STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056149	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Healthcare and Rehabilitation Center	6700 Sepulveda Blvd. Van Nuys, CA 91411

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 38469 Based on observation, interview, and record review, the facility failed to ensure the window screen was affixed to the frame and did not have gaps or openings from top to bottom for one of 18 resident's room (Room A) investigated under physical environment. This deficient practice had the potential to result in insect infestation that could pose harm to the residents. Findings: During the initial facility tour and room observation on 5/28/2024 at 11:37 a.m., observed Room A occupied by three residents. Upon closer observation of the room environment, observed one panel of the window screen was not affixed on the window frame creating a gap or opening from top to bottom measuring half an inch. During a concurrent observation and interview on 5/29/2024 at 11:46 a.m., with the Assistant Director of Nursing (ADON), the ADON verified the observation by stating there was a gap on the window screen of Room A. The ADON stated staff frequently conduct room inspections to ensure the environment is safe for the residents. The ADON stated that they make sure rooms are clutter free and free from insect infestations. The ADON stated that if the screens are not tightly sealed to the frame or there are openings, it could pose a potential hazard to the occupants if insects can gain access to the inside of the rooms. The ADON stated that she will have maintenance fix the window screens. A review of the facility's policy and procedure, titled Maintenance Service, last reviewed on 10/17/2023, indicated, The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .

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: 056149	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549 Based on interview and record review, the facility failed to complete a resident's Admission Minimum Data Set (MDS - a standardized assessment and care screening tool) timely for one of 37 sampled residents (Resident 172). This deficient practice had the potential to delay care and services for the resident. Findings: A review of Resident 172's Admission Record indicated the facility admitted the resident on 1/5/2024 with diagnoses including osteoarthritis (a chronic condition that occurs when flexible tissue at the ends of bones wears down) of the right hip and aftercare following joint replacement surgery (procedure in which a surgeon removes a damaged joint and replaces it with a new one). A review of Resident 172's Admission MDS, dated [DATE], indicated the resident had intact cognition (thought processes) and was dependent on staff for most activities of daily living (ADLs - activities related to personal care). During a concurrent interview and record review on 5/29/2024 at 2:58 p.m., with Minimum Data Set Nurse 1 (MDS Nurse 1), reviewed Resident 172's Admission MDS dated [DATE]. MDS Nurse 1 stated that the MDS assessment was not completed until 1/26/2024, which was 21 days after Resident 172's admitted . MDS Nurse 1 stated that timely completion of the assessment was important because it affected the establishment of the resident's plan of care. During an interview on 5/30/2024 at 12:48 p.m., with MDS Nurse 1, when asked what policy he followed regarding the schedule for completing MDS assessments, MDS Nurse 1 stated the facility did not have a policy but that he followed the MDS Resident Assessment Instrument (RAI) Manual. During an interview on 5/30/2024 at 2:38 p.m., with the Director of Nursing (DON), the DON stated it was important to complete the resident's Admission MDS timely because it allowed the facility to get a clearer picture of the resident's needs and plan of care. A review of the Centers for Medicare and Medicaid Services (CMS- a federal agency within the United States Department of Health and Human Services [HHS] that administers the Medicare program) RAI 3.0 Manual dated 10/2023, indicated that, for an Admission MDS, the MDS completion date should be no later than the 14th calendar day of the resident's admitted .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549 Based on interview and record review, the facility failed to create and transmit a Discharge Minimum Data Set (MDS - a standardized assessment and care screening tool) upon a resident's discharge on 1/19/20204 for one of 37 sampled residents (Resident 172). This deficient practice had the potential to delay care and services for the resident. Findings: A review of Resident 172's Admission Record indicated the facility admitted the resident on 1/5/2024 with diagnoses including osteoarthritis (a chronic condition that occurs when flexible tissue at the ends of bones wears down) of the right hip and aftercare following joint replacement surgery (procedure in which a surgeon removes a damaged joint and replaces it with a new one). A review of Resident 172's MDS, dated [DATE], indicated the resident had intact cognition (thought processes) and was dependent on staff for most activities of daily living (ADLs - activities related to personal care). During a concurrent interview and record review on 5/29/2024 at 2:58 p.m., with Minimum Data Set Nurse 1 (MDS Nurse 1), reviewed Resident 172's MDS dated from 1/5/2024 to 2/2/2024. MDS Nurse 1 stated that Resident 172 was discharged from the facility on 1/19/2024. MDS Nurse 1 stated he just realized today that the resident did not have a Discharge MDS completed. MDS Nurse 1 stated the facility should have completed a Discharge MDS by 2/2/2024, within 14 days after the discharge date and should have transmitted the Discharge MDS to Centers for Medicare and Medicaid Services (CMS- a federal agency within the United States Department of Health and Human Services [HHS] that administers the Medicare program) within 14 days after the completion of the MDS. MDS Nurse 1 stated it was important to complete and transmit a Discharge MDS for the resident because it reflected the resident's status upon leaving the facility. MDS Nurse 1 stated the Discharge MDS showed if the resident improved or declined during their stay in the facility. During an interview on 5/30/2024 at 12:48 p.m., with MDS Nurse 1, when asked what policy he followed regarding the schedule for completing MDS assessments, MDS Nurse 1 stated the facility did not have a policy but that he followed the MDS Resident Assessment Instrument (RAI) Manual. During an interview on 5/30/2024 at 2:38 p.m., with the Director of Nursing (DON), the DON stated it was important to have a Discharge MDS upon a resident's discharge in order to accurately track the resident. The DON stated it also showed whether the resident improved or declined during their stay in the facility. A review of the CMS RAI 3.0 Manual, dated 10/2023, indicated that, for a Discharge MDS, the MDS assessment should have been completed no later than the discharge date + 14 calendar days and transmitted within 14 days after the MDS completion date.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 38469 Based on interview and record review, the facility failed to ensure a resident had a comprehensive care plan (a written document that summarizes a patient's needs, goals, and care/treatment) addressing the use of insulin (a hormone that lowers the level of glucose [sugar] in the blood) for one of one sampled resident (Resident 57) investigated for insulin use. This deficient practice had the potential to result in failure to deliver the necessary care and services. Findings: A review of Resident 57's Admission Record indicated the facility initially admitted the resident on 10/27/2014 and readmitted the resident on 3/5/2024 with diagnoses that included muscle weakness, type two (2) diabetes mellitus (DM- a chronic condition that affects the way the body processes blood glucose [sugar]), and gastro-esophageal reflux disease (stomach contents flow backward, up into the esophagus, the tube that carries food from your throat into stomach). A review of Resident 57's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 4/14/2024, indicated the resident had the capacity to make self-understood and the capacity to understand others. The MDS indicated the resident is totally dependent on staff for activities of daily living (ADLs- activities related to personal care). A review of Resident 57's physician's orders indicated the following orders: - Insulin aspart (rapid-acting insulin) injection solution 100 unit/milliliter (U/ml- unit of measurement) inject as per sliding scale (progressive increase in the insulin dosage, based on pre-defined blood glucose ranges) subcutaneously (SQ - administering medication where a short needle is used to inject a medication into the tissue layer between the skin and the muscle) before meals and at bedtime for hyperglycemia (high blood sugar), ordered 4/2/2024. - Insulin glargine solution 100 U/ml, inject nine (9) units subcutaneously at bedtime, ordered 3/5/2024. During a concurrent interview and record review on 5/29/2024 at 11:01 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 57's physician's orders and care plans dated 3/5/2024 to 5/29/2024. The ADON stated that Resident 57 is currently on insulin therapy for his diabetes mellitus diagnosis and stated Resident 57 did not have a care plan for insulin therapy. The ADON stated that for resident's on insulin therapy, there has to be a care plan identifying the resident's problem and risks, such as hypoglycemia (condition in which the body's blood sugar level goes below the standard range) and hyperglycemia. The ADON stated that a care plan for residents on insulin therapy would indicate the resident`s current condition, the goals and objectives and intervention to attain the stated goals and timeframe of when to evaluate if the care plan is effective or if the resident is progressing and meeting his treatment goals. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, The Resident Care Plan, last reviewed on 10/17/2023, indicated, The Resident Care Plan shall be implemented for each resident on admission and developed throughout the assessment process. Healthcare professionals involved in the care of the resident shall contribute to the resident's written care plan .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. 38549 Based on interview and record review, the facility failed to: 1. Ensure licensed nurses attempted non-pharmacological interventions (any type of healthcare intervention which is not primarily based on medication) prior to administering narcotic pain medication (also known as opioids, a class of drugs that treat moderate to severe pain) to one of 37 sampled residents (Resident 11). This deficient practice had the potential to place the resident at increased risk of experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention). 2. Ensure one of one sampled resident (Resident 179), who was at risk for pain, received care and services in accordance with professional standards of practice by failing to provide pain medication as ordered by the physician. This deficient practice had the potential to result in Resident 179 experiencing unrelieved pain. Findings: 1. A review of Resident 11's Admission Record indicated the facility originally admitted the resident on 9/27/2017 and readmitted the resident on 12/28/2023 with diagnoses including fracture (broken bone) of the left femur (thigh bone). A review of Resident 11's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/16/2024, indicated the resident had intact cognition (thought processes) and was dependent on staff for most activities of daily living (ADLs - activities related to personal care). During a concurrent interview and record review on 5/30/2024 at 10:02 a.m., with Minimum Data Set Nurse 1 (MDS Nurse 1), reviewed Resident 11's physician's orders and Medication Administration Record (MAR - a report detailing the drugs administered to a patient by a healthcare professional) dated 5/2024. MDS Nurse 1 stated for Resident 11's pain, the physician prescribed the following medications: - Acetaminophen (medication used to relieve mild pain or reduce fever) 325 milligrams (mg - unit of measurement) via gastrostomy tube (g-tube - an opening to the stomach from the abdominal wall made surgically for the introduction of food and medication) two times a day for generalized pain management and ADLs, ordered on 4/3/2024. - Hydrocodone-acetaminophen (medication used for moderate to severe pain) 10-325 mg via g-tube every eight (8) hours as needed for severe pain 7-9/10 (numerical scale used to measure pain with 0 being no pain and 10 being the worst pain), ordered on 5/14/2024. - Hydrocodone-acetaminophen 5-325 mg via g-tube every six (6) hours as needed for moderate pain, ordered on 5/12/2024. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Acetaminophen 325 mg two tablets via g-tube every 6 hours as needed for mild pain (1-3), ordered on 4/3/2024. MDS Nurse 1 stated Resident 11 received hydrocodone-acetaminophen 5-325 mg as needed on the following dates and times: - 5/12/204 at 9:58 a.m. and 4:34 p.m. - 5/13/2024 at 2:35 a.m. and 9:30 a.m. - 5/14/2024 at 1:00 a.m., 10:00 a.m., and 9:47 p.m. - 5/15/2024 at 7:19 a.m. - 5/16/2024 at 1:15 a.m., 8:20 a.m., and 7:08 p.m. - 5/17/2024 at 4:02 p.m. and 10:39 p.m. - 5/18/2024 at 8:20 a.m. - 5/19/2024 at 5:00 a.m., 11:30 a.m., and 10:00 p.m. - 5/20/2024 at 2:00 a.m. and 4:22 p.m. - 5/21/2024 at 1:06 a.m., 8:30 a.m., and 4:09 p.m. - 5/22/2024 at 12:01 a.m., 8:45 a.m., 5:58 p.m. - 5/23/2024 at 12:00 a.m., 9:30 a.m., and 3:36 p.m. - 5/24/2024 at 5:21 p.m. - 5/25/2024 at 8:28 a.m. and 7:00 p.m. - 5/26/2024 at 8:40 a.m. and 6:42 p.m. - 5/27/2024 at 2:00 a.m., 8:40 a.m., and 4:39 p.m. - 5/28/2024 at 3:11 a.m., 9:30 a.m., and 6:59 p.m. - 5/29/2024 at 5:00 a.m. and 8:38 p.m. - 5/30/2024 at 2:38 a.m. When asked what non-pharmacological interventions the nurses attempted prior to administering hydrocodone-acetaminophen 5-325 mg on the above dates, MDS Nurse 1 stated he could not find any documentation that indicated the nurses had attempted non-pharmacological interventions prior to administering the medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 11's care plan (a written document that summarizes a patient's needs, goals, and care/treatment) for potential for alteration in comfort/pain related to left upper thigh pain, initiated on 5/8/2024, indicated a goal of reducing episodes of pain or discomfort through appropriate interventions daily until the next assessment. Among some of the interventions listed included to provide non-pharmacological interventions (positioning for comfort, hot pack, cold pack, massage, and distraction). During an interview on 5/30/2024 at 2:42 p.m., with the Director of Nursing (DON), the DON stated it was important to first try non-pharmacological interventions prior to administering as needed pain medication because the resident may not need the medication after all. The DON stated if narcotic pain medication is given before attempting non-pharmacological interventions first, then the resident is at increased risk of experiencing adverse side effects from the medication, such as respiratory decline or increased risk for falls. A review of the facility's policy and procedure titled, Pain Management, last reviewed on 10/17/2023, indicated that non-pharmacological interventions shall be utilized as part of the Pain Management Program. Physician orders are to be made for pharmacological and non-pharmacological interventions as needed. Non-pharmacological interventions may include, but are not limited to the following: Repositioning the resident; dimming lighting or maintaining a quiet environment; hot or cold applications; instruction in relaxation techniques; providing activities or distractions; providing music; and massaging the resident. 48142 2. A review of Resident 179's Admission Record indicated the facility admitted the resident on 3/9/2024 and readmitted the resident on 4/1/2024 with diagnoses of fracture (broken bone) of right femur (thighbone), fracture of left tibia (two bones between the knee and ankle), and fracture of right lower leg. A review of Resident 179's History and Physical (H&P - a formal assessment of a patient and their problem), dated 4/1/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 179's Order Summary Report, dated 4/1/2024, indicated to give oxycodone hydrochloride (medication used to treat moderate to severe pain) tablet 7.5 milligram (mg- a unit of measurement) by mouth three times a day for severe pain. A review of Resident 179's Medication Administration Record (MAR- the report that serves as a legal record of the drugs administered to a resident of a facility by a health care professional) dated 5/2024, indicated Resident 179 did not receive her prescribed oxycodone 7.5 mg on the following dates and times: - 5/13/2024 at 10:00 a.m., 4:00 p.m., and 10:00 p.m. - 5/14/2024 at 10:00 a.m., 4:00 p.m., and 10:00 p.m. The MAR included a note indicating that the medication was awaiting supply. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Refill Request Form dated 5/11/2024 at 1:00 p.m., indicated Licensed Vocational Nurse 1 (LVN 1) requested to refill oxycodone. A review of Resident 179's care plan (a written document that summarizes a patient's needs, goals, and care/treatment) for potential for alteration in comfort/pain, initiated on 4/15/2024, indicated to administer medication as ordered. During a concurrent interview and record review on 5/30/2024 at 11:48 a.m., with Registered Nurse 2 (RN 2), reviewed Resident 179's MAR dated 5/2024. RN 2 stated Resident 179 did not receive oxycodone 7.5 mg on 5/13/2024 and 5/14/2024 due to unavailability. RN 2 stated the medication was still awaiting delivery from the pharmacy. RN 2 stated that in such situations, the charge nurse should contact the pharmacy for follow-up and utilize medication from the emergency kit (e-kit- basic emergency medical kit that includes common emergency drugs) if necessary. During a concurrent interview and record review on 5/30/2024, at 2:01 p.m., reviewed Resident 179's MAR dated 5/2024. LVN 1 stated that Resident 179's oxycodone 7.5 mg was not administered on 5/13/2024 due to unavailability. LVN 1 stated that in future instances of medication unavailability, LVN 1 will contact the pharmacy and obtain authorization from the pharmacist to utilize the e-kit. During an interview on 5/30/2024 at 2:59 p.m., with the Director of Nursing (DON), the DON stated that if the facility does not have the medication the staff should call the pharmacy to get an authorization to use the e-kit while waiting for the medication to be delivered. The DON stated Resident 179 could suffer from pain. A review of the facility's policy and procedure titled, Medication Ordering and Receiving from Pharmacy, last reviewed on 10/17/2023, indicated the ordered medication is obtained either from the emergency supply or from the provider pharmacy. Reorder medication five days in advance of need to assure an adequate supply is on hands. A review of the facility's policy and procedure titled, Pain management, last reviewed on 10/17/2023, indicated to provide guidelines for the consistent assessment, management, and documentation of pain of resident, in order to provide maximum comfort and quality of life. Effective pain control is an important part of a resident's treatment. Implement the medication regimen as ordered, carefully documenting the results of the interventions.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 38549 Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse 4 (LVN 4) was competent in taking orthostatic blood pressure (taking a blood pressure [BP] lying down flat, sitting up, and standing up to ensure a resident does not have orthostatic hypotension [a form of low blood pressure that happens when standing after sitting or lying down which can cause dizziness or lightheadedness and possibly fainting]) measurements for one of 37 sampled residents (Resident 158). This deficient practice had the potential to place the resident at increased risk of experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention) of hypotension (low blood pressure). Findings: A review of Resident 158's Admission Record indicated the facility admitted the resident on 5/4/2023 with diagnoses including schizophrenia (a serious mental health condition that can cause people to have abnormal interpretations of reality). A review of Resident 158's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/16/2024, indicated the resident had intact cognition (thought processes) and required setup or clean-up assistance from staff for most activities of daily living (ADLs - activities related to personal care). A review of Resident 158's physician's orders indicated the following: - Seroquel (antipsychotic medication- a medication used to treat psychosis [a mental condition in which thought, and emotions are so affected that contact is lost with external reality]) 200 milligrams (mg - unit of measurement) by mouth two times a day for schizophrenia manifested by paranoid feeling causing fear, ordered on 5/4/2023. - Monitor for orthostatic hypotension (a sudden drop in blood pressure that occurs when standing up from a sitting or lying position) (sitting position) every Monday, ordered on 5/5/2023. - Monitor for orthostatic hypotension (lying position) every Monday, ordered on 5/5/2023. A review of Resident 158's care plan (a written document that summarizes a patient's needs, goals, and care/treatment) for the use of Seroquel, initiated on 5/16/2023, indicated a goal to minimize the risk of adverse side effects of medication use daily. Among some of the interventions included to observe for side effects and document occurrence of side effects per policy: .orthostatic hypotension. A review of Resident 158's Medication Administration Record (MAR - a report detailing the drugs administered to a patient by a healthcare professional) dated 5/2024 indicated the following: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 5/6/2024, Resident 158's blood pressure reading was 132/68 millimeters of mercury (mmHg - unit of measurement) in the lying position and 132/68 mmHg in the sitting position. - On 5/13/2024, Resident 158's blood pressure reading was 130/66 mmHg in the lying position and 130/66 mmHg in the sitting position. - On 5/20/2024, Resident 158's blood pressure reading was 132/78 mmHg in the lying position and 132/78 mmHg in the sitting position. - On 5/27/2024, Resident 158's blood pressure reading was 128/77 mmHg in the lying position and 128/77 mmHg in the sitting position. During a concurrent interview and record review on 5/29/2024 at 11:47 a.m., with LVN 4, reviewed Resident 158's MAR dated 5/2024. When asked how LVN 4 takes a resident's orthostatic blood pressure, LVN 4 stated he would take the resident's blood pressure while the resident was sitting down on the bed. When asked if he took the resident's blood pressure while lying down on the bed, LVN 4 stated no, he only took the resident's blood pressure in one position, the sitting position. LVN 4 stated those were his signatures on the MAR for 5/6/2024, 5/13/2024, 5/20/2024, and 5/27/2024 for Resident 158's orthostatic blood pressure readings. During an interview on 5/30/2024 at 2:44 p.m., with the Director of Nursing (DON), the DON stated the correct way to take a resident's orthostatic blood pressure was to first get a reading while the resident was lying down, wait 30 minutes, then take another measurement with the resident in a sitting position. The DON stated the two blood pressure readings should not be exactly the same. The DON stated she would expect her licensed nurses to know how to take an orthostatic blood pressure because she provided in-services (training intended for those actively engaged in a profession) about it when teaching about antipsychotic medications. The DON stated the resident can potentially experience adverse side effects of hypotension such as an increased risk for falls if the nurse does not take the resident's orthostatic blood pressure correctly. A review of the facility's policy and procedure titled, Staffing, Sufficient and Competent Nursing, last reviewed on 10/17/2023, indicated the facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. Staff must demonstrate the skills and techniques necessary to care for resident needs including (but not limited to) .basic nursing skills.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49252 Based on interview and record review, the facility failed to ensure the Controlled Drug Record form (CDR- accountability record of medications that are considered to have a strong potential for abuse) reflected what was on the Medication Administration Record (MAR - report that serves as a legal record of the drugs administered to a resident by a health care professional) for one of three sampled residents (Residents 492). These deficient practices resulted in inaccurate reconciliation of the controlled medication and placed the facility at potential for inability to readily identify loss and drug diversion (illegal distribution of abuse of prescription drugs or their use for unintended purposes) of controlled medications. Findings: A review of Resident 492's Admission Record indicated the facility admitted the resident on 5/8/2024 with diagnoses including respiratory failure (condition in which not enough oxygen passes from your lungs into your blood). A review of Resident 492's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/21/2024, indicated the resident had moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) in daily decision making and was completely dependent (helper does all of the effort to complete the task) on a helper to roll left and right. A review of Resident 492's physician's orders, dated 5/8/2024, indicated an order for lorazepam (medication used to treat anxiety [intense, excessive, and persistent worry and fear about everyday situations]) oral tablet 0.5 milligram (mg, a unit of measurement) to be given via percutaneous endoscopic gastrostomy tube (PEG tube- a long-term feeding tube that is surgically inserted into the stomach through the abdominal wall) every eight (8) hours as needed for anxiety for 14 days for agitation leading to shortness of breath. During a concurrent interview and record review on 5/30/2024 at 11:48 a.m., with Licensed Vocational Nurse 1 (LVN 1), reviewed Resident 492's CDR for lorazepam 0.5 mg and MAR dated 5/2024. LVN 1 stated the entries on the CDR for lorazepam 0.5 mg on 5/18/2024 at 1:01 a.m. and 5/19/2024 at 9:32 p.m., were not documented on the MAR. LVN 1 stated as soon as medications are given to residents, they should be documented on the MAR. LVN 1 further stated, the nurses would not know the last time the medication was administered unless the CDR was checked and if they failed to check the CDR and gave the medication, the resident might overdose. During a concurrent interview and record review on 5/30/2024 at 3:09 p.m., with the Director of Nursing (DON), reviewed Resident 492's CDR for lorazepam 05 mg and MAR dated 5/2024. The DON verified by stating that the licensed nurses documented the following: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Lorazepam 0.5 mg was documented on the CDR on 5/18/2024 at 1:01 a m. but was not documented on the MAR. - Lorazepam 0.5 mg was documented on the CDR on 5/19/2024 at 9:32 p.m. but was not documented on the MAR. The DON stated it was important for the CDR and the resident's MAR to match to allow the next nurse to know when the lorazepam was last given. The DON stated if the records were not reconciled, the nurses could give another dose, cause more side effects or overdose the resident. A review of the facility's policy and procedure titled, Medication Administration - General Guidelines, dated 10/17/2023, indicated, The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 50033 Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 187) did not exceed more than 3,000 milligrams (mg, unit of measure) of acetaminophen (Tylenol, a medication used to treat pain and fever) per day per physician order. This deficient practice had the potential to cause toxic levels of acetaminophen to build up in the blood which can lead to nausea, vomiting, abdominal pain, and/or liver failure. Findings: A review of Resident 187's Admission Record Face Sheet indicated the facility admitted the resident on 4/25/2024 with diagnoses including fracture (broken bone) of shaft of left tibia (lower leg) and multiple fractured ribs. A review of Resident 187's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/5/2024, indicated the resident is dependent on staff for toileting, bathing, and dressing. A review of Resident 187's History and Physical (H&P - a formal assessment of a patient and their problem), dated 5/14/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 187's physician's order indicated the following: - Tylenol extra strength 500 mg tablet, take two tablets by mouth two times per day for generalized body pain, order dated 4/26/2024 to 5/29/2024. Order indicated not to exceed 3,000 mg of acetaminophen per day. - Hydrocodone-acetaminophen 10 mg-325 mg tablet, take one tablet by mouth every four hours as needed for moderate pain, order dated 4/25/2024 to 5/13/2024. - Oxycodone-acetaminophen 5 mg-325 mg tablet, take one tablet by mouth every four hours as needed for severe pain 7-9/10, order dated 5/9/2024 to 5/29/2024. During a concurrent interview and record review on 5/28/2024 at 10:36 a.m., with Licensed Vocational Nurse (LVN) 1 and the Assistant Director of Nursing (ADON), reviewed Resident 187's Medication Administration Record (MAR) dated 5/2024. Resident 187's MAR indicated on 5/12/2024, Resident 187 was administered four acetaminophen 500 mg tablets, three hydrocodone-acetaminophen 10 mg - 325 mg tablets, and five oxycodone-acetaminophen 5 mg - 325 mg tablets. The total acetaminophen administered that day was 4,600 mgs. LVN 1 stated Resident 187 received over 3,000 mgs of acetaminophen on 5/12/2024. The ADON stated there is an order indicating Resident 187 should not receive over 3,000 mgs of acetaminophen per day. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/20/2024 at 3:00 p.m., with the Director of Nursing (DON), reviewed Resident 187's MAR dated 5/2024. The DON stated the maximum amount of acetaminophen a resident should receive in a day is 3,000 mgs. The DON stated Resident 187 received over 3,000 mgs of acetaminophen on 5/12/2024. The DON stated an excess of acetaminophen can cause multiple side effects like a decrease in functioning and negatively affect the kidneys and liver. A review of the facility's policy and procedure titled, Medication Administration - General Guidelines, dated 4/2008, indicated medications should be administered in accordance with the physician's orders.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38549 Based on interview and record review, the facility failed to ensure licensed nurses attempted non-pharmacological interventions (any type of healthcare intervention which is not primarily based on medication) prior to administering as needed lorazepam (medication used to treat anxiety [intense, excessive, and persistent worry and fear about everyday situations]) to two of 37 sampled residents (Residents 11 and 166). This deficient practice had the potential to place the residents at increased risk of experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention). Findings: a. A review of Resident 11's Admission Record indicated the facility originally admitted the resident on 9/27/2017 and readmitted the resident on 12/28/2023 with diagnoses including anxiety disorder. A review of Resident 11's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/18/2024, indicated the resident had intact cognition (thought processes) and was dependent on staff for most activities of daily living (ADLs - activities related to personal care). During a concurrent interview and record review on 5/30/2024 at 9:48 a.m., with Minimum Data Set Nurse 1 (MDS Nurse 1), reviewed Resident 11's physician's orders and Medication Administration Record (MAR - a report detailing the drugs administered to a patient by a healthcare professional) dated 5/2024. MDS Nurse 1 stated Resident 11 had an order for lorazepam one (1) milligram (mg - unit of measurement) via gastrostomy tube (g-tube - an opening to the stomach from the abdominal wall made surgically for the introduction of food and medication) every six (6) hours as needed for anxiety manifested by hyperventilation (when someone breathes in more oxygen than their body needs) leading to shortness of breath, for 14 days, ordered on 5/26/2024. MDS Nurse 1 stated Resident 11 received lorazepam on 5/26/2024 at 4:44 p.m. and 11:55 p.m., 5/27/2024 at 8:30 a.m. and 6:10 p.m., 5/28/2024 at 8:33 a.m. and 11:59 p.m., 5/29/2024 at 11:54 p.m., and 5/30/2024 at 8:35 a.m. When asked what non-pharmacological interventions the nurses attempted prior to administering lorazepam to Resident 11, MDS Nurse 1 stated he could not find any documentation indicating the nurses had attempted non-pharmacological interventions prior to administering lorazepam. During an interview on 5/30/2024 at 2:42 p.m., with the Director of Nursing (DON), the DON stated it was important to first try non-pharmacological interventions prior to administering as needed psychotropic medications (medications capable of affecting the mind, emotions, and behavior) because the resident may not need the medication after all. The DON stated if lorazepam is given before attempting non-pharmacological interventions first, then the resident is at increased risk of experiencing adverse side effects from the medication, such as increased risk for falls. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Psychotropic Medication Use, last reviewed on 10/17/2023, indicated that non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. b. A review of Resident 166's Admission Record indicated the facility admitted the resident on 1/12/2024 with diagnoses including dementia (decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities). A review of Resident 166's MDS, dated [DATE], indicated the resident had severely impaired cognition and was dependent on staff for most ADLs. The MDS also indicated the resident received antianxiety medication. During a concurrent interview and record review on 5/30/2024 at 10:31 a.m., with MDS Nurse 1, reviewed Resident 166's physician's orders and MAR dated 5/2024. MDS Nurse 1 stated Resident 166 had a prior order for lorazepam 1 mg via g-tube every 6 hours as needed for anxiety manifested by restlessness leading to shortness of breath, for 14 days, ordered on 5/7/2024. MDS Nurse 1 stated Resident 166 received lorazepam on the following dates: 5/8/2024, 5/10/2024, 5/11/2024, 5/12/2024, and 5/14/2024 - 5/21/2024. When asked what non-pharmacological interventions the nurses attempted prior to administering lorazepam to Resident 166, MDS Nurse 1 stated he could not find any documentation indicating the nurses had attempted non-pharmacological interventions prior to administering lorazepam. During an interview on 5/30/2024 at 2:42 p.m., with the DON, the DON stated it was important to first try non-pharmacological interventions prior to administering as needed psychotropic medications because the resident may not need the medication after all. The DON stated if lorazepam is given before attempting non-pharmacological interventions first, then the resident is at increased risk of experiencing adverse side effects from the medication, such as increased risk for falls. A review of the facility's policy and procedure titled, Psychotropic Medication Use, last reviewed on 10/17/2023, indicated that non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49252 Based on observation, interview, and record review, the facility failed to properly store six boxes of Santyl ointment (medication used for removing damaged tissue or burned skin to allow for wound healing and growth of healthy skin) in the medication's room discontinued medication cabinet for one of three residents (Resident 57) when it was discontinued by the physician on 5/22/2024. The deficient practice had the potential to cause unintentional medication administration and a loss of control against drug loss, diversion, or theft. Findings: A review of Resident 57's Admission Record indicated the facility admitted the resident on 3/5/2024 with diagnoses that included respiratory failure (condition in which not enough oxygen passes from your lungs into your blood), tracheostomy (procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck), and cervical (the first seven bones of the spine composing the neck) spinal cord injury. A review of Resident 57's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 3/14/2024, indicated Resident 57 had moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 57 was dependent (helper does all the effort to complete the activity) in repositioning in bed and transferring to and from a bed to a chair. A review of Resident 57's physician's orders, dated 5/22/2024, indicated Santyl external ointment 250 unit/gram (U/gm, a unit of measurement) was discontinued on 5/22/2024 at 2:28 p.m. During an observation on 5/30/2024 at 12:01 p.m., with Registered Nurse 1 (RN 1), observed in Medication Room A, a cardboard box that contained Santyl ointment on a shelf against the wall. The box contained medication for three residents with six tubes of Collagenase (breaks down collagen [protein found in skin and connective tissue] in damaged tissue and helps healthy tissue grow) Santyl Ointment 250 units/gram for Resident 57 that were discontinued and unmarked with a discontinuation date. During an interview on 5/30/2024 at 12:45 p.m., with RN 1, RN 1 stated the order was discontinued by the physician and should have been placed in the locked discontinued medications cabinet and into the discontinued medications box labeled for liquids by nursing staff. RN 1 further stated the medication discontinuation cabinet is used to store all the medications that are discontinued or were from discharged residents to prevent it from accidentally being given to other residents. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/2024 at 3:03 p.m., with the Director of Nursing (DON), the DON stated when medications are discontinued the licensed nurse should write the discontinuation date on the medication then place it in the locked discontinued medications cabinet to allow proper medication disposition. The DON stated if the procedure is not followed, it can create a safety risk from hazardous waste, or the drug could be given to another resident. The DON further stated Resident 57's medications should have been put in the discontinued medication cabinet immediately after its discontinuation. A review of the facility's policy and procedure titled, Disposal of Medications and Medication-Related Supplies, dated 10/17/2023, indicated when a prescriber discontinues a medication, the discontinued drug container shall be marked or otherwise identified or shall be stored in a separate location designated solely for this purpose. The date the medication was discontinued shall be indicated on the medication container. Medications awaiting disposal or return are stored in a locked secure area designed for that purpose until destroyed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38469 Based on observation, interview, and record review, the facility failed to ensure an eight-ounce glass of milk was not left at the resident's bedside for more than four (4) hours for one of three sampled residents (Resident 94). This deficient practice had the potential to result in food borne illness (when contaminated food is consumed which causes an infection resulting illness) upon ingestion of a spoiled milk. Findings: A review of Resident 94's Admission Record indicated the facility originally admitted the resident on 9/3/2020 and readmitted the resident on 10/29/2023, with diagnoses including gastro-esophageal reflux disease (stomach contents flow backward, up into the esophagus, the tube that carries food from your throat into stomach), shortness of breath, and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 94's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 4/4/2024, indicated that the resident's cognitive (thought processes) skills for daily decision making was intact and the resident required supervision with oral hygiene, upper body dressing and personal hygiene. During a concurrent observation and interview on 5/28/2024 at 10:47 a.m., observed an eight-ounce glass of milk on Resident 94's bedside table. Resident 94 stated the eight-ounce glass of milk was from his breakfast tray. During a concurrent observation and interview on 5/28/2024 at 3:01 p.m., with Resident 94 and the Director of Nursing (DON), observed an eight-ounce glass of milk. Resident 94 stated that the milk at his bedside table was from his breakfast tray. The DON stated dairy products such as milk must be consumed within 30 minutes of delivery or the same time the meal is served. The DON stated that milk products, if not consumed within the timeframe as stated in the policy and federal guidelines, can potentially make the resident acquire food borne illnesses. The DON acknowledged Resident 94's statement that the glass of milk was from his breakfast tray. A review of the facility's policy and procedure titled, Handling of Potentially Hazardous Food, last revised on 2019, indicated, All potentially hazardous food (PHF) shall be cooked and handled in a safe and sanitary manner to protect residents and staff from food borne illness . A review of the US Department of Agriculture Food Safety and Inspection Service Guidelines, undated, indicated, Leaving food out too long at room temperature can cause bacteria to grow to dangerous levels that can cause illness. Bacteria grow most rapidly in the range of temperatures between 40 F and 140 F, doubling in number in as little as 20 minutes. This range of temperatures is often called the 'Danger Zone'.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 34659 Based on interview and record review, the facility failed to implement its antibiotic stewardship program (a program to promote the appropriate use of antibiotics [medication used to treat bacterial infections] in effectively treating infections and to reduce negative side effects) by failing to complete an infection surveillance form (a systematic collection of data to track infection which is collected when a resident has certain signs and symptoms that could be a bacterial infection) once signs and symptoms of an infection were identified and antibiotics were initiated for two of five sampled residents (Resident 178 and 179). This deficient practice had the potential for the residents to develop antibiotic resistance (not effective to treat infection) from unnecessary or inappropriate antibiotic use for future infections. Findings: a. A review of Resident 178's Admission Record indicated the facility admitted the resident on 4/13/2024 and readmitted the resident on 5/7/2024 with diagnoses that included acute respiratory failure with hypoxia (condition where you don't have enough oxygen in the tissues in your body). A review of Resident 178's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/26/2024, indicated Resident 178 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 178 was dependent on staff for toileting, dressing, and personal hygiene. A review of Resident 178's physician's orders, dated 5/22/2024, indicated an order for ceftriaxone (an antibiotic medication) one gram (g, a unit of measurement), intravenously (to be given through a vein) every 24 hours for leukocytosis (increased white blood cells [blood cell that helps the body fight infections and other disease] that occurs during an infection) for seven days. A review of Resident 178's Change of Condition form (COC - a structured communication tool that can be used to share information about a resident's condition), dated 5/22/2024, indicated Resident 178 had labs results of an abnormal white blood cell count of 17.1 (WBC, normal reference range is 4,500 to 11,000 WBC per microliter [4.5 - 11 x 109/L]). Resident 178's COC indicated vital signs (clinical measurements that indicate the state of a patient's essential body functions) were normal and Resident 178 remains without any signs of distress (emotional, social, spiritual, or physical pain or suffering). A review of Resident 178's Laboratory Values, dated 5/21/2024, indicated Resident 178's WBC count was 17. 1 WBC/microliter. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/29/2024 at 2:47 p.m., with the Director of Staff Development (DSD) and the Infection Preventionist (IP), reviewed the infection surveillance forms for Resident 178. The IP stated once a resident is prescribed an antibiotic, an infection surveillance form should be created to ensure the McGeer's (a criteria of signs and symptoms that must be met to qualify an infection as being a true infection) criteria is met. The IP stated if the resident does not meet the criteria for the illness to be a bacterial infection, the resident's physician is notified, and the physician decides if they want to continue the medication or to discontinue it. The IP stated Resident 178 did not have an infection surveillance form regarding their lab values and antibiotic that was prescribed, but one should have been created. The IP stated it is important that each resident prescribed an antibiotic should have an infection surveillance form created so that a resident's physician can then be made aware if they do not meet the McGeer's criteria for infection. The IP stated this was important so that a resident is not prescribed an antibiotic unnecessarily because a resident could develop a resistance to this medication and not be effective in treating future infections. During an interview on 5/30/2024 at 2:38 p.m., with the Director of Nursing (DON), the DON stated licensed nurses should fill out a surveillance form when a resident is started on an antibiotic to ensure the resident is on the appropriate medication and is not an unnecessary medication. A review of the facility's policy and procedure titled, Antimicrobial Stewardship Program, last reviewed 10/17/2023, indicated the IP will be responsible for infection surveillance. The policy and procedure indicated the IP will collect and review: - Type of antibiotic ordered, route of administration, antibiotic costs. - Whether the order was made by phone, if attending physician or on-call doctor gave the order. - Whether a culture (a test to find germs that can cause an infection) was obtained before ordering the antibiotic. - Whether the antibiotic was changed during the course of treatment. 48142 b. A review of Resident 179's Admission Record indicated the facility admitted the resident on 3/9/2024 and readmitted the resident on 4/1/2024 with diagnoses of fracture (broken bone) of right femur (thighbone), fracture of left tibia (two bones between the knee and ankle), and fracture of right lower leg. A review of Resident 179's History and Physical (H&P - a formal assessment of a patient and their problem), dated 4/1/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 179's Order Summary Report, dated 4/25/2024, indicated an order for vancomycin (used to treat and prevent various bacterial infections) 1.25 gram (gm, a unit of measurement) intravenously (entering by way of a vein) every 12 hours for surgical infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056149	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER California Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6700 Sepulveda Blvd. Van Nuys, CA 91411	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/30/2024 at 3:32 p.m., with the Director of Staff Development (DSD), reviewed the infection surveillance forms for the month of 4/2024. The DSD stated that the infection surveillance forms must be collected before starting an antibiotic. The DSD stated this is done to confirm the presence of a true infection, categorize the resident's symptoms, and determine the necessity of antibiotic treatment. The DSD stated the infection surveillance form could not be located for Resident 179. The DSD stated she will seek assistance from another nurse to locate this information. During a concurrent interview and record review on 5/30/2024 at 3:59 p.m., with the DSD and Licensed Vocational Nurse 3 (LVN 3), reviewed the infection surveillance forms for the month of 4/2024. LVN 3 stated they were unable to locate the infection surveillance form for Resident 179. LVN 3 emphasized the importance of completing the infection surveillance forms prior to antibiotic administration and following the McGeer criteria to ensure the necessity of treatment. LVN 3 explained that failure to do so could lead to antibiotic resistance and unnecessary antibiotic use. A review of the facility's policy and procedure titled, Antimicrobial Stewardship Program, last reviewed on 10/17/2023, indicated the facility to implement an Antimicrobial Stewardship program that focus on a coordinated interventions designed to improve and measure the appropriate use of antimicrobial agents by promoting the selection of optimal antimicrobial drug regimen including dosing, duration of therapy and route of administration: to achieve best clinical outcomes related to antimicrobial use while minimizing the unintended consequences of the antimicrobial use and reducing treatment related cost.