| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056250 | A. Building<br>B. Wing | 03/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Sherman Oaks Health & Rehab | 14401 Huston St.<br>Sherman Oaks, CA 91423 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1) was free of any significant medication errors on [DATE] in accordance with the prescriber's order and accepted professional standards, when Licensed Vocational Nurse (LVN) 1 prepared and brought an insulin pen (an injection device that looks similar to a writing pen and that contains the insulin medication which lowers blood sugar) to Resident 1's bedside that was labeled with Resident 2's name. This deficient practice resulted in Resident 1 seeing the insulin pen with another resident's name on it and feeling stressed from discovering the medication error. Findings: During a review of Resident 1's admission Record, dated [DATE], the admission Record indicated Resident 1 was originally admitted to the facility on [DATE], and most recently re-admitted on [DATE]. The admission Record indicated that Resident 1 was diagnosed with type 2 diabetes mellitus (a condition where the body cannot properly use or make enough of the hormone called insulin, leading to high blood sugar levels), morbid obesity (a condition defined as being 100 pounds over a person's ideal body weight), and essential hypertension (a condition in which high blood pressure develops over time with no single, known medical cause). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 1 needs maximal assistance (a helper does more than half the effort of the activity) for shower/bathe, upper body dressing, and lower body dressing. The MDS indicated Resident 1 needs moderate assistance (a helper does less than half the effort of the activity) for oral hygiene and toileting hygiene. During a review of Resident 1's Order Summary Report, dated [DATE], the Order Summary Report indicated on [DATE], Resident 1's doctor ordered Insulin Glargine (a medication that treats diabetes by increasing insulin in the body, thereby decreasing the blood sugar level) 60 units (the amount of the medication to be given) to be injected at bedtime except when the blood sugar level is less than 100 (the medication is not to be given if the blood sugar level is measured at 99 or less using a specific machine). The Order Summary also indicated that on [DATE], Resident 1's doctor ordered Insulin Lispro (a medication to treat diabetes) to be injected per sliding scale (a specific chart that instructs how much insulin medication to give depending on the current blood sugar level) before meals and at bedtime. During a concurrent observation and interview on [DATE] at 10:16 a.m. with Resident 1, Resident 1 stated during the evening of [DATE] at around 11 p.m., LVN 1 came inside [Resident 1's] room and had an insulin pen with a man's name on it. Resident 1 stated Resident 1 read the name listed on the insulin pen, which was placed on top of Resident 1's bedside tray table. Resident 1 stated Resident 1 told LVN 1 that the insulin pen did not belong to Resident 1. Resident 1 stated Resident 1 then took a photo of the insulin pen with her cell phone. When asked if Resident 1 would be agreeable to showing the photo, Resident 1 searched photos in her cell phone and located the photo of the insulin pen. The photo was observed to show an insulin pen labeled with a male's first and last name (Resident 2). Resident 1 stated after verbalizing to LVN 1 that the insulin pen did not belong to Resident 1, LVN 1 left Resident 1's room with Resident 2's insulin pen and came back with the correct insulin pen that had Resident 1's name on it. Resident 1 stated Resident 1 then received her insulin injection and tried to sleep but felt stressed from discovering the medication error. During an<br>(continued on next page) |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | interview on [DATE] at 12:44 p.m. with Registered Nurse (RN 1), RN 1 stated the medication insulin comes in a pen that is initially stored in the refrigerator. RN 1 stated each insulin pen is marked by the pharmacy department who labels the pens with the appropriate residents' names. RN 1 stated when a nurse takes an insulin pen out of the refrigerator and opens it (when the insulin pen is first used), the nurse must write the date the pen was opened and then keep the pen inside the medication cart (a secure, mobile workstation on wheels used by nurses to transport and dispense patient medications). When asked to describe the standard nursing process when preparing to administer medications, RN 1 stated, You need to check the doctor's order and the 5 rights. RN 1 stated the 5 rights consist of the right patient, right drug (the correct medicine ordered by the doctor), right dose (the correct amount of medicine), right route (the correct method that the medicine is delivered to the body, such as by swallowing, being injected, or applied to the skin), and right time (the correct date/time the medication is prescribed by the doctor to be given). During a phone interview on [DATE] at 6:03 p.m. with LVN 1, LVN 1 stated Resident 1 is oriented to (aware of) Resident 1's own self, where Resident 1 is currently located, the date/time, and Resident 1's own situation. LVN 1 stated that when you go to [Resident 1's] room, you have to explain [all the medications] to her before she takes them. When asked if there was a recent incident that occurred involving Resident 1's medications, LVN 1 stated an incident occurred on [DATE] before 9:20 p.m. during LVN 1's shift. LVN 1 stated LVN 1 was at the medication cart in front of Resident 1's room preparing to give Resident 1 medications. LVN 1 stated the medication cart has a container that has multiple insulin pens belonging to different residents and labeled with their names. LVN 1 stated she pulled out an insulin pen that LVN 1 observed was expired, and that expired insulin pen did not have Resident 1's name on it. LVN 1 stated she placed that expired insulin pen on top of the medication cart on the left side. LVN 1 stated: I separated the [expired] insulin pen because I wanted to remind myself to take care of it later. LVN 1 stated she then pulled out Resident 1's insulin pen from the container and placed it on top of the medication cart on the left side because the right side of the cart has a laptop. LVN 1 stated she prepared the rest of Resident 1's medications, which consisted of pills, and then brought all the medications inside Resident 1's room, placing the insulin pen on top of Resident 1's bedside tray table. LVN 1 stated Resident 1 saw [that] the name on the insulin pen was not Resident 1's name. LVN 1 stated Resident 1 verbalized that the insulin pen did not belong to Resident 1, and Resident 1 took a picture of the pen. LVN 1 stated: I hadn't read the name on the insulin pen yet when [Resident 1] saw the pen and said it had the wrong name. LVN 1 stated: My mistake is that I grabbed the other guy's insulin pen from on top of the medication cart. LVN 1 stated LVN 1 took back the wrong insulin pen, left Resident 1's room, and came back with the correct pen. LVN 1 stated LVN 1 brought back both of Resident 1's insulin pens (Insulin Glargine and Insulin Lispro) to show Resident 1 because LVN 1 wanted to make sure [Resident 1] knows we have both of them and LVN 1 wanted [Resident 1] to have peace of mind. LVN 1 stated Resident 1 then allowed LVN 1 to administer the insulin injection in Resident 1's arm. LVN 1 stated: When dealing with one patient, I should not put medications for two patients on top of the medication cart because of the possibility that you can give the patient the wrong medication. During an interview on [DATE] at 9:01 a.m. with LVN 2, LVN 2 stated LVN 2 is familiar with Resident 1 and has been assigned to care for Resident 1 in the past. LVN 2 stated Resident 2 is very alert and Resident 1 knows all her meds. LVN 2 stated the process of preparing a resident's medications at the medication cart consist of checking the resident's name listed on the medication, the name of the medication as ordered by the doctor, the route the medication is to be administered, the time the medication is to be given, and the dose. LVN 2 stated it is important to check when preparing medications because nurses want to avoid medication error. LVN 2 stated, We don't want residents to be hurt like with side-effects from being given the wrong medication. During an interview on [DATE] at 12:16 p.m. with the DON, the DON stated that when preparing to administer medications, the nurse needs to check the right resident, medication, dose, route, [and] time. DON stated it is not standard nursing practice to prepare medications that belong to multiple residents on top of the medication<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | cart. DON stated, you have to pull out medications for one patient at a time to avoid dispensing the wrong medication and getting confused. During a review of the facility's policy and procedure (P&P) titled, Adverse Consequences and Medication Errors, dated 4/2014, the P&P indicated the following: A ?medication error' is defined as the preparation or administration of drugs and biological which is not in accordance with physician's orders,.or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated [m]edications are administered in accordance with prescriber orders. The P&P indicated the individual administering the medications checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. |

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the medical record of one of four sampled residents (Resident 1) was complete and accurately documented, when Licensed Vocational Nurse (LVN 1) failed to document a medication error that occurred on [DATE] in accordance with the facility's own policies and procedures. This deficient practice resulted in an incomplete medical record for Resident 1 on [DATE]. Findings: During a review of Resident 1's admission Record, dated [DATE], the admission Record indicated Resident 1 was originally admitted to the facility on [DATE], and most recently re-admitted on [DATE]. The admission Record indicated that Resident 1 was diagnosed with type 2 diabetes mellitus (a condition where the body cannot properly use or make enough of the hormone called insulin, leading to high blood sugar levels), morbid obesity (a condition defined as being 100 pounds over a person's ideal body weight), and essential hypertension (a condition in which high blood pressure develops over time with no single, known medical cause). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 1 needs maximal assistance (a helper does more than half the effort of the activity) for shower/bathe, upper body dressing, and lower body dressing. The MDS indicated Resident 1 needs moderate assistance (a helper does less than half the effort of the activity) for oral hygiene and toileting hygiene. During a review of Resident 1's Order Summary Report, dated [DATE], the Order Summary Report indicated on [DATE], Resident 1's doctor ordered Insulin Glargine (a medication that treats diabetes by increasing insulin in the body, thereby decreasing the blood sugar level) 60 units (the amount of the medication to be given) to be injected at bedtime except when the blood sugar level is less than 100 (the medication is not to be given if the blood sugar level is measured at 99 or less using a specific machine). The Order Summary also indicated that on [DATE], Resident 1's doctor ordered Insulin Lispro (a medication to treat diabetes) to be injected per sliding scale (a specific chart that instructs how much insulin medication to give depending on the current blood sugar level) before meals and at bedtime. During a concurrent observation and interview on [DATE] at 10:16 a.m. with Resident 1, Resident 1 stated during the evening of [DATE] at around 11:00 p.m., LVN 1 came inside [Resident 1's] room and had an insulin pen with a man's name on it. Resident 1 stated Resident 1 read the name listed on the insulin pen, which was placed on top of Resident 1's bedside tray table. Resident 1 stated Resident 1 told LVN 1 that the insulin pen did not belong to Resident 1. Resident 1 stated Resident 1 then took a photo of the insulin pen with her cell phone. When asked if Resident 1 would be agreeable to showing the photo, Resident 1 searched photos in her cell phone and located the photo of the insulin pen. The photo was observed to show an insulin pen labeled with a male's first and last name (Resident 2). Resident 1 stated after verbalizing to LVN 1 that the insulin pen did not belong to Resident 1, LVN 1 left Resident 1's room with Resident 2's insulin pen and came back with the correct insulin pen that had Resident 1's name on it. Resident 1 stated Resident 1 then received her insulin injection and tried to sleep but felt stressed from the discovering the medication error. During an interview on [DATE] at 12:44 p.m. with Registered Nurse (RN 1), RN 1 stated the medication insulin comes in a pen that is initially stored in the refrigerator. RN 1 stated each insulin pen is marked by the pharmacy department who labels the pens with the appropriate residents' names. RN 1 stated when a nurse takes an insulin pen out of the refrigerator and opens it (when the insulin pen is first used), the nurse must write the date the pen was opened and then keep the pen inside the medication cart (a secure, mobile workstation on wheels used by nurses to transport and dispense patient medications). When asked to describe the standard nursing process when preparing to administer medications, RN 1 stated, You need to check the doctor's order and the 5 rights. RN 1 stated the 5 rights consist of the right patient, right drug (the correct medicine ordered by the doctor), right dose (the correct amount of medicine), right route (the<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | correct method that the medicine is delivered to the body, such as by swallowing, being injected, or applied to the skin), and right time (the correct date/time the medication is prescribed by the doctor to be given). During a phone interview on [DATE] at 6:03 p.m. with LVN 1, LVN 1 stated Resident 1 is oriented to (aware of) Resident 1's own self, where Resident 1 is currently located, the date/time, and Resident 1's own situation. LVN 1 stated that when you go to [Resident 1's] room, you have to explain [all the medications] to her before she takes them. When asked if there was a recent incident that occurred involving Resident 1's medications, LVN 1 stated an incident occurred on [DATE] before 9:20 p.m. during LVN 1's shift. LVN 1 stated LVN 1 was at the medication cart in front of Resident 1's room preparing to give Resident 1 medications. LVN 1 stated the medication cart has a container that has multiple insulin pens belonging to different residents and labeled with their names. LVN 1 stated she pulled out an insulin pen that LVN 1 observed was expired, and that expired insulin pen did not have Resident 1's name on it. LVN 1 stated she placed that expired insulin pen on top of the medication cart on the left side. LVN 1 stated: I separated the [expired] insulin pen because I wanted to remind myself to take care of it later. LVN 1 stated she then pulled out Resident 1's insulin pen from the container and placed it on top of the medication cart on the left side because the right side of the cart has a laptop. LVN 1 stated she prepared the rest of Resident 1's medications, which consisted of pills, and then brought all the medications inside Resident 1's room, placing the insulin pen on top of Resident 1's bedside tray table. LVN 1 stated Resident 1 saw [that] the name on the insulin pen was not Resident 1's name. LVN 1 stated Resident 1 verbalized that the insulin pen did not belong to Resident 1, and Resident 1 took a picture of the pen. LVN 1 stated: I hadn't read the name on the insulin pen yet when [Resident 1] saw the pen and said it had the wrong name. LVN 1 stated: My mistake is that I grabbed the other guy's insulin pen from on top of the medication cart. LVN 1 stated LVN 1 took back the wrong insulin pen, left Resident 1's room, and came back with the correct pen. LVN 1 stated LVN 1 brought back both of Resident 1's insulin pens (Insulin Glargine and Insulin Lispro) to show Resident 1 because LVN 1 wanted to make sure [Resident 1] knows we have both of them and LVN 1 wanted [Resident 1] to have peace of mind. LVN 1 stated Resident 1 then allowed LVN 1 to administer the insulin injection in Resident 1's arm. LVN 1 stated: When dealing with one patient, I should not put medications for two patients on top of the medication cart because of the possibility that you can give the patient the wrong medication. LVN 1 stated that LVN 1 did not document the medication error but had only reported it to her RN supervisor (RN 2). During an interview on [DATE] at 9:01 a.m. with LVN 2, LVN 2 stated LVN 2 is familiar with Resident 1 and has been assigned to care for Resident 1 in the past. LVN 2 stated Resident 2 is very alert and Resident 1 knows all her meds. LVN 2 stated the process of preparing a resident's medications at the medication cart consist of checking the resident's name listed on the medication, the name of the medication as ordered by the doctor, the route the medication is to be administered, the time the medication is to be given, and the dose. LVN 2 stated it is important to check when preparing medications because nurses want to avoid medication error. LVN 2 stated, We don't want residents to be hurt like with side-effects from being given the wrong medication. During a phone interview on [DATE] at 11:19 a.m. with RN 2, RN 2 stated RN 2 worked with LVN 1 on [DATE] during the 3:00 p.m. to 11 p.m. shift. When asked if LVN 1 reported a medication error to RN 2 on [DATE], RN 2 stated, I don't remember [LVN 1] told me anything. RN 2 stated if a medication error occurs, you have to document the error. RN 2 stated it is important to document the medication error because we need to prevent the same mistake from happening again. During a concurrent interview and record review on [DATE] at 11:42 a.m. with RN 1, Resident 1's electronic medical record was reviewed. RN 1 stated there were no nursing progress notes documented on [DATE], involving a medication error or incident. When asked if a nurse must document if there is a medication error, RN 1 stated: Yes, of course. I would document that [a medication error] happened, and if patient had any distress from it. During an interview on [DATE] at 12:16 p.m. with the Director of Nursing (DON), the DON stated it is standard nursing practice to document after discovering a medication error. DON stated that if a medication error was<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | discovered but the actual medication was not given to a resident, then the nurse involved needs to document on a ?concerned record' which is like grievance record. The DON stated the purpose of documenting a medication error is for everyone to know [how the error occurred] and be aware and careful in the future. DON further stated documenting a medication error will ensure that other staff are aware of the error so that it won't happen again.During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 7/2017, the P&P indicated: The following information is to be documented in the resident medical record:.Events, incidents, or accidents involving the resident. During a review of the facility's policy and procedure (P&P) titled, Adverse Consequences and Medication Errors, dated 4/2014, the P&P indicated when a medication error occurs, the prescriber and/or staff.document it in the resident's clinical record. The P&P further indicated the following information is documented.in the resident's clinical record: Factual description of the error. |