STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056042	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Vista Healthcare & Wellness Centre, LP	5901 Downey Ave Long Beach, CA 90805

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 - Some	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** 49606 Based on interview and record review, the facility failed to ensure a resident, who had anxiety (an emotional state that involves feelings of fear, dread and uneasiness), and had Ativan (a medication used to treat anxiety) 1 milligram ([mg] a unit of measurement) to control their anxiety, was provided antianxiety medication, for one of five sampled residents (Resident 1). The facility failed to: 1. Ensure licensed nurses ordered a refill of Ativan 1 mg for Resident 1 ' s anxiety before the medication ' s quantity was depleted. 2. Ensure Resident 1 received Ativan for anxiety, as ordered by Resident 1 ' s physician. 3. Ensure licensed nurses contacted Resident 1 ' s MD 1 to obtain authorization to access the facility ' s emergency kit ([E-Kit] a kit which contains a small quantity of medications which can be dispensed when pharmacy services are not available) containing Ativan 1 mg to administer to Resident 1. 4. Ensure the licensed nurses followed the facility ' s policy and procedure (P&P) titled, Medication Ordering and Receiving from Pharmacy, to reorder medication five days in advance of need to assure an adequate supply is on hand and use the E-Kit as applicable when medication was depleted, to administer to Resident 1. 5. Ensure the licensed nurses followed the facility ' s P&P titled, Medication Orders, to notify Resident 1 ' s MD 1 for direction when the medication was not available. 6. Ensure the licensed nurses followed the facility ' s P&P titled, Medication Administration, indicating medications and treatments will be administered as prescribed. These failures resulted in Resident 1 missing seven doses of Ativan and had the potential for Resident 1 to exhibit behaviors from missed medications such as feelings restlessness, irritability, poor concentration and trouble sleeping. Findings: (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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 diagnoses including anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), schizoaffective disorder (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disorder (a mental illness that causes extreme mood swings. During a review of Resident 1 ' s History and Physical (H&P), dated [DATE] indicated Resident 1 had capacity to consent unless exacerbation of schizoaffective disorder and bipolar disorder. During a review of Resident 1 ' s Minimum Data Set ([MDS] a federally mandated resident assessment tool) dated [DATE], the MDS indicated Resident 1 had severe cognitive (though process) impairment. During a review of Resident 1 ' s Order Summary Report (Physician ' s Orders), dated [DATE], the physician ' s orders indicated Resident 1 was to receive Ativan 1 milligram ([mg] unit of measurement) every 12 hours for anxiety manifested by inability to relax, scheduled at 6 a.m. and 6 p.m. During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications given to a resident) dated ,d+[DATE], the MAR indicated Resident 1 ' s Ativan 1 mg doses scheduled for [DATE] at 6 p.m., on [DATE] at 6 p.m., [DATE] at 6 a.m., [DATE] at 6 a.m. and 6 p.m., and on [DATE] at 6 a.m. and 6 p.m., were not administered. The MAR indicated the licensed nurses documented the medication was unavailable, pending pharmacy delivery and/or Resident 1 ' s physician (MD 1) preauthorization was pending prescription renewal. During an interview on [DATE] at 3:32 p.m., LVN 3 stated she did not administer Resident 1 ' s Ativan on [DATE] at 6 p.m. because it was pending pharmacy delivery. LVN 3 stated she did not obtain an Ativan from the E-Kit, call the pharmacy to follow-up, nor notify Resident 1 ' s MD 1 of the preauthorization needed to renew the prescription. During a phone interview on [DATE] at 1:33 p.m., LVN 5 stated she did not administer Resident 1 ' s Ativan on [DATE] at 6 p.m. because it was not available was pending delivery from the pharmacy. LVN 5 stated she should have followed-up with the pharmacy and requested access from the E-Kit to administer the Ativan to Resident 1. LVN 5 stated she did not inform Resident 1 ' s provider to requested preauthorization needed to renew the prescription. During a phone interview on [DATE] at 3:15 p.m., the Pharmacy Supervisor (PS) 1 stated there was an order placed for Resident 1 ' s Ativan on [DATE] at 4:42 a.m. and six doses were delivered at 5:53 a.m. PS 1stated the reason why the facility only receive six doses was because that was the amount available on Resident 1 ' s prescription. PS 1 stated that since Resident 1 ' s prescription had expired it was going to require a provider preauthorization for a renewal to be approved. PS 1stated it is the facilities responsibility to obtain the preauthorization from the Resident ' s provider then fax it to the pharmacy. PS 1stated the pending preauthorization for Resident 1 wasn ' t faxed by the facility until [DATE]. During a phone interview on [DATE] at 3:36 p.m., LVN 4 stated Resident 1 ' s Ativan was not administered on [DATE] because the medication was ordered from the pharmacy and pending delivery. LVN 4 stated it was not his job to follow up with MD 1 to obtain the preauthorization for the prescription renewal. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on [DATE] at 10:54 a.m., LVN 7 stated she documented on [DATE] that she did not administer Resident 1 ' s Ativan because it needed the preauthorization by MD 1. LVN 7 stated on [DATE] at 6 p.m. and [DATE] 6 p.m. dose that she did not administer Resident 1 ' s Ativan because it was not available from the pharmacy. LVN 7 stated she did not inform the provider for the preauthorization needed for the prescription renewal because the providers clinic was closed, and she did not think it was an emergency. LVN 7 stated she endorsed it to next shift and documented in the communication board to follow-up with the pharmacy. LVN 7 stated that documenting in the communication board is for internal communication only and she should have documented it in a nursing progress note. LVN 7 stated that Resident 1 should not have gone without his medication as prescribed and that she should have notified Resident 1 ' s MD 1 as per facilities policy and procedure. During an interview on [DATE] at 11:16 a.m., Registered Nurse Supervisor (RNS) 1 stated that resident ' s medication should always be available for administration. The process of ordering a refill should start before running out of the resident ' s medication. RNS 1 stated that the pharmacy informs the facility staff of the need of a preauthorization for prescription renewal. It is the license nurse responsibility for obtaining the providers preauthorization and then fax it to the pharmacy, so the medication is delivered on a timely manner. If the licensed nurse cannot get a hold of the resident ' s provider, they can get in contact with the medical director (MD) as per facilities policy. RNS 1 stated that the license nursing staff should also notify the Registered Nurse Supervisors and the Director of Nursing (DON) if experiencing any delays. RNS 1 stated that the communication board is not to be used to document the process of obtaining a preauthorization from a provider nor the physician because the communication board is only for internal use, meaning it is not part of the resident ' s chart. RNS 1 stated that the license nurses had the option of using the e-kit and had no idea why the license nursing staff did not opt on using it. RNS 1 stated that Resident 1 should not have missed seven doses of Ativan, and it was not administered as prescribed. During an interview on [DATE] at 11:50 a.m., the DSD stated that the process of ordering a medication renewal or refill should start when there are five pills left in the bubble pack (packaging in which the medication is sealed between cardboard backing and a clear plastic cover). The DSD stated that the pharmacy is notified that the facility needs a refill via a click system the license nursing staff have or if it ' s a controlled substance the license nursing staff should obtain a preauthorization from the resident ' s provider. DSD stated that it is the license nursing staff responsibility to obtain the authorization on a timely manner, if not the license nursing staff know to notify the physician. The DSD stated this process should be documented in a progress note and not in the communication board because the communication board is only for internal use, and it is not part of the resident ' s chart. DSD stated to not know why the license nursing staff obtaining Resident 1 ' s Ativan from the e-kit when they are trained how to utilize their resources, and the e-kit is one of them. The DSD stated she could not find any documentation in Resident 1 ' s medical record that MD 1, nor the MD were notified for the need of a preauthorization for the prescription renewal. The DSD stated that there is no excuse for Resident 1 not getting his Ativan as prescribed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 2:30 p.m., the Administrator (ADM) stated the facilities process in obtaining a prescription renewal for a controlled substance is the license nursing staff ' s responsibility. It is obtained by notifying the residents provider that a preauthorization is needed for the prescription renewal. If this can ' t be done on a timely manner, the next step is for the license nursing staff to notify the MD. The ADM stated she had no idea why the license nursing staff did not access the E-Kit. The ADM stated that she did not find any documentation on Resident 1 ' s chart that any of these steps were followed as per facility ' s policies and procedures. The ADM stated, the license nursing staff should not be documenting resident related information in the communication board because this is used for internal communication, and it is not part of the resident ' s chart. The ADM stated that Resident 1 should not have missed any of his scheduled doses for Ativan and the medication should have been administered on time. During a review of the facility ' s P&P titled, Medication Orders, dated ,d+[DATE], the P&P indicated the prescriber is contacted for direction when the medication will not be available. During a review of the facility ' s P&P titled, Medication Administration, revised [DATE], the P&P indicated medications and treatments will be administered as prescribed to ensure compliance with dose guidelines. During a review of the facility ' s P&P titled, Medication Ordering and Receiving from Pharmacy, dated , d+[DATE], the P&P indicated when an emergency or state of medication is needed, the nurse unlocks the container and removes the required medication. After removing the medication, complete the emergency e-kit slip and re-seal the emergency supply. An entry is made in the emergency logbook containing all required information. Medications, and related products are received from the dispensing pharmacy on a timely basis. Reorder medication five days in advance of need to assure an adequate supply is on hand. The emergency kit or emergency drug supply as applicable is used when the resident needs a medication prior to pharmacy delivery. Schedule II controlled medications prescribed for a specific resident are delivered to the facility on ly if a written prescription has been received by the pharmacy prior to dispensing. A follow up written prescription is sent to the provider pharmacy by the prescriber.