

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055918	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/26/2024
NAME OF PROVIDER OR SUPPLIER  Villa Del Sol Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  16910 Woodruff Ave. Bellflower, CA 90706	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425</b></p> <p>Based on interview, and record review, the facility failed to ensure a resident, who underwent a right total knee replacement (a surgical procedure to replace damaged parts of the knee joint with artificial parts to relieve pain and improve movement) and complained of a pain level of eight out of 10 on a pain rating scale from a zero to 10 (an 11 eleven point scale where pain is rated from zero to 10; 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain) was medicated for pain for one out of three sampled residents (Resident 1).</p> <p>The facility failed to:</p> <ol style="list-style-type: none"> <li>1. Ensure Resident 1 received Oxycodone-Acetaminophen (a medication used to help relieve moderate to moderately severe pain) 5-325 milligrams ([mg] a metric unit of measurement, used for medication dosage and/or amount), when she complained of a pain level of eight out of 10 on a pain rating scale from zero to 10.</li> <li>2. Ensure the keys to the medication cart were endorsed to a licensed nurse during the 11 p.m., to 7 a.m., shift and not locked in a medication room where licensed nurses could not access them after a Registered Nurse Supervisor (RNS 1) left the facility and took the keys to the medication room with him.</li> <li>3. Contact Resident 1's physician and/or the facility's pharmacy to request access to the facility's Emergency Kit ([E-Kit] a kit containing a small supply of medication that can be dispensed when medication was not available) to obtain pain medication to administer to Resident 1.</li> <li>4. Ensure licensed nurses contacted the Director of Nursing (DON), for instructions on how to access the medication keys, when Resident 1 complained of a pain level of eight out of 10 and they were unable to access Resident 1's prescribed pain medication in the facility's medication cart and/or the E-Kit after RNS 1 took the supervisor's keys with him when he left the facility.</li> <li>5. Ensure Licensed Vocational Nurse 1 (LVN 1), when she was made aware of Resident 1's complaint of pain, assessed Resident 1's pain level and implemented interventions, such as talking to her in a soothing tone to deescalate her anxiety and reassure her, that her needs would be met, to minimize and/or relieve Resident 1's pain, according to Resident 1's care plan.</li> </ol> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055918
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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>These deficient practices resulted in Resident 1 experiencing increased, and unrelieved severe pain for over two hours, Resident 1 became angry, and her anxiety level was through the roof as she was pacing in the hallways of the facility trying to find the licensed nurse who had the medication cart key.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with the diagnosis including right knee osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), a right artificial knee joint (a man-made joint that replaces a damaged knee joint), major depressive disorder ([MDD] a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).</p> <p>During a review of Resident 1's Minimum Data Set ([MDS] a Federally mandated resident assessment tool) dated 9/7/2024, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and Resident 1 required supervision or touch assistance (the helper provides verbal cues and/or touching/steadying as the resident completes activity) to complete activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a review of Resident 1's Physician's Orders dated 11/30/2023, the Physician's Orders indicated Resident 1 was to receive Oxycodone-Acetaminophen 5-325 mg, two tablets, every four hours as needed for severe pain (8-10).</p> <p>During a review of Resident 1's Care Plan dated 9/5/2024, the Care Plan indicated Resident 1 had panic attacks due to overwhelming stressors related to the fear of not getting her controlled, as needed, every four hours pain medication as evidenced by claimed hyperventilation (rapid or deep breathing, usually caused by anxiety or panic), palpitations (abnormally rapid or irregular beating of the heart usually caused by panic, agitation, or exercise), and dizziness. Under this care plan goals were set for Resident 1 to demonstrate a reduced anxiety (feelings of fear, dread, and uneasiness that may occur as a reaction to stress) level as evidenced by controlled breathing, reduced heart rate, and verbalization of feelings. The care plan's interventions included ensuring as needed pain medications were available when needed to manage Resident 1's pain and to provide reassurance to deescalate the situation, speak in a calm and soothing tone, and reassure Resident 1 that her needs would be met.</p> <p>During a review of Resident 1's Medication Administration Record [(MAR] a record used to document medications taken by each individual) dated 9/2024, the MAR indicated on 9/15/2024 at 1:30 a.m. Resident 1 complained of a pain level of eight out of 10 and was administered two tablets of Oxycodone-Acetaminophen 5-325 mg.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/24/2024 at 10:17 a.m., Resident 1 stated on 9/14/2024, she pressed her call light around 11:40 p.m., because her pain was between 8-9 out of 10. Resident 1 stated she saw Certified Nursing Assistant 1 (CNA 1) in the hallway and told CNA 1 that she was in pain and wanted her pain medication. Resident 1 stated CNA 1 told her, she (CNA 1) would inform one of the licensed nurses that she (Resident 1) was in pain. Resident 1 stated no nurse came to her room and she became impatient, so she walked to the Nursing Station II, to request pain medication and was told by LVN 2 and RNS 2 that her assigned nurse (LVN 1) was busy with another resident. Resident 1 stated RNS 2 told her that she (RNS 2) could administer the pain medication to her (Resident 1). Resident 1 stated by 12 a.m., RNS 2 had not come back to her room with her pain medication, so around 12:30-12:35 a.m., she (Resident 1) decided to sit at the Nursing Station II and wait. Resident 1 stated approximately 18 minutes later RNS 1 entered the facility, and she (Resident 1) observed RNS 1 give the keys to the medication cart to LVN 1. Resident 1 stated she received her pain medication at 1:45 a.m., (over two hours after she requested it on 9/14/2024 at 11:40 p.m.). Resident 1 stated by the time she finally receive her medication her pain had increased to 10 out of 10 and her anxiety was through the roof because of her pain, waiting for someone to give her, her pain medication and wondering when she would receive the pain medication.</p> <p>During a phone interview on 9/25/2024 at 4:06 p.m., CNA 1 stated on 9/14/2024 (she could not remember the time), Resident 1 kept complaining that she was in pain and how it was taking the licensed nurses a long time to respond. CNA 1 stated she reported to the licensed staff a couple of times that Resident 1 was upset because she was in pain and wanted pain medication. CNA 1 stated there were no licensed nurses available to give Resident 1 pain medication and RNS 1, who had the key to the medication cart, was not at the facility. CNA 1 stated she saw Resident 1 in the hallway, upset, because she (Resident 1) was told LVN 1 was the only one who could give her (Resident 1) medication, because she (LVN 1) had the keys to the medication cart, but LVN 1 was not available.</p> <p>During a telephone interview on 9/25/2024 at 4:16 p.m., RNS 1 stated on 9/14/2024, during the 3 p.m., to 11 p.m., to the 11 p.m., to 7 a.m., change of shift, he was given keys by RNS 2, but stated he did not check to see what the keys were for and he left them locked in the medication room when he left the facility to get supplies from another facility. RNS 1 stated LVN 1 called him on his cell phone looking for the keys to the medication cart, and that was when he realized the supervisor's key, that opened the medication room, the Director of Nursing's (DON) office, and the supply room, were in his pocket. RNS 1 stated when he returned to the facility, Resident 1 was sitting at the nurses' station, she was upset and waiting for her pain medication. RNS 1 stated Resident 1 should not have had to wait for pain medication for over two hours.</p> <p>During an interview on 9/26/2024 at 5:59 a.m., LVN 1 stated on 9/14/2024, she came to work late, and started her shift at 12:54 a.m., (9/15/202), she was told that RNS 1 had the keys to the medication cart, but RNS 1 was not at the facility. LVN 1 stated she called RNS 1 around 1:13 a.m., and again at 1:14 a.m., to ask him about the keys to the medication room and the medication cart because Resident 1 was in pain and was asking for pain medication. LVN 1 stated she could have given Resident 1 pain medication from the facility's E-Kit, but she did not have access to the E-Kit because it was located in the medication room, which was locked and RNS 1 had the keys to the medication room. LVN 1 stated when Resident 1 came to Nursing Station II, she was upset and stated she had been in excruciating pain (pain that is extremely painful, causing intense suffering, or unbearably distressing) since 11 p.m., (9/14/2024).</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 9/26/2024 at 8:26 a.m., LVN 2 stated on 9/14/2024 after 11 p.m., she overheard Resident 1 asking for pain medication and observed Resident 1 at Nursing Station II (time is unknown), yelling at RNS 1, when RNS 1 returned to the facility, about the medication cart key and her pain medication. LVN 2 stated Resident 1 was ballistic (extremely and usually suddenly excited, upset, or angry) and very unhappy with RNS 1. LVN 2 stated Resident 1 not receiving her pain medication when she (Resident 1) complained of pain could have been avoided if RNS 1 had not taken the keys to the medication room with him when he left the facility.</p> <p>During an interview on 9/26/2024 at 9 a.m., the DON stated during change of shift, the licensed nurses count the narcotics in the medication cart and the keys to the medication cart are given to the oncoming licensed nurse. The DON stated on 9/14/2024, LVN 1 began her shift late (9/15/2024 at 12:54 a.m.) and RNS 1 had the supervisor's keys with him when he left the facility. The DON stated the facility staff should have notified her if they had a problem opening the medication room, because the other LVN, who was at the facility, had the keys that could have opened the medication room, and if they did not know that she could have told them, or the facility staff could have called the physician and pharmacy to open the E-kit. The DON stated Resident 1 should not have had to wait over two hours for pain medication, and this caused Resident 1's pain and increased anxiety when the resident could not get her medication.</p> <p>During a review of the facility's policy and procedure (P/P) titled Pain Management dated 12/19/2022, the P/P indicated in order to help a resident attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being and to prevent or manage pain the facility will manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goal and preferences.</p>		