STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056321	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympia Convalescent Hospital	1100 S. Alvarado St Los Angeles, CA 90006

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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(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 - Few	Based on interview, and record review, the facility failed to ensure:1) Licensed Vocational Nurse (LVN) 1 verified all medications, including controlled substance medications, received from pharmacy were checked and accounted for accuracy.2) LVN 2 and LVN 5 did not sign the narcotic count sheets ahead of time indicating that they (LVN 2 and LVN 5) actually counted and confirmed with the oncoming licensed nurse that the narcotics count was accurate/correct during shift change narcotics count. These deficient practices of not verifying medications received from pharmacy were accurate and not signing out on the narcotic sheets without counting/verifying with another licensed nurse present had the potential for diversion of narcotics. Findings: During a record review, the facility's In-Service Education (a professional development for workers aimed to enhance their skills, knowledge, and competence to improve job performance) dated 5/09/2025 indicated, several LVNs and RNs received education on Medication Order and Receiving. The education's lesson plan indicated all licensed nurses verify and document medications, including controlled substance, were received. The lesson plan also indicated that all licensed nurses will promptly report any discrepancies and omissions to the pharmacy and the charge nurse/supervisor. During a record review, the facility pharmacy receipt dated 8/20/2025, indicated the pharmacy receipt was signed by LVN 1 on 8/21/2025. During a record review, the facility pharmacy receipt dated 8/21/2025, indicated the pharmacy receipt was signed by a licensed nurse on 8/21/2025 at 6:24 PM. During a record review, LVN 1's timecard dated 8/16/2025 through 8/31/2025 of, indicated, LVN 1 clocked in on 8/20/2025 at 11:04 PM and clocked out on 8/21/2025 at 7:58 AM. During a record review, the Notice of Investigatory Suspension letter addressed to LVN 1 dated 8/21/2025, indicated, LVN 1 was suspended effective 8/21/2025. During a record review, the facility document titled One on One Education/Retraining (a type of training where a professional trainer guides a single individual through a session, tailoring the program to their specific goals, needs, and fitness level) dated 8/21/2025, indicated, LVN 1 received education on Receiving Controlled Medications. The lesson plan for retraining education indicated that a nurse signs for the medications received from pharmacy and inspects the medications and reconciles controlled substance orders.against what has been received from the pharmacy. During a record review, the Pharmacy's Management record, dated 8/22/2025, indicated, while the medication (tramadol) did appear on the packing slip (pharmacy receipt), it was unfortunately not in the delivery bag. We have since located the medication and ensured it was redelivered to [the facility]. During a record review, the facility Medication Cart 1 Narcotic Sheet dated 8/25/2025, indicated LVN 2 had already signed out on the narcotic sheet before the end of LVN 2's shift. During a record review, the Medication Cart 1 Narcotic Sheet dated 8/25/2025, indicated LVN 5 had already signed out on the narcotic sheet before the end of LVN 5's shift. During a concurrent record review and interview on 8/25/2025 at 10:53 AM with LVN 5, Medication Cart 2 narcotic sheet dated 8/25/2025, was reviewed. When LVN 5 was asked why a narcotic sheet require two licensed nurses' signatures on it, LVN 5 stated their signatures tell everyone they both checked the medications together and everything is accounted for. Medication Cart 2 narcotic sheet dated 8/25/2025 indicated LVN 5 had already signed the narcotic sheet ahead of time and before end of LVN 5's shift. LVN 5 was asked why the 8/25/2025 narcotic sheet was signed ahead of time, LVN 5 stated it was a mistake. LVN 5 stated the narcotic sheet should have been signed at the end of the shift, around 3 pm today (8/25/25) with another nurse. LVN 5 stated the signatures of two licensed nurses on the medication cart 2 narcotic sheet indicated the signatures of the nurses verify they counted the medications together. LVN 5 also stated the potential harm to Resident 1 when the medication cart 2 narcotic sheet was signed ahead of time that the medication may be missing, the resident has to wait for the medication replacement causing resident additional pain and discomfort. During a concurrent record review and interview on 8/25/2025 at 12:14 PM with LVN 2, LVN 2 was asked if it was acceptable to sign the narcotic sheet ahead of time, LVN 2 stated no.if the narc sheet is signed ahead of time, then it means the nurse didn't really check the medications with another nurse. Medication Cart 1 narcotic sheet for 8/25/2025 was signed by LVN 2 ahead of time. LVN 2 was asked why LVN 2 signed the medication cart 1 narcotic sheet ahead of time, LVN 2 stated that was a mistake. LVN 2 also stated the potential harm to the resident when the medication cart 1 narcotic sheet was signed ahead of time the resident's med may be missing.causing the resident to have increased pain and suffering.may need additional pain medication when the resident's pain is not relieved by the pain medication replacement. During an interview on 8/25/2025 at 12:14 PM with LVN 2, LVN 2 stated the licensed nurse who received