STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056195	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Brea Rehabilitation Center	505 N. LA Brea Avenue Los Angeles, CA 90036

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 43454 Based on observation, interview and record review, the facility failed to ensure the actual hours worked by licensed and unlicensed nursing staffing directly responsible for resident care per shift were accurate for two of two sampled days (8/1/2024 and 8/2/2024). This deficient practice resulted in incorrect actual hours staffing information and had the potential to cause inadequate staffing. Findings: During an observation of the facility on 8/1/2024 at 10:44 a.m., Direct Care Services Hours Per Patient Day (DHPPD) were observed posted on a wall indicating actual PPD hours of 3.58 in the DHPPD posting. The DHPPD included the information of total staff and starting census for 7 a.m. to 3 p.m. shift, 3 p.m. to 11 p.m. shift and 11 p.m. to 7 a.m. shift. During an observation of the facility on 8/2/2024 at 10:43 a.m., observed Direct Care Services Hours Per Patient Day (DHPPD) posted on the wall with an actual PPD hours of 3.61 indicated in the DHPPD posting. The DHPPD included the information of total staff and starting total census for 7 a.m. to 3 p.m. shift, 3 p.m. to 11 p.m. shift and 11 p.m. to 7 a.m. shift. During an interview with Director of Staff and Development (DSD) on 8/2/2024 at 3:37 p.m., DSD stated, the DHPPD was posted daily in the morning with the number of staff assigned to work that day and the actual hours included in the posting. DSD stated the posting was for the projected hours. When asked if the actual number of staff working was calculated within two hours of the beginning of each shift, DSD stated, no, only the projection hours are calculated and posted. DSD stated the actual hours were not accurate. During an interview on 8/2/2024 at 4:45 p.m., the Director of Nursing (DON) stated the DHPPD hours posted on the wall was inaccurate. The DON stated the actual number of staff and total census had to be calculated and added within two hours of the beginning of each shift, so that the correct hours were reflected on the posting. (continued on next page)

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

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s policy and procedure (P&P) titled Posting Direct Care Daily Staffing Numbers revised on 6/2024 indicated, within two hours of the beginning of each shift, the charge nurse or designee computes the number of direct staff and completes the Nurse Staffing Information form. The charge nurse completes the form and posts the staffing information in the location(s) designated by the administrator.

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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 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** 43454 Based on observation, interview and record review, the facility failed to ensure the Controlled Drug Record (CDR- accountability record of medications that are considered to have a strong potential for abuse) coincided with the Medication Administration Records (MAR) for four of five sampled residents (Resident 7, 9, 11 and 13). This deficient practice had the potential to result in medication errors and/or drug diversion (illegal distribution or abuse of prescription drugs). Findings: A review of Resident 7 ' s Admission Record indicated the facility originally admitted the resident on 5/9/2024 and readmitted on [DATE] with diagnoses including cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one ' s daily activities), and type two diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]). A review of Resident 7 ' s Minimum Data Set (MDS-standardized assessment and screening tool) dated 7/9/2024, indicated resident had intact cognition (ability to think and make decisions). A review of Resident 7 ' s Order Summary Report (OSR) dated 7/3/2024, indicated an order for hydrocodone-acetaminophen (Norco - used to relieve moderate to severe pain) 10-325 (mg-unit of measurement) one tablet by mouth every four hours as needed for moderate to severe pain. A review of Resident 7 ' s Medication Administration Record (MAR), dated 8/1/2024, indicated Norco was administered and given to Resident 7 at 9 a.m. on 8/1/2024. A review of Resident 7 ' s CDR for Norco HCL 10-325 mg, give one tablet by mouth every four hours, indicated the medication was not removed from the narcotic storage on 8/1/2024 at 9 a.m. During a concurrent interview and record review with Licensed Vocational Nurse (LVN 2) on 8/1/2024 at 12:54 p.m., LVN 2 stated she administered Resident 7 ' s Norco that morning (8/1/2024) but forgot to sign the Norco out on the CDR. LVN 2 was then observed signing the CDR in front of the surveyor. LVN 2 stated the Norco had to be signed out and counted at the time of administration, so that it would reflect the correct narcotic count. A review of Resident 9 ' s Admission Record indicated the facility originally admitted the resident on 5/23/2023 and readmitted on [DATE] with diagnoses including cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue), kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), cognitive social or emotional deficit following cerebral infarction (impairment of different domains of cognition). A review of Resident 9 ' s MDS dated [DATE], indicated resident had moderately impaired cognition. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 9 ' s OSR dated 7/3/2024, indicated an order for Ativan (lorazepam - used to relieve anxiety) oral tablet 0.5 mg -1/2 tablet two times a day for anxiety. A review of Resident 9 ' s MAR, dated 8/1/2024, indicated Ativan was administered and given to Resident 9 at 9 a.m. on 8/1/2024. A review of Resident 9 ' s CDR for Ativan 0.5 mg, indicated the medication was not removed from the narcotic storage on 8/1/2024 at 9 a.m. During a concurrent interview and record review with LVN 2 on 8/1/2024 at 1 p.m., LVN 2 stated she administered Resident 7 ' s Ativan that morning (8/1/2024) but forgot to sign the Ativan out on the CDR. LVN 2 was then observed signing the CDR in front of the surveyor. LVN 2 stated the Ativan had to be signed out and counted at the time of administration, so that it would reflect the correct narcotic count. A review of Resident 11 ' s Admission Record indicated the facility originally admitted the resident on 6/12/2012 and readmitted on [DATE] with diagnoses including hemiplegia and hemiparesis (loss of the ability to move in one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting right dominant side, neuralgia and neuritis (are nerve conditions that often result in pain, numbness, and tingling sensations) and DM. A review of Resident 11 ' s MDS dated [DATE], indicated resident had severely impaired cognition. A review of Resident 11 ' s OSR dated 7/3/2024, indicated an order for Lyrica capsule 50 mg (Pregabalin - can treat nerve and muscle pain) -50 mg by mouth three times a day. A review of Resident 11 ' s MAR, dated 8/1/2024, indicated Lyrica was administered and given to Resident 11 at 9 a.m. and 1 p.m. on 8/1/2024. A review of Resident 11 ' s CDR for Lyrica 50 mg, indicated the Lyrica doses for 9 a.m. and 1 p.m. were not removed from the narcotic storage on 8/1/2024 at 9 a.m. and 1 p.m. During a concurrent interview and record review on 8/1/2024 at 1:56 p.m., LVN 3 stated she administered Resident 9 ' s Lyrica on 8/1/2024 at 9 a.m. and at 1 p.m. but forgot to sign the Lyrica out on the CDR because LVN 3 was in a rush. A review of Resident 13 ' s Admission Record indicated the facility admitted the resident on 11/8/2022 with diagnoses including cerebral infarction, encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), and anxiety disorder. A review of Resident 13 ' s MDS dated [DATE], indicated resident had intact cognition. A review of Resident 13 ' s OSR dated 7/3/2024, indicated a physician order for Ativan 1 mg - give 1 tablet by mouth every 12 hours as needed for anxiety. A review of Resident 13 ' s MAR, dated 8/1/2024, indicated Ativan was administered and given to Resident 13 at 9 a.m. on 8/1/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 13 ' s CDR for Ativan 1 mg, indicated the Ativan was not removed from the narcotic storage on 8/1/2024 at 9 a.m. During a concurrent interview and record review on 8/1/2024 at 1:59 p.m., LVN 3 stated she administered Resident 13 ' s Ativan on 8/1/2024 at 9 a.m. but forgot to sign the Ativan out on the CDR because LVN 3 was in a rush. During an interview on 8/2/2024 at 4:34 p.m., the Director of Nursing (DON) stated medication administration had to be documented at the time of administration and the narcotics had to be counted and documented on the CDR at the time of removing the narcotics from the narcotic storage. A review of the facility ' s policy and procedure (P&P) titled, Administering Medications revised 6/2024, indicated the individual administering the medication was to initial the resident ' s MAR on the appropriate records in the resident ' s medical record with the date and time the medication was administered. A review of the facility ' s P&P titled Controlled Drugs undated, indicated the nurse had to enter the following information on the narcotic drug record immediately after a dose of a controlled drug is administered: date and time of administration, dose administered, signature of the nurse that administered the dose.

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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** 43454 Based on observation, interview, and record review, facility failed to ensure one of five sampled residents (Resident 8) was free from significant medication error by failing to ensure the Ativan (lorazepam - used to relieve anxiety) 0.5 milligram (mg-unit of measurement) one tablet by mouth every 12 hours as needed for anxiety was not administered after 14 days ([DATE]) when the order expired. This deficient practice has the potential to result in Resident 8 in unintended complications related to the management of medication. Findings: A review of Resident 8 ' s Admission Record indicated the facility admitted the resident on [DATE] with diagnoses including major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one ' s daily activities), and Alzheimer ' s disease (a progressing brain disorder that destroys memory and other important mental function). A review of Resident 8 ' s Minimum Data Set (MDS-standardized assessment and screening tool), dated [DATE], indicated resident had severely impaired cognition (ability to think and make decisions). A review of Resident 8 ' s Order Summary Report (OSR) dated [DATE], indicated physician ordered Ativan 0. 5 milligram (mg-unit of measurement) give one tablet by mouth every 12 hours as needed for anxiety for 14 days. A review of Resident 8 ' s Controlled Drug Record (CDR- accountability record of medications that are considered to have a strong potential for abuse) for Ativan 0.5 mg indicated the medication was removed from the narcotic storage on the following days: i. [DATE] at 10 a.m., ii. [DATE] at 10 a.m., iii. [DATE] at 9 p.m., iv. [DATE] at 9 a.m. During a concurrent interview and record review on [DATE] at 1:16 p.m., Licensed Vocational Nurse (LVN 2) stated she administered Ativan to Resident 8 on [DATE] at 9 a.m. A review of Resident 8 ' s Medication Administration Record (MAR) with LVN 2 indicated, there was no MAR for Ativan 0.5 mg. LVN 2 stated, the order for Ativan on [DATE] was only for 14 days and she did not notice that the Ativan order had expired and is no longer active. LVN 2 further stated, she did not look at the physician's order and she did not document in the MAR after administering Ativan to Resident 8. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 4:34 p.m., the Director of Nursing (DON) stated there had be an active order by the physician for medications. The DON stated staff had to check the five rights of medication administration (right patient, the right drug, the right time, the right dose, and the right route) and physician ' s order before administering medications. The DON stated not verifying a physician ' s order could put residents at risk of adverse effects (negative) of medications. A review of the facility ' s policy and procedure (P&P) titled Administering Medications revised ,d+[DATE], indicated the individual administering medications checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication . The individual administering the medication initials the resident ' s MAR on the appropriate line after giving each medication and before administering the next ones.