure) eye drops in both eyes 9. Two tablets of vitamin D 1000 international units (IU - a unit of dose for vitamins) 10. One tablet of cranberry 450 mg 11. Seven and a half (7.5) mL of ferrous sulfate elixir 220 mg/5 mL 12. Five (5) mL of vitamin C liquid LVN 2 placed each medication listed above in separate plastic bags, then crushed each medication separately using a crushing device. LVN 2 then opened the pregabalin capsule and placed the contents (powder) in a separate medicine cup and the ferrous sulfate elixir into another medicine cup. LVN 2 stated she would use 10 mL to dissolve each medication separately. LVN 2 stated she did not have physician orders for g-tube administration for Resident 6, but she would follow standard g-tube instructions such as use 15 to 30 mL water volume to flush before and after medication administration, five mL to dissolve medications and five mL in between medications. LVN 2 stated she would contact the physician to clarify orders for Resident 6's g-tube administration. During a concurrent interview and record review on 6/7/2024 at 11:59 a.m., with LVN 2, the order was reviewed. LVN 2 stated the physician orders received were as follows: flush enteral tube with 15-30 mL water before and after medication administration, five mL water between each medication and five mL to dissolve medication. (continued on next page)

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	06/11/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 6/7/2024 at 12:10 p.m., LVN 2 used five mL water to dissolve each medication separately in individual cups. LVN 2 used the gravity method to flush the syringe before and after medication administration and to administer each medication via g-tube. LVN 2 flushed the g-tube with 30 mL water before and after medication administration. LVN 2 administered medications listed above, except Lokelma, one-by-one via gravity method. LVN 2 administered five mL water in between each medication. During an interview on 6/8/2024 at 7:54 p.m., LVN 2 stated she was glad to have been stopped before medications were administered. LVN 2 stated it is important to follow physician orders. LVN 2 stated there are patients with fluid restriction and so it is important to have enteral orders for every resident and not assume to follow one method for all residents. c. During a review of Resident 47's Admission Record, dated 6/8/2024, the admission record indicated, Resident 47 was admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses including gastrostomy malfunction and encounter for attention to gastrostomy. During a review of Resident 47's History and Physical, dated 7/26/2023, the history and physical indicated Resident 47 does not have the capacity to understand and make decisions. During a review of Resident 47's Order Summary Report, dated 6/8/2024, the order summary report indicated the following physician's orders for enteral feed for g-tube medication administration: 1. Enteral Feed Order every shift enteral feeding: flush enteral tube with 15-30 mL water before and after medication administration and 10 mL water between each medication and 10 mL to dissolve medication, order date 6/8/2024 2. Enteral Feed Order every shift enteral feeding: flush enteral tube with 15-30 mL water before and after medication administration and five mL water between each medication and five mL to dissolve medication, order date 6/7/2024 During a concurrent observation and interview on 6/8/2024 at 4:17 p.m. with LVN 5, LVN 5 prepared the following medication for Resident 47: 1. One tablet of metoclopramide 10 mg LVN 5 stated he would be administering the metoclopramide and then wait at least 30 minutes before administering other medications. LVN 5 placed the medication listed above in a plastic bag, then crushed the medication using a crushing device. LVN 5 stated he would use five mL to 10 mL water to dissolve the medication. LVN 5 then stated there was excess water volume so will discard that solution and prepare a new crushed tablet for g-tube administration. LVN 5 used the gravity method throughout the g-tube administration, during syringe flushes with 30 mL water before and after medication administration and to administer medication. During an observation on 6/8/2024 at 5:40 p.m., LVN 5 prepared the following medications for Resident 47: (continued on next page)

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	06/11/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. One tablet of docusate sodium 100 mg 3. One tablet of baclofen (a medication used to treat muscle spasms) 20 mg 4. One tablet of sulfasalazine 500 mg 5. One tablet of simethicone 125 mg 6. Five mL of ferrous sulfate 220 mg/5 mL LVN 5 placed each medication listed above in separate plastic bags, then crushed each medication separately using a crushing device. LVN 5 stated he would use 10 mL to dissolve each medication separately because that is his standard method of dissolving medications for g-tube administration. LVN 5 was stopped by the surveyor to show the physician orders for g-tube medication administration. LVN 5 stated he did not see any physician orders for water volume to be used to dissolve medications, to flush before and after medication administration and in between medications. LVN 5 rechecked the physician orders and stated it was his mistake because there was a physician order that indicated to use five mL water to dissolve medications. LVN 5 then placed medications back inside his cart and stated he would contact physician to clarify orders. During an interview on 6/8/2024 at 6:16 p.m., LVN 5 stated he would follow new physician orders that indicated to flush enteral tube with 15-30 mL water before and after medication administration, 10 mL water between each medication and 10 mL water to dissolve medication. During an observation on 6/8/2024 at 6:23 p.m., LVN 5 used the gravity method to flush the syringe before and after medication administration and to administer each medication via g-tube. LVN 5 flushed g-tube with 30 mL water before and after medications administration. LVN 5 administered medications listed above, one-by-one via gravity method. LVN 5 administered 10 mL water in between each medication. During an interview on 6/8/2024 at 7:23 p.m., LVN 5 stated it is very important to check for physician orders first before administering medications. LVN 5 stated that if he was not stopped by the surveyor, he would have made a mistake by assuming that all enteral feed orders for g-tube medication administration are the same for all residents. During an interview on 6/5/2024 at 11:00 a.m., with the Director of Nurses (DON), the DON stated all facility staff is trained during orientation and annual skills check for medication administration via g-tube. The DON stated licensed nurses should use the gravity method to administer g-tube medications because there is a risk for infection for the resident if medications were administered using poor g-tube technique by pushing the syringe into the g-tube multiple times and pulling way to withdraw medications from the medication cup. The DON stated thorough one-on-one in-services (staff education) would be conducted for g-tube administration and following physician orders to maintain effectiveness and safety of medications. (continued on next page)

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	06/11/2024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled, Medication Administration via Enteral Tube, dated 12/19/2022, the P&P indicated, Verify physician orders for medication and enteral tube flush amount. Flush enteral tube with at least 15 mL of water prior to administering medications unless otherwise ordered by prescriber. Dilute the solid or liquid .and administer using a clean oral syringe. Flush tube again with at least 15 mL water .Repeat with the next medication (if appropriate) .Flush the tube with a final flush of at least 15 mL of water to ensure drug delivery and clear the tube.

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	06/11/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to: 1. Ensure availability of metoprolol tartrate (a medication used to treat high blood pressure), apixaban (a medication used to prevent and reduce the risk of blood clot), furosemide (a medication for heart failure and high blood pressure), amoxicillin (a medication used to treat infection), lidocaine (a medication used to treat localized pain) cream, and tussin DM ([Generic name - guaifenesin and dextromethorphan] a medication used to provide cough relief) in accordance with physician orders or professional standards of practice for five of nine sampled residents (Residents 6, 26, 209, 210 and 211.) 2. Maintain accurate medication administration records as per facility's policies and procedures (P&P) titled, Medication Administration for two of nine sampled residents (Resident 19 and 209.) These failures resulted in falsification of medication administration records, and failed to provide medications in accordance with the physician's orders or professional standards of practice increasing the risk that Residents 6, 26, 209, 210 and 211 may have experienced significant medical complications resulting in hospitalization or death due to stroke (a medical condition when something blocks blood supply to brain or when blood vessel in the brain bursts), poor blood pressure control, and infection. Findings: 1a. During a review of Resident 26's Admission Record (a document containing demographic and diagnostic information), dated 6/4/2024, the admission record indicated, Resident 26 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (a medical condition where kidneys stop functioning with the need for regular course of long-term dialysis [a procedure to remove waste products and excess fluid from the blood]), essential (primary) hypertension and atherosclerosis (a medical condition with buildup of fat and calcium) of arteries of extremities with intermittent claudication (a medical term used to describe pain caused by reduced blood flow to the legs or arms), right leg. During a review of Resident 26's History and Physical, dated 3/15/2023, the document indicated resident has the capacity to understand and make decisions. During a review of Resident 26's Minimum Data Set ([MDS], a standardized assessment and care screening tool) dated 2/29/2024, the MDS indicated Resident 26 has intact cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) and required partial or moderate to setup or cleanup assistance from facility staff for activities of daily living (tasks of everyday life that include eating, dressing, getting in and out of bed or chair, bathing and toileting). (continued on next page)

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	06/11/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 26's Order Summary Report (a list of all currently active medical orders), dated 5/28/2024, the order summary report indicated, Metoprolol Tartrate 75 milligrams (mg - a unit of measure for mass), give 1 tablet by mouth one time a day every Tuesday, Thursday, Saturday, Sunday, for hypertension (HTN - a medical term used for high blood pressure), hold for systolic blood pressure (SBP - the pressure caused by heart while contracting) less than 110 millimeters of mercury (mmHg - a measurement of pressure) or diastolic blood pressure (DBP - the pressure in the arteries when the heart rests between beats) less than 70 mmHg and pulse less than 60 beats per minute (BPM) (administer with food for enhanced absorption), order date: 11/8/2023. During a concurrent observation and interview during medication administration with the Licensed Vocational Nurse (LVN 1) on 6/4/2024 at 8:47 a.m., LVN 1 prepared medications to administer to Resident 26. LVN 1 stated Resident 26 was supposed to also receive one tablet of metoprolol tartrate 75 mg with instructions to be given every Tuesday, Thursday, Saturday, and Sunday for hypertension, hold for SBP less than 110 mmHg or DBP less than 70 mmHg and pulse less than 60 BPM, but the facility did not have medication in stock. During a review of the pharmacy label on the empty medication bubble pack (a card prepared by the pharmacy containing the individual doses of medications) for metoprolol tartrate 75 mg on 6/4/2024 at 8:52 a.m., the label showed the medication was last refilled for a quantity of eight tablets (fourteen day-supply) on 5/19/2024. During an interview on 6/4/2024 at 3:19 p.m. with LVN 1, LVN 1 stated she did not have a chance to call Resident 26's doctor or pharmacy to inform them about metoprolol tartrate being out of stock. LVN 1 stated she would order medication from the pharmacy when there are three or less doses remaining for the resident, but she did not see documentation about when the medication was last requested. LVN 1 stated Resident 26's blood pressure was checked, and she received nifedipine (a medication used to treat high blood pressure) according to physician orders in the afternoon. LVN 1 stated by not receiving medications as prescribed, Resident 26 could have high blood pressure and an increased risk for stroke leading to serious health complications and hospitalization . During a phone interview on 6/6/2024 at 9:05 a.m., with registered pharmacist (RPH) 1 at pharmacy (PH) 1, RPH 1 stated the facility requested metoprolol tartrate for Resident 26 on 5/19/2024, medication was delivered on 5/21/2024 for 14 days' supply, and another refill was requested on 6/4/2024. 1b. During a review of Resident 209's Admission Record, dated 6/4/2024, the admission record indicated, she was admitted to the facility on [DATE] with diagnoses including paroxysmal atrial fibrillation (a medical condition characterized with abnormal heart beats), chronic systolic (congestive) heart failure (CHF - a medical condition where heart cannot pump blood well enough to give normal supply throughout body), essential (primary) hypertension, and atherosclerosis of aorta (a medical term used for the large blood vessel of the body.) During a review of Resident 209's History and Physical, dated 5/26/2024, the document indicated resident can make medical decisions with assistance of granddaughter. During a review of Resident 209's Order Summary Report, dated 6/4/2024, the order summary report indicated, Apixaban 2.5 mg, give 1 tablet by mouth two times a day for CVA (cerebrovascular accident - a medical condition with an interruption in the flow of blood to cells in the brain) prophylaxis (prevention) in addition to other medications. (continued on next page)

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	06/11/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation of LVN 1 taking BP for Resident 209 at bedside on 6/4/2024 at 9:10 a.m., LVN 1 stated BP for Resident 209 was 97/41 and HR was 69. During an observation of medication administration on 6/4/2024 at 9:10 a.m. with LVN 1, LVN 1 prepared the following medications for Resident 209: 1. One tablet of furosemide 20 mg, hold for SBP less than 110, HR less than 60 2. One tablet of metoprolol succinate ER 25 mg, hold for SBP less than 110, HR less than 60 During an interview on 6/4/2024 at 9:10 a.m. with LVN 1, LVN 1 stated the two medications listed above were the only medications to administer to Resident 209 this morning. During a concurrent observation and interview on 6/4/2024 at 9:20 a.m. with LVN 1 in Resident 209's room, LVN 1 was stopped by the surveyor before the medication was administered and advised to discuss the medications with the surveyor in the hallway. LVN 1 stated she got nervous and did not realize Resident 209's recorded BP and HR parameters would not permit giving medications at this time. During an interview on 6/4/2024 at 3:19 p.m. with LVN 1, LVN 1 stated she did not have apixaban in stock to administer to Resident 209. LVN 1 then stated she thought she gave apixaban and looked for overflow stock in the medication room. LVN 1 stated missing a dose of apixaban for Resident 209, increased resident 209's risk for stroke due to risk for blood clots and deep venous thrombosis (a medical term to describe blood clot formation in deep veins in the body in the legs). During a phone interview on 6/6/2024 at 9:05 a.m., with RPH 1 at PH 1, RPH 1 stated apixaban for Resident 209 was delivered to facility on 5/26/2024 for seven days' supply and another refill was requested on 6/5/2024. 1c. During a review of Resident 211's Admission Record, dated 6/4/2024, the admission record indicated, Resident 211 was admitted to the facility on [DATE] with diagnoses including hypertensive heart disease with heart failure, atherosclerotic heart disease of native coronary artery (a medical term for blood vessel supplying blood to the heart) with unstable angina pectoris (a medical condition in which heart does not get enough blood flow and oxygen), unspecified atrial fibrillation, edema (a medical term used to describe swelling caused by too much fluid in the body's tissues) unspecified, and encounter for palliative care (a medical term used for special care provided for people living with a serious illness.) During a review of Resident 211's History and Physical, dated 5/30/2024, the document indicated Resident 211 does not have the capacity to understand and make decisions. During a review of Resident 211's Order Summary Report, dated 6/4/2024, the order summary report indicated the following medications: Amoxicillin 500 mg, give 1 capsule by mouth three times a day for ear infection for 10 days, order date 5/29/2024 Furosemide 40 mg, give 1 tablet by mouth one time a day for edema/HTN, hold for SBN less than 110 or HR less than 60, order date 5/29/2024 (continued on next page)

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	06/11/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview during medication administration on 6/4/2024 at 9:45 a.m. with LVN 1, LVN 1 prepared the following medications for Resident 211: 1. One tablet of docusate sodium 100 mg 2. Four capsules of potassium ER 10 milliequivalent (mEq - a unit of measure for mass) LVN 1 stated the two medications listed above were the only medications to administer to Resident 211 at that time. During a concurrent interview and record review on 6/4/2024 at 4:33 p.m. with LVN 1, Resident 211's medication administration details for amoxicillin and furosemide, dated 5/30/2024 to 6/4/2024 were reviewed. The document for amoxicillin indicated codes 2 or 6 on dates 6/1/2024 to 6/4/2024 along with notes such as not administered, no medication, medication not delivered, not available, pending pharmacy delivery, awaiting pharmacy. LVN 1 stated pharmacy did not deliver both medications and LVN 1 was not able to administer amoxicillin because facility did not have it in stock for Resident 211. LVN 1 stated Resident 211's infection would not be treated without amoxicillin. LVN 1 stated Resident 211 was at an increased risk for edema and high blood pressure if she needed furosemide based on prescribed parameters because facility did not have furosemide in stock at the time. During a phone interview on 6/6/2024 at 10:02 a.m., with RPH 2 at PH 2, RPH 2 stated PH 2 is a hospice pharmacy. RPH 2 stated the only time amoxicillin for Resident 211 was ordered and delivered was on 5/21/2024 for 10 days' supply. RPH 2 stated the only time furosemide for Resident 211 was requested and delivered was on 6/5/2024. 1d. During a review of Resident 210's Admission Record, dated 6/5/2024, the admission record indicated, Resident 210 was admitted to the facility on [DATE] with diagnoses including fibromyalgia, lumbar region radiculopathy (a medical condition described by symptoms of pain, tingling, numbness due to pinched nerve along lumbar region of the spine), other symptoms and signs involving the musculoskeletal system, unspecified diastolic (congestive) heart failure, essential (primary) hypertension, and depression. During a review of Resident 210's History and Physical, undated, the document indicated Resident 210 has fluctuating capacity to understand and make decisions. During a review of Resident 210's Order Summary Report, dated 5/30/2024, the order summary report indicated, Lidocaine external cream 5%, apply to affected site topically every 12 hours for arthritic pain, order date 5/30/2024. During an observation of medication administration on 6/4/2024 at 10:04 a.m., LVN 1 prepared and administered 12 medications except lidocaine 5% cream. During an interview on 6/4/2024 at 4:22 p.m., with LVN 1, LVN 1 stated she did not have lidocaine cream in stock for Resident 210. LVN 1 stated Resident 210 would tell LVN 1 to apply lidocaine cream to her right foot below the knee for arthritis pain but Resident 210 did not complain of pain on that day. LVN 1 stated Resident 210 did not receive topical treatment for pain, potentially making her uncomfortable due to facility not having the medication in stock. (continued on next page)

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	06/11/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1e. During a review of Resident 6's Admission Record, dated 6/7/2024, the admission record indicated, Resident 6 was admitted the facility on 3/31/2019 and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (a medical condition causing restricted airflow and breathing problems). During a review of Resident 6's History and Physical, dated 4/12/2024, the document indicated resident has fluctuating capacity to understand and make decisions. During a review of Resident 6's Order Summary Report, dated 6/7/2024, the order summary report indicated, Tussin DM ([Generic name - Guaifenesin and Dextromethorphan] - a medication used to provide relief from cough symptoms by loosening mucus and suppressing cough) 10-100 mg / 5 milliliters (mL - a unit of measure for volume), give 10 mL via gastrostomy tube (g-tube - a surgically placed tube used to administer mediations or food directly into the stomach) every 6 hours as needed for cough for 14 days, order date 6/7/2024. During a concurrent observation and interview on 6/7/2024 at 10:57 a.m., with LVN 2, LVN 2 prepared medications to administer via g-tube for Resident 6. LVN 2 stated Resident 6 was coughing and would need tussin DM syrup according to physician order to be treated for cough, but station 2 medication cart did not have medication available. 2a. During a review of Resident 19's Admission Record, dated 6/4/2024, the admission record indicated, Resident 19 was admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses including nonrheumatic mitral (valve) insufficiency (a medical condition where the valve between left heart chambers does not close properly), acute on chronic systolic (congestive) heart failure, paroxysmal atrial fibrillation, essential (primary) hypertension, gastro-esophageal reflux disease without esophagitis, overactive bladder, and encounter for attention to gastrostomy. During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19 had severe cognitive impairment and is dependent on helper or facility staff for activities of daily living (tasks of everyday life that include eating, dressing, getting in and out of bed or chair, bathing, and toileting). During a review of Resident 19's Order Summary Report, dated 6/5/2024, the order summary report indicated, Vitamin D3 50 mcg, give 1 capsule via g-tube one time a day for supplement in addition to other medications. During an observation on 6/4/2024 at 10:52 a.m., LVN 1 prepared and administered ten medications to Resident 19 except vitamin D3. During a review of Resident 19's Medication Administration Record (MAR - a record of all medication administered to a resident), for June 2024, the MAR indicated LVN 1 marked vitamin D3 as administered in the record for 9:00 a.m. on 6/4/2024. During a concurrent interview and record review on 6/4/2024 at 4:33 p.m. with LVN 1, Resident 19's medication administration details for vitamin D3 were reviewed. LVN 1 stated she thought she gave vitamin D3 during medication pass, but it was not given and should not have been marked as administered. (continued on next page)

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	06/11/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2b. During a review of Resident 209's Order Summary Report, dated 6/4/2024, the order summary report indicated the following medications: Apixaban 2.5 mg, give 1 tablet by mouth two times a day for CVA prophylaxis, order date 5/25/2024 Potassium chloride extended release (ER - a medication formulation aiding the medication release slowly over time) 10 mEq, give 1 tablet by mouth two times a day for potassium supplement, order date 5/25/2024 Lactobacillus capsule, give 1 capsule by mouth one time a day for probiotic supplement, order date 5/25/2024 During an observation of medication administration on 6/4/2024 at 9:10 a.m. with LVN 1, LVN 1 prepared following medications for Resident 209 and confirmed these were the only two medications to administer at that time. 1. One tablet of furosemide 20 mg, hold for SBP less than 110, HR less than 60 2. One tablet of metoprolol succinate ER 25 mg, hold for SBP less than 110, HR less than 60 During a review of Resident 209's MAR for June 2024, the MAR indicated LVN 1 marked lactobacillus, potassium chloride ER, and apixaban as administered in the record for 9:00 a.m., on 6/4/2024. During a concurrent interview and record review on 6/4/2024 at 3:19 p.m. LVN 1 stated it was a mistake to mark lactobacillus, potassium chloride and apixaban as administered for Resident 209. LVN 1 stated she thought that she gave these medications, but she did not. During an interview on 6/5/2024 at 10:51 a.m., with the Director of Nurses (DON), the DON stated licensed nurses should call pharmacy and physician when medications are unavailable. The DON stated licensed staff should check for medication that is out of stock in the emergency kit (E-kit). The DON stated staff should order medication when three to five doses remain. The DON stated for Residents 6, 26, 209, 210 and 211, the residents' condition would not improve if he/she are not given medications on time or doses are missed. The DON stated facility did not administer amoxicillin to Resident 211 for four days, that is 6/1/2024 to 6/4/2024 which could worsen resident's condition because of an untreated infection. The DON stated the facility increased residents' risk for high blood pressure, edema, heart attack, hospitalization , and even death by not having medications available such as furosemide, apixaban and metoprolol available for residents. The DON stated she will check medication carts at least twice per week or more frequently to ensure medication availability. (continued on next page)

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	06/11/2024

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 6/10/2024 at 1:38 p.m. with the DON, the hospice (HOS) current treatment / medication list was reviewed. The HOS medication list indicated amoxicillin 500 mg three times a day, start date 5/21/2024 and stop date 5/31/2024. The DON stated Resident 211 was a transfer resident from another facility where amoxicillin was started on 5/21/2024 for ten days until 5/31/2024. The DON stated facility staff failed to clarify the medication order which potentially led to undertreatment of infection due to mediation unavailability and/or increased the risk for antibiotic resistance due to excess use. During an interview on 6/5/2024 at 10:51 a.m., with the DON, the DON stated it would be lying and falsification of records if MAR is marked as administered but medication was not given. The DON stated MAR should only be documented as administered if and after a medication was given to the resident. The DON stated the residents would not be treated for their conditions if they were not receiving medications, and if medication records were inaccurately documented as given. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 12/19/2022, the P&P indicated, Medications are administered by licensed nurses, or other staff who are legally authorized .as ordered by the physician and in accordance with professional standards of practice .to prevent contamination or infection. Obtain and record vital signs, when applicable or per physician orders . when applicable, hold medication for those vital signs outside the physician's prescribed parameters. Sign MAR after administered. Correct any discrepancies and report to nurse manager. During a review of the facility's P&P titled, Medication Reordering, dated 12/19/2022, the P&P indicated, It is the policy of this facility to provide .pharmaceutical services accurately and safely .in a timely manner to meet the needs of each resident. Acquisition of medications should be completed .to ensure medications are administered in a timely manner. Each time a nurse is administering medications, the nurse will observe how many doses are left, that nurse will reorder the medication, time permitting. Cross-referenced with F759 and F760

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	06/11/2024

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 0758 Level of Harm - Actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 A.Based on interview and record review, the facility failed to ensure psychotropic drugs (any medication capable of affecting the mind, emotions, and behavior) were not used unnecessarily for two of five sampled residents (Resident 22, and Resident 6) by: A1. Failing to ensure one of two sampled residents (Resident 22) did not receive routine and as needed psychotropic drugs unless the medication was necessary to treat a diagnosed specific condition that was documented in the clinical record for Resident 22. A2. Failing to ensure one of two sampled residents (Resident 6) did not receive routine and as needed psychotropic drugs unless the medication was necessary to treat a diagnosed specific condition that was documented in the clinical record for Resident 6. This deficient practice had the potential to result in use of unnecessary psychotropic drugs for Residents 22, and Resident 6 which can lead to side effects and adverse consequence such as a decline in quality of life and functional capacity. B. Failing to ensure, the residents did not develop an adverse effect (an undesired effect of a medication or other type of treatment) from receiving antipsychotic (medication used to treat mental health conditions like schizophrenia (a serious mental disorder in which people interpret reality abnormally), bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs and lows), medications Seroquel, Risperdal and Ativan and for two of 18 sampled residents (Resident 25 and Resident 34). These deficient practices resulted in Resident 25 having increased confusion, becoming lethargic (sluggish) and difficult to arouse with low blood pressure of 96/59. Blood pressure reference range is 120/80. On 6/5/2024 at 9:16 a.m., Emergency medical services (EMS) were called and transferred Resident 25 to a general acute care hospital (GACH). Resident 25 was admitted to the GACH from 6/5/2024 to 6/11/2024 for evaluation and treatment. At the GACH's emergency room (ER) the resident was hypoxic (low blood oxygen level) upon arrival with high blood sugar of 209 milligrams per deciliter (mg/dL). Blood sugar reference range is 70 to 99 mg/dL. Findings: A1. During a review of Resident 22's Admission Record, the Admission Record indicated, Resident 22 was admitted to the facility on [DATE] with diagnoses including anxiety disorder (persistent and excessive worry that interferes with daily activities), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks). During a review of Resident 22's History and Physical (H&P), dated 5/10/2024, the H&P indicated, Resident 22 had no capacity to understand and make decisions. (continued on next page)

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	06/11/2024

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 0758 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 22's Minimum Data Set ([MDS]-a standardized assessment and care screening tool), dated 5/13/2024, the MDS indicated Resident 22 required dependent assistance (helper does all of the effort) from two or more staff for shower, toileting hygiene, personal hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, moderate assistance (helper does less than half the effort) from one staff for eating, oral hygiene, and independent for rolling left and right. The MDS indicated, sit to lying, lying to sitting on the side of bed, sit to stand, chair/bed to chair transfer was not attempted due to medical condition or safety concerns. The MDS Section N (medications) indicated, Resident 22 was taking antipsychotic (a group of drugs that have been used for treating a variety of mental disorders), antianxiety (a drug used to treat symptoms of anxiety, such as feelings of fear, dread, uneasiness, and muscle tightness, that may occur as a reaction to stress), and opioid (a class of drug used to reduce moderate to severe pain) medications. The MDS section E (Behavior) indicated, Resident 22 had no hallucinations (an experience involving the apparent perception of something not present) or delusions (an unshakable belief in something that's untrue) and no physical, verbal other behavioral symptoms. The MDS section E indicated, Resident 22 had no behavior or rejecting care or wandering. During a review of Resident 22's Preadmission Screening and Resident Review (PASARR), dated on 5/7/2024, the PASARR indicated, Negative level I screening, which indicated a level II mental evaluation was not required. During a review of Resident 22's Care Plan (CP), initiated on 5/11/2024, the CP Focus indicated, Resident 22 received a psychotropic medication (Seroquel-an antipsychotic medication to treat certain mental/mood disorders) related to behavior management. The CP Interventions indicated, administer psychotropic medication as ordered by physician and monitor for side effects. During a review of Resident 22's CP, initiated on 5/11/2024, the CP Focus indicated, Resident 22 received psychotropic medication (Ativan-medication to treat anxiety disorder) related to anxiety. The CP Interventions indicated, administer antianxiety medication as ordered by physician and monitor for side effects. During a review of Resident 22's Order Summary Report (OSR), dated 6/6/2024, the OSR indicated, to monitor for episodes of anxiety manifested by restlessness. Tally by hashmark every shift. Ordered on 6/1/2024. The OSR indicated, Ativan 0.5milligrams (mg - a unit of measure of weight) one tablet by mouth every six hours as needed for anxiety manifested by agitation. Ordered 5/7/2024. The OSR indicated, Quetiapine Fumarate (Seroquel) 25mg by mouth every 24 hours as needed for anxiety manifested by restlessness ordered originally 5/7/2024 and reordered on 5/27/2027. During a review of Resident 22's Medication Administration Record (MAR), dated from 5/7/2024 to 6/4/2024, The MAR indicated, Quetiapine Fumarate (Seroquel) 25 mg, Give one tablet by mouth in the afternoon for anxiety manifested by restlessness. The MAR indicated, there was charting Yes on restless behavior for 6/1/2024 (4:00 p.m.) and 6/3/2024 (4:00 p.m.). The MAR indicated, there was no other behavior charted except 6/1/2024 and 6/4/2024. During a review of Resident 22's MAR, dated 6/5/2024, the MAR indicated, Quetiapine Fumarate (Seroquel) 50 mg, Give one tablet by mouth two times a day for psychosis manifested by aggression and combativeness. The MAR indicated, Resident 22 refused Seroquel on 6/5/2024 (5:00 p.m.) and 6/6/2024 (5:00p.m.) and no behavioral episode were charted on the MAR. (continued on next page)

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	06/11/2024

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 0758 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 22's MAR, dated from 5/7/2024 to 6/4/2024, the MAR indicated, Ativan 0.5mg by mouth every six hours as needed was given on 5/7/2024 (8:46 p.m.), 5/15/2024 (3:55 p.m.), 5/16/2024 (7:33 p.m.), 5/25/2024 (6:27 p.m.), 5/26/2024 (4:03p.m.), 5/30/2024 (8:32 p.m.), and 5/31/2024 (9:33 p.m.) and charted as medication was effective. During a review of Resident 22's Hospice (comfort care for residents nearing end of life) RN Visit Note dated 6/4/2024, the Hospice RN Visit Note indicated, Resident 22 had behavioral issues at night per staff and staff reports that Ativan is not effective with calming the resident down. New orders from a doctor for Seroquel 50 mg twice daily for psychosis received. (Dose was increased). During a review of Resident 22's Hospice RN Visit Note, dated 6/7/2024, the Hospice RN Visit Note indicated, Resident 22 had no anxiety, depression, agitation, and other symptoms. The Hospice RN Visit Note indicated that staff reports that Resident 22 is still having a lot of behavioral issues, especially during bathing and diaper changes, not allowing staff to adequately clean her. Resident is also having a lot of agitation at night, attempting to get out for bed and calling out for her family and confusion in Narrative section. During a review of Resident 22's Interdisciplinary Care Conference ([IDT]-different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities), dated 5/10/2024 and signed 5/16/2024, the IDT care conference indicated, Gradual dose Reduction ([GDR]- the stepwise tapering of a dose to best diagnose whether a patient's symptoms or risks can be adequately managed through a lower dose or even if the medication can be eliminated) was not documented. The IDT care conference indicated that there were no behaviors noted at this time in the behavior problem/psychotropic medication section. During an interview on 6/6/2024, at 11:15 a.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated, Resident 22 did not have many behavioral episodes and there was no reason to increase the dose for Seroquel. RNS 1 stated, staff should have documented the number of behavioral episodes, instead of yes or no. RNS 1 stated, irritation and aggression could be signs and symptoms of dementia and Alzheimer's disease. During a concurrent interview and record review on 6/6/2024, at 12:02 p.m., with the Medical Records Director (MRD), Resident 22's psychotropic medication informed consent, undated, was reviewed. The informed consent indicated, it was obtained from surrogate (one appointed to act in place of another) for Ativan 0.5 mg and Seroquel 25 mg without date. The MRD stated, the date of the consent obtained should be documented. The MRD stated, she could not find or provide the informed consent for the new order of Seroquel 50 mg. A2. During a review of Resident 6's Admission Record, the Admission Record indicated, Resident 6 was initially admitted to the facility on [DATE] and last admission was 4/3/2024 with diagnoses including recurrent major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia and Alzheimer's disease. During a review of Resident 6's H&P, dated 4/12/2024, the H&P indicated, Resident 6 had fluctuating capacity to understand and make decisions. (continued on next page)

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	06/11/2024

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 0758 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 required maximal assistance (Helper does more than half the effort) from one staff for toilet hygiene, shower, lower body dressing, putting on/taking off footwear, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, toilet transfer, and moderate assistance (Helper does less than half the effort) from one staff for oral hygiene. The MDS indicated, eating was not attempted due to medical condition or safety concerns. The MDS section E(Behavior) indicated, Resident 6 did not have hallucination or delusions. The MDS section E indicated, Resident 6 did not reject the care. During a review of Resident 6's PASARR level I, dated 8/10/2023, the PASARR I indicated, positive level I screening which indicates a level II mental health evaluation was required. During a review of Resident 6's PASARR level II, dated on 8/10/2023, the PASARR II indicated, unable to complete level II evaluation. The individual has no serious mental illness. During a review of Resident 6's CP, initiated on 3/20/2023 and revised on 6/4/2024, the CP Focus indicated, Resident 6 received antianxiety medication (Ativan) related to anxiety manifested by verbalization of feeling anxious. The CP Interventions indicated, administer antianxiety medication as ordered by physician and monitor for side effects. During a review of Resident 6's CP, initiated 3/20/2023 and revised 6/4/2024, the CP Focus indicated, Resident 6 received antidepressant medication (Sertraline-medication to treat mood disorder/depression) related to depression manifested by verbalization of sadness. The CP Interventions indicated, administer antidepressant medication as ordered by physician and monitor for side effects. During a review of Resident 6's OSR, dated 6/6/2024, the OSR indicated, to monitor for depression. Tally episodes every shift for Sertraline use. Ordered 5/2/2024. The OSR indicated, to monitor for anxiety. Tally episodes every shift for Lorazepam (Ativan) use. Ordered on 5/2/2024. During a review of Resident 6's OSR, dated 6/6/2024, the OSR indicated to monitor for episodes of depression manifested by verbalization of feeling depressed. Tally episodes every shift for Sertraline use. Ordered 5/10/2024. The OSR indicated, to monitor for episodes of anxiety manifested by verbalization of feeling anxious. Tally episodes every shift for Lorazepam (Ativan) use. Ordered on 5/10/2024. During a review of Resident 6's MAR, dated 6/2024, The MAR indicated, Lorazepam (Ativan) 0.5mg, give one tablet by mouth every 12 hours as needed for anxiety manifested by verbalization of feeling anxious. During a review of Resident 6's MAR, dated 6/2024, the MAR indicated, Sertraline 50mg, give one tablet at bedtime enterally (in a way that involves putting food substances or medicine into someone's digestive system) for depression manifested by verbalizing feeling depressed. During a concurrent interview and record review on 6/6/2024, at 11:25 a.m., with the RNS 1, Resident 6's MAR, dated from 3/1/2024 to 6/4/2024 was reviewed. The MAR indicated, there was no documentation of anxiety and depression episodes under behavior monitoring sections. The RNS 1 stated, GDR should have been attempted because there was no behavioral episodes documented. (continued on next page)

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	06/11/2024

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 0758 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 6/6/2024, at 12:07 p.m., with the MRD, Resident 6's Sertraline medication informed consent, undated, was reviewed. The informed consent indicated, there was no documentation about who consented, and it was left blank. The informed consent indicated, there was no date for when the informed consent was obtained. The MRD stated, the consent form was incomplete, and staff should have followed up. During a concurrent interview and record review on 6/6/2024, at 12:09 p.m., with the MRD, Resident 6's Ativan medication informed consent, dated 5/10/2024, was reviewed. The informed consent indicated, there was no documentation about who consented. and it was left blank. The MRD stated, the consent form was incomplete. During a review of Resident 6's IDT, dated 5/15/2024, the IDT Care Conference indicated, GDR was contraindicated at this time because the resident is on optimal dose and is clinically stable. During an interview on 6/7/2024, at 10:36 a.m., with the Director of Nursing (DON), the DON stated, the facility should have attempted GDR for Residents 22 and 6 based on their behavioral episodes. The DON stated, nursing staff should have checked the informed consent for its completion before giving medication. The DON stated, Resident 22 and Resident 6 had dementia and Alzheimer and staff should have considered and ruled out symptoms of those diagnoses before giving psychotropic medication. The DON stated, it could be considered as a chemical restraint if psychotropic medications were given unnecessarily, and its use should be minimized. During an interview on 6/10/2024, 2:30 p.m., with Psychiatry Physician Assistant (PPA) 1, PPA 1 stated, GDR should have been attempted if the resident did not have any behavioral episodes or a reasonable number of episodes such as two or three episodes per month to prevent giving psychotropic medications to the residents excessively. PPA 1 stated, the goal was giving psychotropic medication as little as possible to control the behavior. PPA 1 stated, psychosis behaviors were similar to behaviors of dementia and Alzheimer disease. PPA 1 stated, healthcare practitioners should rule out those diagnoses before giving psychotropic medications to avoid giving unnecessary medications. PPA 1 stated, residents could suffer from adverse reaction and side effects. B. Based on observation, interview, and record review the facility failed to ensure, the residents did not develop an adverse effect (an undesired effect of a medication or other type of treatment) from receiving antipsychotic (medication used to treat mental health conditions like schizophrenia [a serious mental disorder in which people interpret reality abnormal], bipolar disorder [a mental health condition that causes extreme mood swings that include emotional highs and lows]), medications Seroquel, Risperdal and Ativan for two of 18 sampled residents (Resident 25 and Resident 34). The facility failed to: 1. Ensure Resident 25, who had a physician's order to discontinue administration of Seroquel 25 milligrams ([mg]- a unit of measure of weight) dated 5/14/2024, did not receive Seroquel for an additional 20 days, a total of 20 extra doses from 5/14/2024 to 6/4/2024. 2. Ensure the licensed nurses monitored Resident 25 for psychotropic medication adverse effects including Seroquel and Depakote Sprinkles. (continued on next page)

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	06/11/2024

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 0758 Level of Harm - Actual harm Residents Affected - Few	3. Ensure licensed staff followed the facility's policy titled Use of Psychotropic Medication, which indicated residents are not given psychotropic medication unless the medication is necessary to treat a specific condition and ensure Resident 25 was not prescribed Seroquel. 4. Ensure Resident 34 did not receive Risperdal and Ativan without indication for use and a obtain consent to receive these medications for one month from 5/9/2024 to 6/11/2024. These deficient practices resulted in Resident 25 having increased confusion, becoming lethargic (sluggish) and difficult to arouse with low blood pressure 96/59. Blood pressure reference range is 120/80. On 6/5/2024 at 9:16 a.m., Emergency medical services (EMS) were called and transferred Resident 25 to a general acute care hospital (GACH). Resident 25 was admitted to the GACH from 6/5/2024 to 6/11/2024 for evaluation and treatment. At the GACH's emergency room (ER) the resident was hypoxic upon arrival with high blood sugar of 209 milligrams per deciliter (mg/dL). Blood sugar reference range is 70 to 99 mg/dL. A review of the article titled Drugs and Supplements-Seroquel from the nationally recognized Mayo Clinic; indicated Seroquel may increase the amount of sugar in the blood. High blood sugar levels associated with Seroquel can, in some cases, be extreme and lead to a precipitous drop in blood pH (chemical balance in the blood that can cause harm if not in balance) levels (ketoacidosis - dangerous imbalance of chemicals in the blood), coma (where a person is unresponsive and cannot be woken), or death. https://www.mayoclinic.org/drugs-supplements/quetiapine-oral-route/precautions B1.During a review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (disrupted blood flow to the brain caused by issues with the blood vessels that supply it), hemiplegia (severe weakness on one side of the body), hemiparesis (one sided weakness without complete paralysis), dementia (a group of symptoms that affects memory and thinking) without behavioral disturbance (aggression, anxiety) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 25's MDS, dated [DATE], the MDS indicated Resident 25 did not exhibit behaviors such as hallucinating (seeing, hearing, touching, or smelling something that is not actually there), delusions, or physical (hitting, biting) and verbal (screaming at others) behaviors. The MDS indicated Resident 25 was moderately depressed. The MDS indicated Resident 25 required maximal assistance from staff for transferring from chair to bed, rolling in bed left and right and required moderate assistance for toileting, bathing, and dressing. During a review of the H&P dated 4/14/2024, the H&P indicated Resident 25 did not have the capacity to make medical decisions. During a review of the psychiatrist's (a medical practitioner that specializes in the diagnosis and treatment of mental illness) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055758	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024

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 0758 Level of Harm - Actual harm Residents Affected - Few	note dated 5/14/2024, the psychiatrist's note indicated Resident 25 had a diagnosis of anxiety and treatment for anxiety and psychosis and had episodes of disruptive behaviors or behaviors that interfere with activities of daily living, restlessness and constant attempts to get out of bed, was difficult to redirect, easily frustrated and agitated, constant fidgeting and unable to keep still, inability to relax, frequent shakes and tremors, and had persistent sad facial expressions. The Psychiatrist's note indicated to start Depakote Sprinkles (medication used to treat bipolar disorder) 25 mg twice a day, Lexapro (medication used to treat depression) 10 mg once a day, and to continue Ativan (medication used for anxiety and insomnia) 0.5 mg every six hours as needed for 14 days then re-evaluate. The Psychiatrist's note indicted to discontinue Seroquel on 5/14/2024. During a review of the OSR dated 6/6/2024, the OSR indicated Resident 25 had the following physician's orders: 1. Lexapro oral tablet 10 mg one time a day for depression manifested by (m/b) low interest in activities of daily living (ADL's) ordered on 5/15/24. 2. Monitor for episodes of depression m/b low interest in ADL's, tally by hashmark every shift for Lexapro ordered on 5/21/2024. 3. Depakote Sprinkles delayed release oral capsule 125 mg by mouth two times a day for dementia m/b constantly getting up ordered on 5/14/2024. 4. Seroquel 25 mg by mouth at bedtime for depression m/b verbalization of feeling sad. During a review of Resident 25's MAR for May 2024, the MAR indicated there was an order for Seroquel 25 mg one tablet by mouth at bedtime for depression manifested by verbalization of feelings of sadness to start on 5/2/2024 with a discontinue date of 6/4/2024. The MAR indicated Resident 25 had been receiving Seroquel 25 mg from 5/15/2024 until 6/3/2024, after it was discontinued. During a review of the MAR for the month of June 2024 there was no documentation to indicate Resident 25 was monitored for adverse effect from Seroquel including anticholinergic effects (dry mouth, constipation, urinary retention, bowel obstruction, dilated pupils, blurred vision, increased heart rate, and decreased sweating), akathisia (feeling of muscle quivering, restlessness, and inability to sit still, sometimes a side effect of antipsychotic or antidepressant medication), parkinsonism (brain conditions that cause slowed movements, rigidity (stiffness) and tremors), orthostatic hypotension (a form of low blood pressure that happens when standing after sitting or lying down) cerebrovascular ([CVA]- stroke) event, neuroleptic malignant syndrome ([NMS] a life-threatening idiosyncratic (having strange or unusual habits, ways of behaving, or features)reaction to antipsychotic drugs characterized by fever, altered mental status, muscle rigidity, and autonomic dysfunction) tardive dyskinesia (condition affecting the nervous system, often caused by long-term use of some psychiatric drugs) and excessive sedation (a state of calm or sleep). During an observation on 6/4/2024 at 7:41 a.m., Resident 25 was observed sleeping in bed. During an interview on 6/5/2024 at 7:40 a.m. in Resident's 25 room, Licensed Vocational Nurse (LVN7) stated that the resident was always very sleepy and was hard to wake up. (continued on next page)

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	06/11/2024

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 0758 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 6/5/2024 at 8:10 a.m., Certified Nurse Assistant (CNA 6) stated she was not sure why Resident 25 had been getting very sleepy every day and was not given breakfast because CNA 6 could hardly keep the resident awake. During an interview on 6/6/2024, at 11:15 a.m., Registered Nurse Supervisor (RNS 1) stated that it was the responsibility of the nurses to carry out doctor's orders. During a concurrent interview and record review of the OSR on 6/10/2024 at 9:54 a.m. with RNS 1, RNS 1 stated that was the only order for monitoring the side effects of taking psychotropic medication. RNS 1 stated Resident 25 was supposed to have an order to monitor Resident 34 for adverse effects of Seroquel when the medication was ordered. During an interview on 6/10/2024 at 2:12p.m., PPA 1, PPA 1 stated on 5/14/2024 Resident 25's Seroquel was discontinued, and the resident was started on Depakote, which is a mood stabilizer, for his behaviors. PPA 1 stated he tries to avoid using antipsychotic medications, such as Seroquel, for residents with dementia (the loss of cognitive functioning - thinking, remembering, and reasoning) unless the resident is having psychosis with delusions such as the resident thinking the facility is trying to poison their food and would weigh the risks and benefits, but it would depend on the resident. PPA 1 stated if a medication is not necessary, he would discontinue it. PPA 1 stated antipsychotic medications are not necessary for behaviors such as confusion as it is not a sign and symptoms of psychosis such as delusions and hallucinations. PPA 1 stated if the resident is confused due to dementia, a mood stabilizer such as Depakote is more appropriate. During a concurrent interview and record review on 6/11/2024 at 12:49 p.m., PPA 1 stated the order for Seroquel 25 mg on the May MAR should have been discontinued effective 5/14/2024 but was missed and he (PPA 1) should have placed an order to discontinue this medication. PPA 1 stated for residents with dementia who are trying to get out of bed, Depakote is a better medication to manage the behavior than antipsychotics such as Seroquel. According to the National Institute of Health ([NIH]- the [NAME] medical research agency), use of an antipsychotic medication in residents with dementia is limited, due to its significant adverse effects. The NIH indicated antipsychotics should be used as a last resort. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4994396 During a concurrent interview with the DON on 6/11/2024 at 4:45p.m and a record review of the Behavioral Management note (group of staff that meets monthly consisting of Social Service Designee(SSD), MDS nurse, Activities Director, Dietician and Pharmacy Consultant) dated 5/14/2024, the DON stated on that it was documented to discontinue the Seroquel 25 mg in the Behavioral Management note on 5/14/2024, but it was not carried out or followed up on. On 6/11/2024 at 4:48p.m, during a concurrent interview and review of Resident 25's MAR for June 2024 with the DON, the DON stated the physician's order to discontinue Seroquel on 5/14/2024 was not carried over to MAR. During a review of the PPA 1's note dated 5/14/2024, PPA' 1s note indicated Resident 25 was reported to be very sleepy and that it could have been caused by the adverse effects of the Seroquel, which had not been monitored. (continued on next page)

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	06/11/2024

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 0758 Level of Harm - Actual harm Residents Affected - Few	During a review of the Change of Condition ([COC]- facility's documentation of a resident's sudden change from baseline) form dated 6/5/2024, the COC indicated Resident 25 was observed very difficult to arouse, deep sternal (bone in the middle of the chest) rub (a lifesaving painful technique used to get a response from an unresponsive person) was initiated, but the resident was not responding and appeared very lethargic with low blood pressure 96/59. During a review of Resident 25's GACH emergency record (ER) notes dated 6/5/2024, the record indicated Resident 25 was admitted due to increased confusion, immediately falls back to sleep, obviously weak and lethargic. During a review of the facility's P&P titled, Dementia Care, revised 12/19/2022, the P&P indicated it is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Individualized, non-pharmacological approaches to care will be utilized, to include meaningful activities aimed at enhancing the resident's well-being. During a review of the facility's P&P titled, Use of Psychotropic Medication, revised 12/19/2022, the P&P indicated residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). The indications for initiating, withdrawing, or withholding medication(s), as well as the use of non-pharmacological approaches, will be determined by assessing the resident's underlying condition, current signs, symptoms, expressions, and preferences and goals for treatment .identification of underlying causes (when possible). The indications for use of any psychotropic frug will be documented in the medical record .psychotropic medications shall be initiated only after medical, physical, functional, psychosocial, and environmental causes have been identified and addressed .nonpharmacological interventions that have been attempted, and the target symptoms for monitoring shall be included in the documentation. Residents who use psychotropic drugs shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs. Other medications not classified as antipsychotic, antidepressant, antianxiety, or hypnotic medications but can affect brain activity should not be used as a substitution for another psychotropic medication unless prescribed with a documented clinical indication consistent with accepted clinical standards of practice. The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as but not limited to during the pharmacist's monthly medication regimen review .in accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive care plan of care. (continued on next page)

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	06/11/2024

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 0758 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's P&P titled, Unnecessary Drugs-Without Adequate Indication for Use, revised 12/19/2022, the P&P indicated it is the facility's policy that each resident's drug regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being free form unnecessary drugs. Adverse consequence is a broad term referring to unwanted, uncomfortable, or dangerous effects that a drug may have, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. Indication for use is the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and is consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies, or evidence-based review articles that are published in medical and/or pharmacy journals. Documentation will be provided in the resident's medical record to show adequate indications for the medication's use and the diagnosed condition for which it was prescribed. B2. During a review of Resident 34's Admission Record, the Admission Record indicated, Resident 34 was admitted to the facility on [DATE], with diagnoses including dementia without behavioral disturbances, psychotic disturbances (severe mental disorder that causes abnormal thinking and perceptions), mood disturbances (mood disorders that affect a person's emotional state and quality of life) and anxiety (an intense excessive and persistent worry and fear about everyday situations During a review of Resident 34's Progress Notes, dated 5/8/2024, the Progress Note indicated Resident 34 was admitted to the facility with diagnoses of weakness, hypertension and rule out dementia. The Progress Note indicated Resident 34 was alert and oriented to name, place, and time and was able to make needs known. The Progress Notes indicated Resident 34 was pleasant upon approach, had a pleasant mood, and no unwanted behavior was witnessed. The Progress Notes indicated Resident 3[TRUNCATED]

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	06/11/2024

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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%). Twenty medication errors out of total 41 opportunities contributed to an overall medication error rate of 48.78 % affecting five of five residents observed for medication administration (Residents 19, 26, 209, 210, and 211.) The medication errors noted were as follows: 1. Omitted administration of Metoprolol Tartrate (a medication used to treat high blood pressure) 75 milligrams ([mg] a unit of measure for weight) to Resident 26. 2. Failure to administer Clonidine (a medication used to treat high blood pressure) 0.1 mg to Resident 26 for systolic blood pressure ([SBP] - the pressure caused by heart while contracting) greater than or equal to 150 millimeters of mercury ([mmHg] - a unit measurement of pressure) parameters set by Resident 26's physician). On 6/4/2024 at 8:47 a.m., during medication pass observation Resident 26's BP was 153/52 and the HR was 72. 3. An attempt to give Resident 209 medication Furosemide (a medication used for heart failure and high blood pressure) 20 mg outside of the physician's prescribed order to hold medication for SBP less than 110 or heart rate (HR) less than 60 beats per minute (BPM). On 6/4/2024 at 9:10 a.m., during medication pass observation Resident 209's BP was 97/41 and HR was 69. 4. An attempt to give Resident 209 medication Metoprolol Succinate extended release ([ER]- a medication has a slow release over time) 25 mg outside of the physician's ordered parameters to hold for SBP less than 110 or HR less than 60 BPM. On 6/4/2024 at 9:10 a.m., during medication pass observation Resident 209's BP was 97/41 and HR was 69. 5. Omitted administration to Resident 209 of Potassium Chloride (a medication used to treat low potassium [a mineral that organs such as the heart need to function properly] level) ER 10 milliequivalent ([mEq] - a unit of measure for mass). 6. Omitted administration to Resident 209 of Eliquis ([Generic name - Apixaban] a medication used to prevent and reduce the risk of blood clots formation) 2.5 mg. 7. Omitted administration to Resident 209 of Lactobacillus (a dietary supplement or probiotic used to promote normal bacterial flora of the intestinal tract). 8. Omitted administration of Amoxicillin (a medication used to treat infection) 500 mg to Resident 211. 9. Omitted application of Lidocaine (a medication used to treat localized pain) 5% cream to Resident 210. (continued on next page)

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	06/11/2024

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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	10. Administration of Multivitamins with Minerals (a supplement used to treat vitamin and mineral deficiency) to Resident 19 via gastrostomy tube ([G-tube] a soft tube surgically placed directly into the stomach for administration of medication and nutrition) instead of plain Multivitamins as ordered. 11. Incorrect medication administration technique to Resident 19 via G-tube by pushing [applying pressure to force the medication down the tube into the resident's stomach] on a syringe plunger instead of using gravity [allowing medication to travel down the tube naturally] and without having the five milliliters ([mL] a unit of measure for liquid volume] of water flush between medications per physician order. 12. Incorrect administration technique of Vitamin C 500 mg to Resident 19 via G-tube by pushing on a syringe plunger instead of using gravity. 13. Incorrect administration technique of Aspirin (a medication used to prevent and reduce the risk of blood clots) 81 mg to Resident 19 via G-tube by pushing on a syringe plunger instead of using gravity. 14. Incorrect administration technique of Ferrous Sulfate (a medication used to treat iron deficiency) 220 mg/mL to Resident 19 via G-tube by pushing on a syringe plunger instead of using gravity. 15. Incorrect administration technique of Metoprolol Tartrate 25 mg to Resident 19 via G-tube by pushing on a syringe plunger instead of using gravity. 16. Incorrect administration technique of Furosemide 40 mg Resident 19 via G-tube by pushing on a syringe plunger instead of using gravity. 17. Incorrect administration technique of Docusate Sodium (a medication used to treat constipation) 100 mg to Resident 19 via G-tube by pushing on a syringe plunger instead of using gravity. 18. Incorrect administration technique of Oxybutynin (a medication used to treat overactive bladder) 5.0 mg to Resident 19 via G-tube by pushing on a syringe plunger instead of using gravity. 19. Incorrect administration technique of Pantoprazole (a medication used to treat gastroesophageal reflux disease) 40 mg to Resident 19 via G-tube by pushing on a syringe plunger instead of using gravity. 20. Incorrect administration technique of Zinc Sulfate (a dietary supplement used to treat zinc deficiency and promote wound healing) 50 mg to Resident 19 via G-tube by pushing on a syringe plunger instead of using gravity. These failures to administer medications in accordance with the physician's orders placed Residents 19, 26, 209, 210, and 211 at risk to experience significant medical complications including, progression of infection, pain, high blood pressure, myocardial infarction (heart attack), blood clots development, stroke, G-tube dislodgement (sudden pulling out or displacement of the G tube) hospitalization and possible death. (continued on next page)

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	06/11/2024

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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/6/2024 at 4:03 p.m., the California Department of Public Health (CDPH) called an Immediate Jeopardy (IJ) situation (a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) due to overall medication administration error rate of 48.78 % the presence of the Administrator (ADM) and Director of Nursing (DON.) On 6/7/2024 at 4:47 p.m., the facility provided CDPH with an Immediate Jeopardy Removal Plan containing the following immediate corrective actions: 1. A medication reconciliation for active medication orders and medication availability was completed by licensed staff for the residents listed above. Identified medication that was not available was called to the pharmacy for immediate delivery. Metoprolol Tartrate 75 mg one tablet by mouth (Resident 26). Medication was delivered on 6/5/2024. Apixaban 2.5 mg tab (Resident 209). Amoxicillin (Resident 211) was discontinued on 6/4/2024. Lidocaine (Resident 210). Resident 210 was discharged on [DATE]. Medications available based on physician summary orders on 6/6/2024 to 6/7/2024, there were no missing medications. 2. On 6/6/2024 the Regional Nurse Consultant (RNC) provided re-education to the Director of Nursing (DON), the Director of Staff Development (DSD) and the Infection Preventionist (IP) regarding medication administration, documentation, and medication availability. RNC observed the DON, the DSD and the IP perform medication administration. 3. From 6/6/2024 to 6/7/2024, the pharmacy consultant reviewed physician orders and availability of the medications in the medication carts. There were no missing medications identified. 4. Starting on 6/6/2024 all active licensed nurses identified were provided re-education related to medication administration, documentation, and medication availability by the Director of Nurses/Designee to include medication administration competency. Those nurses who did not have medication administration competency skill check will not be allowed to work on the floor. There are 21 licensed nurses who are eligible to administer medications. Medication administration competency was initiated on 6/6/2024 and will continue until the eligible active licensed nurses have completed the course by 6/7/2024. Staff members on Family Medical Leave Act (FMLA) will be prohibited from administering medications until they have completed the competency skills. The DON, DSD, and IP observed licensed nurses conduct medication administration. 5. Resident 26 was assessed, and denied chest pain, weakness, difficulty talking. No sudden vision change was noted. Resident was placed on monitoring for medical complications due to medication administration error. 6. Resident 209 was assessed, and denied lightheadedness, and chest pain. No shortness of breath or nausea was noted. Resident was placed on monitoring for medical complications due to medication administration error. 7. Resident 211 was assessed and denied ear pain or muffled hearing. No ear drainage was noted. Resident was placed on monitoring for medical complications due to medication administration error. Resident did not have any signs / symptoms of ear infection. Medication was discontinued on 6/4/2024. (continued on next page)

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	06/11/2024

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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	8. Resident 19 was assessed, and resident denied stomach pain nor discomfort. No bleeding was noted. No signs and symptoms of infection noted, and resident was placed on monitoring for medical complication due to medication administration error. 9. Resident 210 was discharged to home per resident and responsible party (RP) request on 6/5/2024. Resident was assessed before leaving the facility. Resident was in stable condition. No complaint of pain or any discomfort noted upon discharge. 10. Seven residents with g-tube were re-evaluated by licensed staff for medical complications due to potential medication administration error on 6/6/2024. 11. Thirty-seven (37) residents with medications requiring parameters were re-evaluated by licensed staff for medical complications due to medication administration error. None were identified. 12. A medication reconciliation for active medication orders and medication availability were completed by licensed staff. Any identified medications not available were called to the pharmacy for immediate delivery. There were no missing medications identified. 13. On 6/6/2024 the Director of Nurses/Designee initiated re-education related to medication administration, documentation, medication availability, and re-ordering of medications by the Director of Nurses to include medication administration competency. There are 21 Licensed Nurses eligible to administer medications. Starting 6/6/2024, medication administration competency was conducted until active eligible Licensed Nurses completed by 6/7/2024 (2 staff on FMLA will not be allowed to administer meds without completing competency skills.) 14. On 6/6/2024 the Director of Nurses initiated retraining to the night shift staff on how to audit the medication carts, re-order, and track medication. The medication cart audits will be reviewed weekly by the Director of Nursing/Designee for any necessary follow-up for the next 3 months or until substantial compliance is met. 15. Quality Assurance Performance Improvement (QAPI - a facility's data driven approach to resident care quality improvement) Project was implemented on 6/6/2024. The Director of Nursing / Designee will monitor medication administration and medication availability and documentation. Any trends will be discussed on Cottage Crest Post Acute (CCPA) monthly QA meetings on every third (3rd) Wednesday of the month x (times) 3 months. Based on observation, interview, and record review on 6/8/2024 at 7:04 p.m. after verifying the facility's implementation of the immediate corrective actions, CDPH removed the immediate jeopardy in the presence of the ADM, DON and Nurse Consultant. Findings: 1. During observation of Licensed Vocational Nurse (LVN 1) medication administration and concurrent interview on 6/4/2024 at 8:47 a.m., LVN 1 was observed preparing the following medications for Resident 26: a. One tablet of Aspirin 81 mg. (continued on next page)

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	06/11/2024

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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	b. One tablet of Clopidogrel ([Plavix]a medication used to prevent blood clots, heart attack [a medical condition when the artery sending blood and oxygen to the heart is blocked] and stroke) 75 mg. c. One tablet of Nephro (vitamins to support kidney function) vitamins. d. One unit of insulin Lispro (a medication used to treat and reduce blood sugar levels) 100 units per one milliliter (mL), subcutaneously ([SQ]- under the skin). During concurrent interview LVN 1 stated Resident 26 had to receive one tablet of Metoprolol Tartrate 75 mg every Tuesday, Thursday, Saturday, and Sunday for hypertension, but the facility currently had no available Metoprolol Tartrate. LVN 1 stated the medication should have been ordered on Saturday 5/31/2024. LVN 1 stated she would check again in the medication room. LVN 1 stated she could not find Metoprolol Tartrate in the medication room and would follow up with the pharmacy to obtain the missing medication. During an interview on 6/4/2024 at 8:47 a.m. LVN 1 stated the four medications listed above were the only medications to administer to Resident 26 this morning besides the missing Metoprolol Tartrate 75 mg. During an observation on 6/4/2024 at 9:00 a.m., Resident 26 was observed taking three medications including one tablet of Aspirin 81 mg, one tablet of Clopidogrel 75 mg, and one tablet of Nephro vitamins by mouth with water. LVN 1 was observed injecting SQ one unit of insulin Lispro to Resident 26. During a review of Resident 26's Admission Record dated 6/4/2024, the Admission Record indicated Resident 26 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (a medical condition where kidneys stop functioning with the need for regular course of long-term dialysis [a procedure to remove waste products and excess fluid from the blood]), essential (primary) hypertension and atherosclerosis (a disease of the arteries characterized by the deposition of plaque [sticky deposit] of fatty material on their inner walls) of the right leg. During a review of Resident 26's Order Summary Report (a list of a physician's orders) dated 5/28/2024, the Order Summary Report indicated Resident 26 had a physician's order for the following medication: a. Aspirin chewable 81 mg by mouth one time a day for cerebrovascular accident ([CVA] a medical condition with an interruption in the flow of blood to cells in the brain) prophylaxis (prevention), ordered on 2/21/2024 with the start date 2/22/2024. b. Clonidine Hydrochloride (HCl) 0.1 mg, give one tablet by mouth every 8 hours as needed for hypertension if systolic blood pressure (SBP) is greater than or equal to 150, ordered 9/20/2023, start date 9/20/2023. c. Metoprolol Tartrate 75 mg, give one tablet by mouth every Tuesday, Thursday, Saturday, and Sunday for hypertension, hold for SBP less than 110 or diastolic blood pressure ([DBP] a pressure in the arteries when the heart rests between beats) less than 70 and pulse less than 60 beats per minute (BPM) (administer with food for enhanced absorption), order date 11/8/2023, start date 11/9/2023. (continued on next page)

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	06/11/2024

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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	d. Clopidogrel one tablet 75 mg, by mouth one time a day for deep venous thrombosis ([DVT] - a medical term to describe blood clot formation in legs deep veins) for prophylaxis, order date 2/25/2022, start date 2/26/2022. e. Renal multivitamin formula tablet (B complex-C-Folic Acid), one tablet by mouth one time a day for supplement, order date 2/25/2022, start date 2/26/2022. f. Insulin Lispro solution 100 units per one milliliter (mL), to administer SQ two times a day for diabetes (a medical condition in which body does not produce enough insulin or when the body cannot effectively use the insulin it produces), per sliding scale (a term used to define the dose based on blood glucose level) ordered on 2/20/2024 as follows: 1. For blood sugar level 150 - 200 = 1 unit 2. For blood sugar level 201 - 250 = 2 units 3. For blood sugar level 251 - 300 = 3 units 4. For blood sugar level 301 - 350 = 4 units 5. For blood sugar level 351 - 400 = 5 units 6. For blood sugar level above 400 = administer 6 units and notify medical doctor (MD). During an interview on 6/4/2024 at 3:19 p.m., LVN 1 stated she did not call Resident 26's physician or the pharmacy to inform about Metoprolol Tartrate was not available. LVN 1 stated she usually orders medication from the pharmacy when there are three or less medication doses remaining. LVN 1 stated she was supposed to administer Clonidine 0.1 mg to Resident 26 for BP 153/52, which is greater than or equal to 150 SBP and she forgot to give that during medication pass. LVN 1 stated by not receiving medications as prescribed, Resident 26 could have a high blood pressure placing the resident at risk for stroke with serious health complications and hospitalization . 2. On 6/4/2024 at 9:10 a.m., before medication pass, LVN 1 was observation checking Resident 209's blood pressure. Concurrently during the observation, LVN 1 stated Resident 209's BP was 97/41 and HR was 69 bpm. During an observation of medication administration on 6/4/2024 at 9:10 a.m. LVN 1 was observed preparing the following medications for Resident 209: a. One tablet of Furosemide 20 mg. b. One tablet of Metoprolol Cuccinate ER (extended release) 25 mg. Concurrently, during an interview on 6/4/2024 at 9:10 a.m. LVN 1 stated Furosemide 20 mg and Metoprolol Cuccinate ER 25 mg were the only medications to administer to Resident 209 this morning. (continued on next page)

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	06/11/2024

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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent observation and interview on 6/4/2024 at 9:20 a.m. with LVN 1 in Resident 209's room, LVN 1 was stopped by the surveyor before LVN 1 would administer Furosemide 20 mg and Metoprolol Cuccinate ER 25 mg to Resident 209 and advised to discuss the medications with the surveyor in the hallway. LVN 1 stated she got nervous and did not realize Resident 209's BP was 97/41 and HR was 69 bpm. LVN 1 stated she should have held Furosemide 20 mg and Metoprolol Succinate ER 25 mg at this time as Resident 209's SBP was 97 which was less than 110. During a review of Resident 209's Admission Record, dated 6/4/2024, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including paroxysmal atrial fibrillation (a medical condition characterized with abnormal heart beats), chronic congestive heart failure ([CHF] - a medical condition where heart cannot pump blood well enough to give normal supply throughout body), essential (primary) hypertension, and atherosclerosis of aorta (a medical term used for the large blood vessel of the body.) During a review of Resident 209's Order Summary Report, dated 6/4/2024, the Order Summary Report indicated Resident 209 had the following medications to be administered every day at 9:00 a.m.: a. Apixaban 2.5 mg, one tablet by mouth two times a day for CVA prophylaxis, ordered on 5/25/2024. b. Furosemide 20 mg, one tablet by mouth two times a day for CHF, hold for SBP less than 110 or HR less than 60, ordered on 5/25/2024. c. Lactobacillus (probiotic or a dietary supplement) one capsule by mouth one time a day for supplement, ordered on 5/25/2024. d. Metoprolol Succinate ER 25 mg one tablet by mouth one time a day for HTN, hold for SBP less than 110 or HR less than 60, ordered on 5/25/2024. e. Potassium Chloride ER 10 milliequivalent (mEq), one tablet by mouth two times a day for potassium supplement ordered on 5/25/2024. During a review of Resident 209's Medication Administration Record (MAR) for June 2024, the MAR indicated LVN 1 marked Lactobacillus, Potassium Chloride ER, and Apixaban as administered at 9:00 a.m., on 6/4/2024. During a concurrent interview and record review on 6/4/2024 at 3:30 p.m., with LVN 1, Resident 209's MAR dated 6/4/2024 was reviewed. The MAR indicated Apixaban tablet 2.5 mg, Furosemide tablet 20 mg, and Lactobacillus one capsule were administered to the resident. LVN 1 stated it was a mistake to mark Apixaban, Lactobacillus and Potassium Chloride as administered to Resident 209. LVN 1 stated she thought that she gave these medications, but she did not. LVN 1 stated that not receiving the Potassium Chloride ER could cause Resident 209 low potassium levels leading to heart function complications. LVN 1 stated missing a dose of Apixaban for Resident 209 could increase the resident's risk for a stroke due to the risk for developing blood clots and deep venous thrombosis (DVT). 3. During an observation of medication pass by LVN 1 on 6/4/2024 at 9:45 a.m., LVN 1 was observed preparing the following medications for administration to Resident 211: a. One tablet of Docusate Sodium 100 mg. (continued on next page)

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	06/11/2024

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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	b. Four capsules of Potassium ER 10 mEq. During concurrent interview on 6/4/2024 at 9:45 a.m., LVN 1 stated Docusate Sodium 100 mg and Potassium ER 10 mEq were the only medications to administer to Resident 211 this morning. During an observation on 6/4/2024 at 10:00 a.m. in Resident 211's room, Resident 211 observed taking Docusate Sodium 100 mg and Potassium ER 10 mEq by mouth with water and Ensure (a supplement given as a nutrition substitute or meal replacement). During a review of Resident 211's Admission Record, dated 6/4/2024, the Admission Record indicated Resident 211 was admitted to the facility on [DATE] with diagnoses including hypertensive heart disease with heart failure, atherosclerotic heart disease of native coronary artery (a medical term for blood vessel supplying blood to the heart) with unstable angina pectoris (a medical condition in which heart does not get enough blood flow and oxygen), unspecified atrial fibrillation, edema (a medical term used to describe swelling caused by too much fluid in the body's tissues) unspecified, and encounter for palliative care (a medical term used for special care provided for people living with a serious illness.) During a review of Resident 211's Order Summary Report, dated 6/4/2024, the Order Summary Report indicated Resident 211 had the following medications to be administered at 9:00 a.m.: a. Amoxicillin 500 mg, give one capsule by mouth three times a day for ear infection for 10 days, ordered 5/29/2024, to start on 5/30/2024. b. Docusate Sodium 100 mg, one tablet by mouth two times a day for constipation, hold for loose stools, ordered on 5/29/2024. c. Furosemide 40 mg, one tablet by mouth one time a day for edema/HTN, hold for SBP less than 110 or HR less than 60, ordered on 5/20/2024 to start on 5/30/2024. d. Potassium Chloride ER 10 mEq, four capsules by mouth one time a day for supplement ordered on 5/29/2024. During a concurrent interview and record review on 6/4/2024 at 4:33 p.m. with LVN 1, Resident 211's MAR dated from 5/30/2024 to 6/4/2024 for Amoxicillin and Furosemide administration was reviewed. The MAR for Amoxicillin administration indicated the Amoxicillin was not administered 5/30/2024 to 6/4/2024. LVN 1 stated she did not have Amoxicillin in stock for Resident 211 that was why this medication was not administered to Resident 211. LVN 1 stated Resident 211's infection would not be treated without Amoxicillin. LVN 1 stated she did not have Furosemide in stock for Resident 211 and that was why Furosemide was not administered from 5/30/2024 to 6/4/2024. LVN 1 stated Resident 211 was at an increased risk for edema and high blood pressure due to facility not having Furosemide available when needed. 4. During an observation of LVN 1's medication pass to Resident 210 on 6/4/2024 at 10:04 a.m., LVN 1 was observed preparing the following medications for administration to Resident 210: a. One tablet of Aspirin 81 mg. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055758	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024

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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	b. One tablet of Carvedilol (a medication used to treat high blood pressure and heart condition) 6.25 mg. c. One tablet of Ferrous Sulfate (a medication used to treat iron deficiency) 325 mg. d. One tablet of Furosemide 20 mg. e. One tablet of Hydralazine (a medication used to treat high blood pressure) 50 mg. f. One tablet of Enalapril (a medication used to treat high blood pressure) 5 mg. g. One tablet of Hydrocodone with Acetaminophen (a combination of two medications used to relieve pain) 10 mg/ 325 mg. h. One capsule of Pregabalin (a medication used to treat nerve pain) 100 mg. i. One tablet of Mirabegron (a medication used to treat symptoms of overactive bladder) ER 25 mg. j. One capsule of Duloxetine (a medication used to treat fibromyalgia [a medical condition characterized by musculoskeletal pain], depression and nerve pain) 20 mg. k. One tablet of Propranolol (a medication used to treat high blood pressure and heart condition) 20 mg. l. One capsule of Vitamin D (a supplement to treat vitamin D deficiency) 25 micrograms ([mcg] - a unit of measure for mass). During an interview on 6/4/2024 at 10:04 a.m. LVN 1 stated the 12 medications listed above were the only medications to administer to Resident 210 this morning. During medication pass observation on 6/4/2024 at 10:28 a.m., Resident 210 was observed taking all 12 medications listed above by mouth with water. During a review of Resident 210's Admission Record, dated 6/5/2024, the Admission Record indicated, Resident 210 was admitted to the facility on [DATE] with diagnoses including fibromyalgia, lumbar region radiculopathy (a medical condition described by symptoms of pain, tingling, numbness due to pinched nerve along lumbar region of the spine), other symptoms and signs involving the musculoskeletal system, unspecified diastolic (congestive) heart failure, essential (primary) hypertension, and depression. During a review of Resident 210's Order Summary Report, dated 5/30/2024, the Order Summary Report indicated Resident 210 had the following medications to be administered at 9:00 a.m.: a. Aspirin 81 one chewable tablet one time a day for CVA prophylaxis, monitor for bleeding, ordered on 5/30/2024. b. Carvedilol 6.25 mg to give one tablet by mouth two times a day for HTN, hold for SBP less than 110 or HR less than 60, ordered on 5/30/2024. (continued on next page)

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	06/11/2024

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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	c. Duloxetine HCl oral capsule delayed release 20 mg, give one capsule one time a day for depression manifested by verbalization of sadness, ordered on 5/30/2024. d. Enalapril oral tablet 5 mg, give one tablet by mouth one time a day for HTN, hold for SBP less than 110 or HR less than 60, ordered on 5/30/2024. e. Ferrous Sulfate oral tablet 325 (65) mg, give one tablet by mouth two times a day for supplement, ordered on 5/30/2024. f. Furosemide oral tablet 20 mg, give one tablet by mouth one time a day for HTN, hold for SBP less than 110 or HR less than 60, ordered on 5/30/2024. g. Hydralazine HCl oral tablet 50 mg, give one tablet by mouth three times a day for HTN, for SBP greater than 160 or DBP greater than 110, hold for SBP less than 110 or HR less than 60, ordered on 5/30/2024. h. Myrbetriq (Mirabegron) ER tablet 25 mg, give one tablet by mouth one time a day for overactive bladder ordered on 5/30/2024. i. Norco (Hydrocodone with Acetaminophen) oral tablet 10/325 mg, give one tablet by mouth every six hours as needed for severe pain (level 8 -10) not to exceed three grams ([gm] - a unit of measure for mass) of Acetaminophen in 24 hours, ordered on 5/30/2024. j. Pregabalin oral capsule 100 mg, give one capsule by mouth two times a day for neuropathy, ordered on 5/30/2024. k. Propranolol HCl oral tablet 20 mg, give one tablet by mouth two times a day for HTN, hold for SBP less than 110 or HR less than 60, ordered on 5/30/2024. l. Vitamin D3 oral capsule 50 mcg, give one capsule by mouth one time a day for supplement, ordered on 5/30/2024. m. Lidocaine external cream 5%, apply to affected site topically every 12 hours for arthritic pain, ordered on 5/30/2024. During an interview on 6/4/2024 at 4:22 p.m., LVN 1 stated she did not have Lidocaine cream in stock for Resident 210. LVN 1 stated Resident 210 would not receive topical treatment for pain, making her uncomfortable. 4. During an observation of medication pass by LVN 1 and concurrent interview on 6/4/2024 at 10:52 a.m., LVN 1 was observed preparing the following medications for administration to Resident 19: a. One tablet of Vitamin C 500 mg. b. One tablet of Aspirin 81 mg. c. Seven and a half (7.5) mL of Ferrous Sulfate elixir 220 mg/5 mL. (continued on next page)

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	06/11/2024

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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	d. One tablet of Metoprolol Tartrate 25 mg. e. One tablet of Furosemide 40 mg. f. One tablet of Docusate Sodium 100 mg. g. One tablet of Multivitamins with minerals. h. One tablet of Oxybutynin 5 mg. i. One packet of Pantoprazole 40 mg dissolved in 7.5 mL apple juice. j. One tablet of Zinc 50 mg supplement. LVN 1 stated Resident 19 has a G-tube, and the resident's medications must be crushed or be in liquid form to administer. LVN 1 stated the ten medications listed above were the only medications to administer to Resident 19 this morning. During an observation on 6/4/2024 at 10:52 a.m., LVN 1 was observed placing one of each medication listed above in individual plastic packet and started crushing each medication separately using a crushing device. LVN 1 was observed pouring each powdered (crushed) medication and liquid Ferrous Sulfate into an individual small plastic water cups. LVN 1 was observed adding 15 mL of water to each cup to dissolve medication. During an observation on 6/4/2024 at 11:02 a.m., before administering medications individually, LVN 1 was observed administering 30 mL of water onto the G-tube by pushing on a syringe plunger. LVN 1 was observed placing 60 ml syringe (a tube with a nozzle and piston or bulb, fitted with a hollow needle, used to inject or withdraw fluid in and out, used for cleaning wounds or body cavities) tip in the medicine cup and pulling syringe plunger to withdraw each medication (Vitamin C, Aspirin, Ferrous Sulfate, Metoprolol Tartrate, Furosemide, Docusate Sodium, Multivitamin with Minerals, Oxybutynin, Pantoprazole, and Zinc) individually and administering each medication, one by one, into Resident 19's G-tube by pushing the syringe plunger. Then, after administering above listed medications, LVN 1 was observed administering another 30 mL of water into Resident 19's G-tube by pushing on the syringe plunger. During a review of Resident 19's Admission Record, dated 6/4/2024, the Admission Record indicated, Resident 19 was admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses including nonrheumatic mitral (valve) insufficiency (a medical condition where the valve between left heart chambers does not close properly), acute on chronic systolic (congestive) heart failure, atrial fibrillation, essential (primary) hypertension, gastro-esophageal reflux disease without esophagitis, overactive bladder, and encounter for attention to gastrostomy. During a review of Resident 19's Order Summary Report, dated 6/5/2024, the Order Summary Report indicated Resident 19 had the following physician's orders for medications to be administered at 9:00 a.m. every day: a. Flushing G-tube with 15-30 mL of water before and after medication administration and with five mL of water between each medication every shift ordered on 5/19/2024. (continued on next page)

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	06/11/2024

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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	b. Vitamin C 500 mg one tablet via G-tube one time a day for supplement, ordered on 5/19/2024. c. Aspirin 81 mg chewable tablet to give one tablet via G-tube one time a day for CVA prophylaxis, ordered on 5/21/2024. d. Docusate Sodium 100 mg to give one tablet via G-tube two times a day for bowel management, hold if loose stools, ordered on 5/19/2024. e. Ferrous Sulfate oral solution 220 mg/5 mL, give seven and a half (7.5) mL via G-tube one time a day for supplement, ordered on 5/19/2024. f. Furosemide 40 mg to give one tablet via G-tube one time a day for HTN, hold if SBP less than 110, HR less than 60, ordered on 5/19/2024. g. Metoprolol Tartrate 25 mg, give one tablet via G-tube two times a day for HTN, hold if SBP less than 110, HR less than 60, ordered on 5/19/2024. h. Multivitamins, give one tablet via G-tube one time a day for supplement, ordered on 5/19/2024. i. Oxybutynin Chloride 5 mg, give one tablet via G-tube two times a day for overactive bladder, ordered on 5/19/2024. j. Pantoprazole oral tablet delayed release 40 mg, give one tablet via G-tube two times a day for gastroesophageal reflux disease ([GERD] - a medical condition in which the stomach contents move up into the esophagus [the part of the alimentary canal that connects the throat to the stomach]), ordered on 5/19/2024. k. Vitamin D3 oral capsule 50 mcg, give one capsule via G-tube one time a day for

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	06/11/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 49130 Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors for two of seven sampled residents (Residents 26 and 209) by failing to administer metoprolol tartrate (a medication used to treat high blood pressure [BP]), clonidine (a medication used to treat high blood pressure), metoprolol succinate (a medication used to treat high blood pressure) extended release (ER - a medication formulation aiding the medication release slowly over time), apixaban (a medication used to prevent and reduce the risk of blood clot), and furosemide (a medication for heart failure and high blood pressure) in accordance with physician orders or professional standards of practice. These failures had the potential to result in significant medical complications resulting in hospitalization or death due to stroke (a medical condition when something blocks blood supply to brain or when blood vessel in the brain bursts), poor blood pressure control, edema (a medical term used to describe swelling caused by too much fluid in the body's tissues) and heart failure (a medical condition where heart cannot pump blood well enough to give normal supply throughout body). Findings: 1. During a review of Resident 26's Admission Record (a document containing demographic and diagnostic information), dated 6/4/2024, the admission record indicated, Resident 26 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (a medical condition where kidneys stop functioning with the need for regular course of long-term dialysis [a procedure to remove waste products and excess fluid from the blood]), essential (primary) hypertension and atherosclerosis (a medical condition with buildup of fat and calcium) of arteries of extremities with intermittent claudication (a medical term used to describe pain caused by reduced blood flow to the legs or arms), right leg. During a review of Resident 26's History and Physical (H&P), dated 3/15/2023, the H&P indicated resident had the capacity to understand and make decisions. During a review of Resident 26's Minimum Data Set ([MDS], a standardized assessment and care screening tool) dated 2/29/2024, the MDS indicated Resident 26 had intact cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) and required partial or moderate to setup or cleanup assistance from facility staff for activities of daily living (tasks of everyday life that include eating, dressing, getting in and out of bed or chair, bathing and toileting). During a review of Resident 26's Order Summary Report (a list of all currently active medical orders), dated 5/28/2024, the order summary report indicated the following medications in addition to other medications prepared by Licensed Vocational Nurse (LVN) 1 during medication pass observation: (continued on next page)

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	06/11/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Metoprolol Tartrate 75 milligrams (mg - a unit of measure for mass), give 1 tablet by mouth one time a day every Tuesday, Thursday, Saturday, Sunday, for hypertension (HTN - a medical term used for high blood pressure), hold for systolic blood pressure (SBP - the pressure caused by heart while contracting) less than 110 millimeters of mercury (mmHg - a measurement of pressure) or diastolic blood pressure (DBP - the pressure in the arteries when the heart rests between beats) less than 70 mmHg and pulse less than 60 beats per minute (BPM) (administer with food for enhanced absorption), order date: 11/8/2023. Clonidine hydrochloride 0.1 mg, give 1 tablet by mouth every 8 hours as needed for hypertension if SBP greater than or equal to 150. During a concurrent observation and interview during medication administration with LVN 1 on 6/4/2024 at 8:47 a.m., LVN 1 prepared four medications to administer to Resident 26. LVN 1 stated Resident 26 was supposed to also receive one tablet of metoprolol tartrate 75 mg with instructions to be given every Tuesday, Thursday, Saturday, and Sunday for hypertension, hold for SBP less than 110 mmHg or DBP less than 70 mmHg and pulse less than 60 BPM, but the facility did not have medication in stock. During a review of the pharmacy label on the empty medication bubble pack (a card prepared by the pharmacy containing the individual doses of medications) for metoprolol tartrate 75 mg on 6/4/2024 at 8:52 a.m., the label showed the medication was last refilled for a quantity of eight tablets (fourteen day-supply) on 5/19/2024. During an interview on 6/4/2024 at 3:19 p.m., with LVN 1, LVN 1 stated she did not have a chance to call Resident 26's doctor or pharmacy to inform them about metoprolol tartrate being out of stock. LVN 1 stated she would order medication from the pharmacy when there are three or less doses remaining for the resident. LVN 1 stated by not receiving medications as prescribed, Resident 26 could have high blood pressure and an increased risk for stroke leading to serious health complications and hospitalization . During a phone interview on 6/6/2024 at 9:05 a.m., with registered pharmacist (RPH) 1 at pharmacy (PH) 1, RPH 1 stated the facility requested metoprolol tartrate for Resident 26 on 5/19/2024, a 14 days' supply of the medication was delivered on 5/21/2024 and another refill was requested today (6/4/2024). 2. During a review of Resident 209's Admission Record, dated 6/4/2024, the admission record indicated, she was admitted to the facility on [DATE] with diagnoses including paroxysmal atrial fibrillation (a medical condition characterized with abnormal heart beats), chronic systolic (congestive) heart failure (CHF - a medical condition where heart cannot pump blood well enough to give normal supply throughout body), essential (primary) hypertension, and atherosclerosis of aorta (a medical term used for the large blood vessel of the body.) During a review of Resident 209's H&P, dated 5/26/2024, the H&P indicated resident can make medical decisions with assistance of granddaughter. During a review of Resident 209's Order Summary Report, dated 6/4/2024, the order summary report indicated the following medications in addition to other medications prepared by LVN 1 during medication pass observation: (continued on next page)

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	06/11/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Apixaban 2.5 mg, give 1 tablet by mouth two times a day for CVA (cerebrovascular accident - a medical condition with an interruption in the flow of blood to cells in the brain) prophylaxis (prevention) in addition to other medications Potassium chloride ER 10 milliequivalent (mEq - a unit of measure for mass), give 1 tablet by mouth two times a day for potassium supplement During an observation of LVN 1 taking BP for Resident 209 at bedside on 6/4/2024 at 9:10 a.m., LVN 1 stated BP for Resident 209 was 97/41 and HR was 69. During an observation of medication administration on 6/4/2024 at 9:10 a.m. with LVN 1, LVN 1 prepared the following medications for Resident 209: 1. One tablet of furosemide 20 mg, hold for SBP less than 110, HR less than 60 2. One tablet of metoprolol succinate ER 25 mg, hold for SBP less than 110, HR less than 60 During an interview on 6/4/2024 at 9:10 a.m. with LVN 1, LVN 1 stated the two medications listed above were the only medications to administer to Resident 209 at that time. During a concurrent observation and interview on 6/4/2024 at 9:20 a.m. with LVN 1 in Resident 209's room, LVN 1 was stopped by the surveyor before the medication was administered and advised to discuss the medications with the surveyor in the hallway. LVN 1 stated she got nervous and did not realize Resident 209's recorded BP and HR parameters would not permit giving medications at this time. During an interview on 6/4/2024 at 3:19 p.m. with LVN 1, LVN 1 stated she missed to give potassium chloride to Resident 209 because she was nervous although she had the medication in her cart that morning. LVN 1 stated that not receiving potassium could cause low potassium levels for Resident 209, leading to heart complications. LVN 1 stated she did not have apixaban in stock to administer to Resident 209. LVN 1 stated missing a dose of apixaban for Resident 209, increased resident 209's risk for stroke due to risk for blood clots and deep venous thrombosis (a medical term to describe blood clot formation in deep veins in the body in the legs). During a phone interview on 6/6/2024 at 9:05 a.m., with RPH 1 at PH 1, RPH 1 stated a seven days' supply of apixaban for Resident 209 was delivered to facility on 5/26/2024 and another refill was requested on 6/5/2024. During an interview on 6/5/2024 at 10:51 a.m., with the Director of Nurses (DON), the DON stated licensed nurses should call pharmacy and physician when medications are unavailable. The DON stated licensed staff should check for medication that are out of stock in the emergency kit (E-kit an emergency supply of medications). The DON stated staff should order medication when three to five doses remain. The DON stated a resident's condition would not improve if he/she are not given medications on time or doses are missed. The DON stated the facility increased residents' risk for high blood pressure, edema, heart attack, hospitalization , and even death by not having medications such as furosemide, apixaban, potassium and metoprolol available for residents. The DON stated she will check medication carts at least twice per week or more frequently to ensure medication availability. (continued on next page)

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	06/11/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 12/19/2022, the P&P indicated, Medications are administered by licensed nurses, or other staff who are legally authorized .as ordered by the physician and in accordance with professional standards of practice .to prevent contamination or infection. Obtain and record vital signs, when applicable or per physician orders . when applicable, hold medication for those vital signs outside the physician's prescribed parameters. During a review of the facility's P&P titled, Medication Reordering, dated 12/19/2022, the P&P indicated, It is the policy of this facility to provide .pharmaceutical services accurately and safely .in a timely manner to meet the needs of each resident. Acquisition of medications should be completed .to ensure medications are administered in a timely manner. Each time a nurse is administering medications, the nurse will observe how many doses are left, that nurse will reorder the medication, time permitting. (Cross-referenced with F759 and F755)

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	06/11/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on observation and interview, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen by: 1. Failing to dispose expired food from the fridge. 2. Failed to store food in the appropriate section. 3. Failed to do proper hygiene when entering the kitchen. These deficient practices had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea and fever and can lead to other serious medical complications and hospitalization . During a concurrent observation of the refrigerator and interview on [DATE] at 8:26a.m. with Dietary Aide 1 (DA 1). DA 1 stated the cilantro in the bag that was dated [DATE] is supposed to be good for one week and was supposed to be thrown away. It was noted the cilantro was changing color and was turning yellow. It was additionally observed there was an avocado, ginger, yellow pepper, and one lemon in the bin with no date. During a concurrent observation of freezer two (2) and interview on [DATE] at 8:36a.m. with DA 1, on the bottom of the shelf, there was a box of bacon dated [DATE], a box of frozen blackberries behind the box of bacon, cookie dough, pizza crust, and pastries. DA 1 stated the bacon and blackberries are not supposed to be there. During a concurrent observation and interview on [DATE] at 8:42a.m. with Dietary Manager (DM) in the dry pantry, there was a Tabasco sauce (a brand of hot sauce) with an expiration date of ,d+[DATE] and DM stated it was supposed to be tossed out. During a concurrent observation and interview on [DATE] at 8:48a.m. with DM in the dry pantry, there was almond extract with an expiration date of ,d+[DATE]. During a concurrent observation and interview on [DATE] at 8:50a.m. with DM in the dry pantry, there was a box of three melons and a few bananas that was browning with no dates. DM stated there are no expiration dates for fruits and it will be thrown away when it goes bad or starts smelling. DM was observed throwing out the bananas because they were brown, soft, and mushy. During a concurrent observation and interview on [DATE] at 8:52a.m. with DM in the dry pantry, there were six unopened instant coffee grounds in the bag with an expiration date of [DATE]. DM stated they no longer use the instant coffee grounds. (continued on next page)

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	06/11/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on [DATE] at 9:02a.m. with DM, DM stated they check the freshness daily for cilantro. DM stated the cilantro dated [DATE] and was bad and had to be thrown out since it was yellowing. During a concurrent observation and interview on [DATE] at 9:05a.m. with DM, DM stated the parsley dated [DATE] with no expiration date is still fresh because there were no issues with the parsley leaves in the bag. DM observed the celery that was a little brown at the top that was in a clear container with no covering dated [DATE] with no expiration date and the DM stated she does not know when the celery came in. During a concurrent observation of freezer two (2) and interview on [DATE] at 12:31p.m. with DM, DM stated the apple bacon box on top of the cookie dough box was acceptable to be stored on the same shelf because the bacon and cookie dough was sealed. During a concurrent observation of the refrigerator and interview on [DATE] at 12:34p.m. with DM, it was observed there was a bag of sausages on the same shelf as fruits with cured meat stored on the bottom shelf. DM stated the bag of sausages are supposed to be at the bottom with the cured meat, because it is raw, and all meats should be at the bottom. DM stated if the bag was open, it can cause cross contamination, but since it is sealed, she stated she does not mind if the meat is touching other items. During a concurrent observation, interview, and record review of the refrigerated storage quick reference guide on [DATE] at 12:37p.m. with DM, DM reiterated the celery in the container dated [DATE] was mislabeled and the celery in the refrigerator was delivered not too long ago. DM stated according to the refrigerated storage quick reference guide, celery that is unopened is stored for one week with no applicable storage time for opened celery. Additionally, the handling hints indicated to keep in crisper or moister resistant wrap or bag and DM stated the celery was supposed to be covered in a bag. DM concurred that the celery that was observed together was not covered, it was in the box, and it was more than a week. Parsley and cilantro were also received and indicated it should be kept for one week and was noted both of them were expired. DM stated expired items are tossed out as it can make people sick, and it has passed its shelf life. DM stated labeling is important to keep the items fresh and prevent the item from expiring. During an observation on [DATE] at 10:39a.m., Dietary Aide 2 (DA 2) that was stationed at the dishwasher station was observed removing her gloves and left the kitchen without performing hand hygiene. During an observation on [DATE] at 10:30a.m. DA 2 was observed coming back into the kitchen, proceeded to wear gloves, and went to the dishwashing section and started cleaning the trays. No hand hygiene was observed from the moment DA 2 entered the kitchen. (continued on next page)

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	06/11/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on [DATE] at 10:47a.m. with DA 1, DA 1 was observed removing the lid off the blender and placed the mix into a container. DA 1 with the same glove reaches into the sanitation red bucket and removes a towel, cleaned the counter, the blender machine, laid out the towel in the sink, rinsed the towel and proceeded to put the towel back into the sanitation box. DA 1 was observed removing her gloves and placed them in the sink. DA 1 continued to get foil, placed it on mix contained that contained the beef and broccoli puree, put on the oven mittens, and placed the mix in the oven. DA 1 stated she is not supposed to use the same glove and get into the sanitation bucket as it would get dirty. DA 1 stated hand washing is performed to prevent the spread of bacteria and for infection control. During an interview on [DATE] at 11:00a.m. with DA 2, DA 2 stated she normally washed her hand at the sink located across the kitchen and stated she washed her hand upon returning to the kitchen earlier. DA 2 stated she was supposed to wash hands after leaving/coming back into the kitchen. DA 2 stated it is not acceptable to not washing hands and touch dirty to clean areas with the same gloves. DA 2 stated hand hygiene should be performed because your hands are dirty and can spread bacteria. During a review of the facility's P&P titled, Food Storage, revised [DATE], the P&P indicated improper storage of food is the main reason for food borne illness. All food stored should be dated when it is placed in the storeroom, refrigerator or freezer. During a review of the facility's P&P titled, Food Storage, revised [DATE], the P&P indicated any expired or outdated food products should be discarded. Fresh vegetables should be checked and sorted for ripeness. Vegetables should be left in cartons, bags, or paper wrapping because it retards spoilage and loss of moisture. During a review of the facility's P&P titled, Handwashing and Glove Use, revised [DATE], the P&P indicated handwashing is a priority for infection control. Hands must be washed prior to beginning work .and following contact with any unsanitary surface i.e. touching hair, sneezing, opening doors, etc. When gloves are used, handwashing must occur per above procedure prior to putting on gloves and whenever gloves are changed. Gloves must be changed as often as hands need to be washed, see above .gloves may be used for one task only. During a review of the facility's P&P titled, Receiving Food and Supplies, revised [DATE], the P&P indicated all foodstuffs are to be dated.

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	06/11/2024

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 46415 Based on observation and interview, the facility failed to dispose of garbage and refuse properly by not completely covering two (2) of 2 dumpsters (a large trash container designed to be emptied into a truck) and two smaller carts for an unknown length of time. This deficient practice had a potential to attract flies, insects, cats, and other animals to the dumpster area placing 54 of 59 facility residents getting food from the kitchen cross-contamination (a transfer of harmful bacteria from one place to another). During a concurrent observation and interview on 6/4/2024 at 12:32p.m. with Dietary Manager (DM), it was observed there were two big garbage dumpsters full and overflowing and the lids were unable to be closed for both of the bins. Additionally, there were two extra carts in the front of the big dumpsters with disposable places with no lid. The DM stated the trash was picked up yesterday and will have another trash pickup on 6/4/2024. The DM stated the garbage bins are supposed to be sealed as it might attract flies, rodents, and cause infestation. During a review of the facility's P&P titled, Disposal of Garbage and Refuse, revised 12/19/2022, the P&P indicated containers and dumpsters shall be kept covered when not being loaded. During a review of Food Code 2017, indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment.

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	06/11/2024

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46537 Based on interview and record review, the facility failed to identify unresolved quality deficiencies, some of which had been cited on previous surveys, and ensure actions were developed and implemented to attempt to correct the deficiencies through the quality assessment and assurance (QAA) process as evidenced by the severity and number of deficiencies cited involving sufficient staffing, significant medication error, providing medications as physician ordered, and maintaining medication in stock. This failure had potential to result in 54 of 54 residents residing in the facility not receiving services and care they need. Findings: During a review of the facility's Census and Direct Care Service Hours Per patient Day (DHPPD), dated from 4/1/2023 to 4/30/2024, the DHPPD indicated as follow: a. 4/15/2024-Actual CNA DHPPD 2.24 b. 4/16/2024- Actual CNA DHPPD 2.40 c. 4/17/2024- Actual CNA DHPPD 2.40 d. 4/19/2024- Actual CNA DHPPD 2.29 e. 4/20/2024- Actual CNA DHPPD 2.06 During an interview on 6/6/2024, 3:21 p.m., with RNA 1, RNA 1 stated, there are two RNAs in the facility and they would be pulled on the floor as a CNA if there was short staff. RNA 1 stated, she would have to work as CNA during the morning and work as RNA afternoon. During a concurrent interview and record review on 6/7/2024, at 9:34 a.m., with Director of Staff Development (DSD), the facility's DHPPD from 4/15/2024 to 4/20/2024 was reviewed. The DHPPD indicated actual CNA direct care hours was equal or below the minimum hours of 2.4. DSD stated, there was two RNAs, but both were unavailable for personal issue during that period. DSD stated 28 residents had not received the RNA service during that period due to unavailability of RNA. DSD stated, there were three CNAs in training, but no one had certificate yet and could not work. DSD stated, the facility had a contract with registry (a staffing agency is a company that provides employees to work in another company on a temporary or permanent basis) but did not use the registry staff. DSD stated, the facility should have contacted registry company. DSD stated, 28 residents did not receive RNA service due to insufficient staffing and this would affect residents' overall functions. (continued on next page)

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	06/11/2024

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's Immediate Jeopardy (a situation in which the nursing home's non-compliance with one or more requirements has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) Template (IJT), dated 6/6/2024, the IJT indicated, the facility failed to administer 20 medications in accordance with physician orders or professional standards of practice out of 41 total opportunities to five of five residents observed for medication administration (Resident 19, 26, 209, 210, and 211.) resulting in a medication error rate of 48.78%. The IJT indicated, metoprolol (a medication to treat high blood pressure) for Resident 26, Apixaban (a prescription medicine used to reduce the risk of stroke and blood clots) for Resident 209, Amoxicillin (medication to treat bacterial infections) for Resident 211, Lidocaine (A substance used to relieve pain by blocking signals at the nerve endings in skin) for 210 were not in stock. During an interview on 6/11/2024, 5:28 p.m., with Administrator (ADM), ADM stated, it was eye opening to find out regarding issues with medication administration and medications in stock during IJ process. ADM stated, he was not aware of those medication issues and staffing issues. ADM stated, there was a contracted registry agency, but they did not use the service. ADM stated, it was important to provide RNA service to maintain and improve residents' optimal function. ADM stated, he would definitely discuss medication issues and staffing shortage in June Quality Assurance Performance Improvement ([QAPI] takes a systemic, interdisciplinary, comprehensive, and data driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families, and all nursing home caregivers in practical and creative problem solving) meeting. ADM stated he realized those issues were identified in previous survey and QAPI committee meeting did not implement effective plan to resolve them. ADM state, he did not include direct resident care staff who works on the floor for QAPI meeting. During a review of the facility's policy and procedure (P&P) titled, Quality Assurance and Performance Improvement (QAPI), revised 12/19/2022, Policy: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. It indicated that QAPI program includes the establishment of a Quality Assessment and Assurance (QAA) Committee and a written QAPI Plan. Tracking and measuring performance. Systematically analyzing underlying causes of systemic quality deficiencies. v. Developing and implementing corrective action or performance improvement activities. vi. Monitoring and evaluating the effectiveness of corrective action/performance improvement b. medical errors and adverse events are routinely tracked. 1. Facility staff monitor residents for medical errors and adverse events in accordance with established procedures for the type of adverse event. An investigation will be conducted on each identified medical error or adverse event to analyze causes.

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	06/11/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 49130 Based on observation, interview and record review, the facility failed to implement infection control measures by failing to: 1.Ensure Certified Nurse Assistant (CNA) 1 performed hand hygiene during and after caring for Resident 31. 2.Ensure CNA 2 wore proper Personal Protective Equipment ([PPE]- equipment used to prevent or minimize exposure to hazards) during the care of Resident 6 who was on enhanced precaution (a level of infection control that requires interventions such as wearing gloves and a gown) and exposed Resident 211 who was not on any precaution for possible cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another). These failures resulted in compromised infection control measures to prevent the spread of Covid-19 (a contagious disease caused by the virus) and other infections among residents, staff, and visitors of the facility. 3.observe infection control measures by not practicing hand hygiene, disinfecting their work area, or wearing the appropriate personal protective equipment (PPE - gowns, gloves, masks used to protecti from and prevent the spread of infections) in between tasks of medication preparation for six of seven sampled residents during medication pass observation (Residents 26, 209, 211, 210, 19 and 47.) These failures had the potential to contaminate medicines in the medication cart and cause the spread of infections for Residents 26, 209, 211, 19 and 47. Findings: These failures resulted in compromised infection control measures to prevent the spread of Covid-19 (a contagious disease caused by the virus) and other infections among residents, staff, and visitors of the facility. Findings: 1.During a review of Resident 31's Admission Record, the Admission Record indicated, Resident 31 was initially admitted to the facility on [DATE] and last readmission was 5/12/2024 with diagnosis including extended spectrum beta lactamase ([ESBL]- enzymes produced by some bacteria that may make them resistant to some antibiotics) resistance, dermatomyositis (an uncommon inflammatory disease marked by muscle weakness and a distinctive skin rash), immunodeficiency (the decreased ability of the body to fight infections and other diseases), and cellulitis (a deep infection of the skin caused by bacteria) of right lower limb. During a review of Resident 31's History and Physical (H&P), dated 5/13/2024, the H&P indicated, Resident 31 had the capacity to understand and make decisions. (continued on next page)

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	06/11/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 31's Minimum Data Set ([MDS]-a standardized assessment and care screening tool), dated 5/16/2024, the MDS indicated Resident 31 required dependent assistance (Helper does all of the effort) from two or more staff for roll left and right, sit to lying, lying to sitting on side of bed, toilet hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, maximal assistance (helper does more than half) from one staff for upper body dressing, moderate assistance (Helper does less than half the effort) from one staff for oral hygiene, and supervision assistance (helper provided verbal cues and/or touching/steadying and /or contact guard assistance) from one staff for eating. During a concurrent observation and interview on 6/4/2024, at 11:16 a.m., with CNA 1 in Resident 31's room, CNA 1 was providing hygiene care and changing Resident 31. CNA 1 came out of the room and took off her gloves, then touched and lifted the trash lid/cover outside of the room. CNA 1 did not wash or sanitize her hands and went to the therapy room to bring other staff to help her. CNA 1 did not wash or sanitize her hands when she re-entered the room and put on a new pair of gloves. After assisting Resident 31 to wheelchair, CNA 1 came out and took off her gloves. CNA 1 lifted trash lid and discard her gloves. CNA 1 did not wash or sanitize her hands and started walking toward the nursing station. CNA 1 stated, she should have washed or sanitized her hands before entering the resident's room and after providing care. CNA 1 stated, she should have washed or sanitized her hands before wearing gloves and after taking off the gloves to prevent spreading infections for vulnerable residents. 2. During a review of Resident 6's Admission Record, the Admission Record indicated, Resident 6 was initially admitted to the facility on [DATE] and last admission was 4/3/2024 with diagnosis including gastrostomy (a surgical operation for making an opening in the stomach), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks). During a review of Resident 6's H&P, dated 4/12/2024, the H&P indicated, Resident 6 had fluctuating capacity to understand and make decisions. During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 required maximal assistance (Helper does more than half the effort) from one staff for toilet hygiene, shower, lower body dressing, putting on/taking off footwear, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, toilet transfer, and moderate assistance (Helper does less than half the effort) from one staff for oral hygiene. The MDS indicated, eating was not attempted due to medical condition or safety concerns. During a review of Resident 211's Admission Record, the Admission Record indicated, Resident 211 was admitted to the facility on [DATE] with diagnosis including heart failure (the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), atrial fibrillation (an irregular and often very rapid heart rhythm), and shortness of breath (the frightening sensation of being unable to breathe normally or feeling suffocated). During a review of Resident 211's H&P, dated 5/30/2024, the H&P indicated, Resident 211 had no capacity to understand and make decisions. (continued on next page)

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	06/11/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 211's MDS, dated [DATE], the MDS indicated Resident 211 required dependent assistance (Helper does all of the effort) from two or more staff for toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, sit to lying, lying to sitting on side of bed, maximal assistance (helper does more than half) from one staff for roll left and right, and supervision assistance (helper provided verbal cues and/or touching/steadying and /or contact guard assistance) from one staff for eating, oral hygiene. During a review of Resident 211's Care Plan (CP), initiated 5/15/2024, the CP Focus indicated, Resident 211 was on Enhanced Barrier Precaution ([EBP]- an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of multidrug-resistant organisms) related to presence of gastrostomy. The CP Intervention indicated, donning/doffing gown and glove use for certain residents during specific high contact resident care activities. During an observation on 6/4/2024, at 10:15 a.m., outside of the Resident 6 and 211's room, there was Enhanced Precautions signage for Resident 6 only and Resident 211 was not on any precautions. During an observation on 6/5/2024, at 7:35 a.m. in Resident 6 and 211's room (Resident 6 and Resident 211 were roommates), Resident 211 pressed the call light to be repositioned to eat breakfast. CNA 2 came in without washing/sanitizing hands and putting the gloves on and CNA 3 came in with PPE on. After both CNAs finished repositioning Resident 211, Resident 6 asked them to be turned to her right side and raised the head of the bed. CNA 2 took off the gloves and sanitized her hands. CNA 2 did put on new pair of gloves and assisted Resident 6 to be turned on her right side and raised head of the bed. Resident 6 asked CNA 2 to fix the blanket and CNA 2 did. CNA 2's scrub uniform was in contact with Resident 6's blanket. Resident 112 asked CNA 2 to cover her with blanket and CNA 2 took off gloves and pulled Resident 211's blanket without washing hands in between assisting the residents. CNA 3 was standing close to Resident 211 and did not assist CNA 2 after repositioning Resident 211. During an interview on 6/5/2024, at 7:45 A.M., with CNA 2, CNA 2 stated, she should have worn her PPE before caring for Resident 6 because Resident 6 was on enhanced precautions. CNA 2 stated, she forgot about EBP at that time. CNA 2 stated, she should have worn PPE even though Resident 211 was not on any precaution because Resident 6 might need her help during caring Resident 211. CNA 2 stated, she should have washed hands between attending two residents to prevent cross-contamination. During an interview on 6/5/2024, at 7:56 a.m., with CNA 3, CNA 3 stated, CNA 2 should have worn PPE before assisting Resident 6 because of EBP. CNA 3 stated, she was standing next to Resident 211's bed because she was little confused. CNA 3 stated, she was wearing PPE, but she already had contact with Resident 211, and she was not sure if she should wear new PPE or not. CNA 3 stated, it was confusing because Resident 6 was on EBP and Resident 211 was not. CNA 3 stated, she believed it would be better to place EBP residents in the same room to avoid cross- contamination. During an interview on 6/7/2024, at 9:04 a.m., with Infection Preventionist Nurse (IPN), the IPN stated, hand washing was important to prevent spreading infection. IPN stated, hand washing was the first line of defense from microorganisms (An organism that can be seen only through a microscope). The IPN stated, PPE should be worn before caring for residents who are on enhanced precautions. (continued on next page)

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	06/11/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/2024, at 3:48 p.m., with Director of Nursing (DON), the DON stated, staff should have washed or sanitized their hands before and after caring the resident to control spreading infection. The DON stated, she would work with IPN to cohort EBP residents together and provide in-service to staff regarding EBP to prevent cross-contamination. 3a. During a review of Resident 26's Admission Record (a document containing demographic and diagnostic information), dated 6/4/2024, the admission record indicated, Resident 26 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (a medical condition where kidneys stop functioning with the need for regular course of long-term dialysis [a procedure to remove waste products and excess fluid from the blood]), essential (primary) hypertension and atherosclerosis (a medical condition with buildup of fat and calcium) of arteries of extremities with intermittent claudication (a medical term used to describe pain caused by reduced blood flow to the legs or arms), right leg. During an observation on 6/4/2024 at 8:47 a.m. during medication administration, Licensed Vocational Nurse (LVN) 1 prepared medications to administer to Resident 26. LVN 1 di not disinfect the medication tray or medication cart counter before and after medication administration. 3b. During a review of Resident 209's Admission Record, dated 6/4/2024, the admission record indicated, she was admitted to the facility on [DATE] with diagnoses including paroxysmal atrial fibrillation (a medical condition characterized with abnormal heart beats), chronic systolic (congestive) heart failure (CHF - a medical condition where heart cannot pump blood well enough to give normal supply throughout body), essential (primary) hypertension, and atherosclerosis of aorta (a medical term used for the large blood vessel of the body.) During an observation on 6/4/2024 at 9:10 a.m. of medication administration, LVN 1 prepared medications to administer to Resident 209. LVN 1 disinfected blood pressure monitor cuff before taking blood pressure for Resident 209. LVN 1 was not observed disinfecting medication tray or medication cart counter before entering and after exiting Resident 209's room. 3c. During a review of Resident 211's Admission Record, dated 6/4/2024, the admission record indicated, Resident 211 was admitted to the facility on [DATE] with diagnoses including hypertensive heart disease with heart failure, atherosclerotic heart disease of native coronary artery (a medical term for blood vessel supplying blood to the heart) with unstable angina pectoris (a medical condition in which heart does not get enough blood flow and oxygen), unspecified atrial fibrillation, edema (a medical term used to describe swelling caused by too much fluid in the body's tissues) unspecified, and encounter for palliative care (a medical term used for special care provided for people living with a serious illness.) (continued on next page)

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	06/11/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/4/2024 at 9:45 a.m. outside of Resident 211's room, a sign was posted for Enhanced Precautions (a level of infection control requiring measures such as wearing gloves and gown use). The Enhanced Precautions sign indicated everyone must clean hands on room entry and when exiting. The sign indicated providers and staff must also wear gloves and a gown for high-contact resident care activities such as caring for devices and giving medical treatments. LVN 1 entered Resident 211's room wearing a gown but did not wear gloves. LVN 1 proceeded to take Resident 211's blood pressure and then LVN 1 stated the monitor was out of battery and will have to find a different device to take resident's blood pressure. LVN 1 found a different blood pressure monitor, took Resident 211's blood pressure and administered medications to the resident. LVN 1 was not observed washing hands or disinfecting medication tray or medication cart counter before entering and after exiting Resident 211's room. 3d. During a review of Resident 210's Admission Record, dated 6/5/2024, the admission record indicated, Resident 210 was admitted to the facility on [DATE] with diagnoses including fibromyalgia, lumbar region radiculopathy (a medical condition described by symptoms of pain, tingling, numbness due to pinched nerve along lumbar region of the spine), other symptoms and signs involving the musculoskeletal system, unspecified diastolic (congestive) heart failure, essential (primary) hypertension, and depression. During an observation on 6/4/2024 at 10:04 a.m., LVN 1 prepared and administered 12 medications to Resident 210. LVN 1 was not observed disinfecting the medication tray or medication cart counter before entering and after exiting Resident 210's room. 3e. During a review of Resident 19's Admission Record, dated 6/4/2024, the admission record indicated, Resident 19 was admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses including nonrheumatic mitral (valve) insufficiency (a medical condition where the valve between left heart chambers does not close properly), acute on chronic systolic (congestive) heart failure, paroxysmal atrial fibrillation, essential (primary) hypertension, gastro-esophageal reflux disease without esophagitis, overactive bladder, and encounter for attention to gastrostomy. During an observation on 6/4/2024 at 10:52 a.m., outside of Resident 19's room, a sign was posted for Enhanced Precautions. During a concurrent observation and interview on 6/4/2024 at 10:52 a.m., with LVN 1, LVN 1 prepared medications to be administered to Resident 19 via gastrostomy tube (g-tube - a surgically placed tube used to administer mediations or food directly into the stomach). LVN 1 stated Resident 19 has a g-tube, and her medications must be crushed or in liquid form to administer. LVN 1 did not wash her hands or disinfect the medication tray or medication cart counter before administering medications via g-tube to Resident 19. 3f. During a review of Resident 47's Admission Record, dated 6/8/2024, the admission record indicated, Resident 47 was admitted to the facility on [DATE] and then readmitted on [DATE] with diagnoses including gastrostomy malfunction and encounter for attention to gastrostomy. During a review of Resident 47's History and Physical, dated 7/26/2023, the history and physical indicated Resident 47 does not have the capacity to understand and make decisions. (continued on next page)

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	06/11/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/8/2024 at 4:17 p.m., outside of Resident 47's room, a sign was posted for Enhanced Precautions. During an observation on 6/8/2024 at 4:17 p.m., LVN 5 prepared and administered one medication for Resident 47 via g-tube. LVN 5 did not wash hands before and after administering medication via g-tube to Resident 47. During an interview on 6/8/2024 at 7:23 p.m. with LVN 5, LVN 5 stated he would usually wash hands at the end of medications administration. LVN 5 stated he did not wash hands after g-tube administration of medications and in between patients. LVN 5 stated, it was important to perform hand hygiene as required to protect patients, to protect himself from any infections, because the resident had patient has an opening (for the g-tube) and so Resident 47 health can be compromised with an infection. During an interview on 6/10/2024 1:38 p.m., with the Director of Nurses (DON), the DON stated, that facility staff was supposed to wash hands before and after g-tube medication administration, otherwise it can lead to cross-contamination and infection the G-tube is an open device into the resident and that increases the risk for infection in residents being treated and other residents in the facility. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 9/2/2022, the P&P indicated, Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE under Standard Precautions section. The P&P indicated All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment under Equipment Protocol section. During a review of the facility's policy and procedure (P&P) titled, Hand Hygiene, revised 12/19/2022, the P&P indicated, Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Policy Explanation and Compliance Guidelines . 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table . Between resident contacts . After handling contaminated objects . Before applying and after removing personal protective equipment (PPE), including gloves . Before and after providing care to residents in isolation . After assistance with personal body functions (e.g., elimination, hair grooming, smoking) .6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. (continued on next page)

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	06/11/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, revised 4/22/2024, the P&P indicated, Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multi drug-resistant organisms .Policy Explanation and Compliance Guidelines: 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available prior to performing task. Note: Face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities .e. The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education .4. High-contact resident care activities include a. Dressing b. Bathing/Shower c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting .5. Enhanced Barrier Precautions/Enhanced Standard Precaution should be followed outside the resident's room when performing transfers and assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating. During an interview on 6/11/2024, at 3:48 p.m., with Director of Nursing (DON), the DON stated, staff should have washed or sanitized their hands before and after caring the resident to control spreading infection. The DON stated, she would work with IPN to cohort EBP residents together and provide in-service to staff regarding EBP to prevent cross-contamination. During an interview on 6/7/2024, at 9:04 a.m., with Infection Preventionist Nurse (IPN), the IPN stated, hand washing was important to prevent spreading infection. IPN stated, hand washing was the first line of defense from microorganisms (An organism that can be seen only through a microscope). The IPN stated, PPE should be worn before caring for residents who are on enhanced precautions.

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	06/11/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44898 Based on interview and record review the facility failed to ensure one of 18 sampled residents (Resident 47) received the pneumonia (an infection that inflames the air sacs in one or both lungs) vaccine (a substance introduced into the system to help the body fight against infections). This failure resulted in enhancing the potential for Resident 47 developing pneumonia and getting hospitalized on [DATE] and again on 5/6/2024. During a review of Resident 47's Admission Record, the admission record indicated Resident 47 was originally admitted to the facility on [DATE] with diagnoses of but not limited to contractures (permanent shortening of muscle fibers, leading to muscle and joint stiffness), tachycardia (an abnormal heart rate over 100 beats a minute), dysphagia (difficulty in swallowing), and anoxic brain damage (damage to the brain due to a lack of oxygen supply). During a review of Resident 47's History and Physical (H&P), dated 7/26/2023, the H&P indicated, Resident 47 does not have the capacity to understand and make decisions. During a review of Resident 47's Minimum Data Set (MDS-a standardized assessment and care planning tool), dated 5/16/24, the MDS indicated Resident 47 was dependent on nursing staff for eating, oral hygiene, toileting, showering, dressing, personal hygiene, and repositioning from left to right. The MDS indicated Resident 47 did not attempt to reposition himself from sitting to lying, sitting to standing transferring to a chair due to medical condition or safety concerns. The MDS indicated Resident 47 did not attempt to walk or put on or take off footwear because the resident did not perform these activities prior to the current illness, exacerbation, or injury. During a review of Resident 47's Order Summary Report, dated 5/9/2023, the Order Summary Report indicated a Physician order for pneumococcal vaccine (PNA vaccination). During a review of Resident 47's Order Summary Report, dated 6/28/2023, the Order Summary Report indicated a Physician order for pneumococcal vaccine (PNA vaccination). During a review of Resident 47's Order Summary Report, dated 9/27/2023, the Order Summary Report indicated, a transfer to GACH via 911 for a diagnosis of shortness of breath (SOB) and desaturation (low blood oxygen levels). During a review of Resident 47's GACH records, dated 10/4/2023, the GACH records indicated, Resident 47 had right lower lobe aspiration pneumonia. (continued on next page)

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	06/11/2024

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview on 6/7/2024 at 10:30 a.m. with the Infection Prevention Nurse (IPN) and review of Resident 47's Order Summary Report dated 9/27/2023, the IPN stated on 9/27/2023 Resident 47 was transferred to the GACH (General Acute Care Hospital) in respiratory distress for coughing and being unable to expectorate (inability to eject waste from the throat and lungs) and was diagnosed with pneumonia. The IPN stated Resident 47 returned back to the facility from the GACH on 10/5/2023. The IPN stated there is no documentation of Resident 47 being offered the pneumonia vaccine and should have been offered the pneumonia vaccine upon admission, weekly or monthly. The IPN stated on 5/6/2024 Resident 47 had a chest x-ray (an electronic picture of bones and various tissue) done and the chest x-ray indicated Resident 47 had right upper lobe pneumonia and was started on an antibiotic (antiinfection) medication Levaquin on 5/7/2024 to treat pneumonia. During an interview on 6/7/2024 at 10:50 a.m. with the IPN, the IPN stated Resident 47's physician ordered the pneumonia vaccine on 5/9/2023, 10/5/2023, and 5/31/2024. The IPN stated the licensed nurses are responsible for following up on vaccine orders. The IPN stated there is no documentation in Resident 47's chart of why the pneumonia vaccine was not given and no documentation on the MAR that Resident 47 received the pneumonia vaccine until today (6/7/2024). The IPN stated if the pneumonia vaccine is not offered or given to the residents, the residents are at risk for developing pneumonia and Resident 47 did develop pneumonia twice and had to be transferred to the GACH on one of the occasions. During an interview with the DON on 6/11/2024 at 2:45 p.m., the DON stated if residents are not offered and do not receive the vaccine for pneumonia it places them at a higher risk for developing pneumonia. The DON stated Resident 47 had a high risk for developing pneumonia due to having a g-tube (a feeding tube used to provide nutrition to people who cannot obtain nutrition by mouth), immobility, CVA (interruption of blood flow or bleeding in a region of the brain) and dysphagia. The DON stated Resident 47 has a history of pneumonia and she does not know why Resident 47 did not receive his pneumonia vaccination until 6/7/2024. During a review of the facility's policy and procedure (P&P) titled, Pneumococcal Vaccine (Series), dated 9/2/2022, the P&P indicated Each resident will be assessed for pneumococcal immunization upon admission. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated, or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders A pneumococcal vaccination is recommended for all adults [AGE] years' and older A pneumococcal vaccination is recommended for adults 19 to [AGE] years' old who have certain chronic medical conditions or other risk factors which may include chronic lung disease, including COPD, emphysema, and asthma.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055758	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER Cottage Crest Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on observation, interview, and record review the facility failed to ensure 33 of 33 resident rooms met the requirements of 80 square feet ([sq. ft.] a unit of area measurement) per residents in multi-bed resident rooms. This deficient practice had the potential to result in an inadequate provision of safe nursing care, and privacy for the residents. Findings: During a review of the facility's Client Accommodations Analysis form, provided by the facility on 6/4/2024, the facility had 33 rooms that measured less than 80 sq. ft. per resident in multi-bedrooms and two rooms that measured less than 100 sq. ft for a single bedroom. The resident rooms were as follow: room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055758	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER Cottage Crest Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER](2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (2 beds) 143.75 sq. ft. room [ROOM NUMBER] (3 beds) 220.00 sq. ft. During an interview on 6/4/2024 at 4:14 p.m., with the Administrator (ADM), ADM stated he was aware of the recommendation of 80 sq. ft. per resident in multiple resident rooms. ADM stated the regulations specify room sq. ft to ensure residents have a home-like environment, are treated with dignity, and to alleviate any safety concerns. The ADM stated he had approved room waiver on 7/31/2023. During a review of the facility's Room Waiver Letter dated on 7/20/2023, the Room Waiver Letter indicated, it was approved on 7/31/2023. During a concurrent interview and record review 6/5/2024 at 3:00 p.m., with ADM, Room Waiver Letter dated on 6/5/2024 was reviewed. Room waiver request letter was faxed to California Department of Public Health (CDPH) region 3 office on 6/5/2024 at 9:17 a.m. ADM stated, he faxed new request for current year. (continued on next page)

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	06/11/2024

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During observations, from 6/4/2024 through 6/11/2024, the residents residing in these rooms had enough space to move freely inside the rooms. Each resident in the above rooms had beds and side tables with drawers. There was adequate room for the operation and use of wheelchairs, walkers, or canes. Resident room size did not affect the nursing care or privacy provided to the residents. During a review of the facility's policy and procedure (P&P) titled, Resident Rooms, revised 12/19/2022, the P&P indicated Resident bedrooms must be designed and equipped for adequate nursing care, comfort and privacy of residents. Policy Explanation and Compliance Guidelines .2. Resident bedrooms will measure at least 80 square feet per resident in multiple resident bedrooms .9. The facility shall request and/or maintain variances from the survey agency if the room variances.