STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555004	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Playa Del Rey Center	7716 Manchester Avenue Playa Del Rey, CA 90293

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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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to: 1. Ensure a request for access to medical records and provide copies to resident representative was fulfilled in a timely manner for one of one sampled resident (Resident 1). This deficient practice had the potential to result in Resident 1 feeling frustrated and violated resident rights to obtain medical records. Findings: During a review of Resident 1's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 1 was admitted to the facility on [DATE]. The Admission Record indicated Resident 1's diagnoses included rupture of other tendons (injuries to the soft tissues that connect muscles and joints), encounter for other orthopedic after care (the care that you need to take after having orthopedic surgery), and unspecified knee patellar tendinitis (an injury to the tendon connecting your kneecap to your shinbone. During a review of Resident 1's History and Physical (H&P), dated 11/11/2024, the H&P indicated, Resident 1 was alert, oriented x 3 (person, place, and time) and had appropriate mood and affect. During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool, dated 11/11/2024, the MDS indicated, Resident 1's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 1 required setup assistance (helper sets up, resident completes activity) on staff with eating, oral hygiene, and personal hygiene. During a review of Resident 1's Request for Access to Protected Health Information ([PHI] any information that relates to an individual's health status, medical history, or treatment), dated 11/18/2024, the PHI indicated, Resident 1 would like to access and inspect his PHI and would like the facility to send a copy of his PHI to his representative. During an interview on 11/26/2024 at 7:57 a.m., with Resident 1's representative, Resident 1's representative stated Resident 1 signed the request to release his medical records on 11/18/2024. Resident 1's representative stated Medical Records Director (MRD) told her Resident 1's medical records will be released in 48 hours. (continued on next page)

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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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/26/2024 at 11:15 a.m., with Resident 1, Resident 1 stated he had asked the staff to view his medical records on 11/18/2024 and requested to send his medical records to his representative. Resident 1 stated the staff had not provided him access to view his medical records. Resident 1 stated the facility sent his medical records to his representative via Electronic mail ([email] a communication method that uses electronic devices to deliver messages across computer networks) on 11/26/2024. During an interview on 11/26/2024 at 3:30 p.m., with the MRD, the MRD stated once she receives the request to release medical records, she informs her Administrator (ADM), Director of Nursing (DON), and corporate office. The MRD stated resident medical records should be released in 2 business days after the request was made. The MRD stated the facility's policy is to charge the resident or his or her representative fifteen dollars ($15) as critical fee before releasing the medical records via email. During an interview on 11/26/2024 at 4:00 p.m., with the DON, the DON stated she was notified on 11/25/2024 that Resident 1 requested to have an access and send his medical records electronically to his representative. The DON stated the critical fee in the amount of $15 only applies for records that needs to be printed. The DON stated sending medical records electronically should be free of charge. The DON stated resident has the right to view his medical records immediately upon request. The DON stated it was a violation of resident rights for not releasing medical records in a timely manner. During an interview on 11/27/2024 at 10:30 a.m., with the ADM, the ADM stated no medical records will be released until the facility got payment from the resident or resident representative. The ADM stated she got an approval on 11/26/2024 from the corporate office to release Resident 1's medical records to his representative free of charge. During a review of the facility's policy and procedure (P&P) titled, Access to Personal and Medical Records, dated 5/2017, the P&P indicated, Access to the resident's personal and medical records will be provided to the resident within 24 hours (excluding weekends and holidays) of his or her request . The P&P also indicated the resident may obtain a copy of his or her personal or medical record within two business days of an oral or written request. During a review of the facility's P&P titled, Resident Rights, dated 12/2021, the P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility that includes resident's right to access personal and medical records pertaining to him or herself .

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, by failing to: 1. Follow-up with orthopedic (a medical specialty that focuses on the diagnosis, treatment, and prevention of injuries and diseases affecting the musculoskeletal system) surgeon in a timely manner for resident with bilateral (having or involving two sides) knee immobilizer (a medical device that restricts movement of the knee joint) for one of one sampled resident (Resident 1). This deficient practice had the potential for Resident 1 to have decline in mobility and range of motion. Findings: During a review of Resident 1's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 1 was admitted to the facility on [DATE]. The Admission Record indicated Resident 1's diagnoses included rupture of other tendons (injuries to the soft tissues that connect muscles and joints), encounter for other orthopedic after care (the care that you need to take after having orthopedic surgery), and unspecified knee patellar tendinitis (an injury to the tendon connecting your kneecap to your shinbone. During a review of Resident 1's History and Physical (H&P), dated 11/11/2024, the H&P indicated, Resident 1 was alert, oriented x 3 (person, place, and time) and had appropriate mood and affect. During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool, dated 11/11/2024, the MDS indicated, Resident 1's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 1 required setup assistance (helper sets up, resident completes activity) on staff with eating, oral hygiene, and personal hygiene. During a review of Resident 1's Orthopedic Office Visit Report, dated 10/30/2024, the Orthopedic Office Visit Report indicated Resident 1 to continue weight bearing as tolerated ([WBAT - patient is medically cleared to put as much as weight as is comfortable through an affected limb, up to their full weight) on his bilateral lower extremities with hinged knee brace (brace that stabilizes the knee joint and keeps the bones from moving around too much) locked in extension (knee in straight position) and starting in 2 weeks he can begin flexion (bending) extension (straightening of joint) of the knee up to 30 degrees (unit of measurement) and increase 10 degrees per week. During a review of Resident 1's Physical Therapy (a treatment that helps people improve their physical movement and manage pain) Evaluation, dated 11/8/2024, the PT Evaluation indicated Resident 1 was referred to PT due to new onset of decrease in functional mobility and decrease in strength. The PT Evaluation indicated Resident 1 had precautions of WBAT, bilateral knee immobilizer at all times, and no knee flexion. The PT Evaluation indicated Resident 1 had impaired right and left knee range of motion due to precaution on knee locked in extension. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 11/26/2024 at 12:45 p.m., with Resident 1 in his room, observed Resident 1 in bed with bilateral hinged knee brace. Resident 1 stated he kept telling the therapist to call and follow-up his orthopedic surgeon so they can adjust his bilateral hinged knee brace so he can start bending his knees. Resident 1 stated he can't bend his knees since he had a surgery. Resident 1 stated he was told by his orthopedic surgeon that he can start bending his knees on 11/14/2024. Resident 1 stated he was frustrated because he can't bend his knees. During an interview on 11/26/2024 at 1:30 p.m., with the Director of Rehabilitation (DOR), the DOR stated the standard of practice for all residents with orthopedic surgery was to follow up with the orthopedic surgeon for further orders and recommendations. The DOR stated she was able to follow-up with Resident 1's orthopedic surgeon on 11/25/2024, 18 days after Resident 1 was admitted to the facility, and clarified the orders of his knee hinged brace and knee precautions. The DOR stated it was important to follow up with Resident 1's orthopedic surgeon because the goal for Resident 1 is to progress his range of motion on the knees by appropriately adjusting the knee hinged brace. The DOR stated by not adjusting Resident 1's knee hinged brace in a timely manner would result in acute tightness of the knee and limited mobility. During an interview on 11/26/2024 at 4:00 p.m., with the Director of Nursing (DON), the DON stated the standard of practice in caring for resident who had a surgery with a brace was to call the orthopedic surgeon to find out the treatment recommendations. The DON stated it is the facility's policy to provide quality of care to all residents by giving optimum care for them to achieve their highest practicable well-being. During a review of the facility's policy and procedure (P&P) titled, Quality of Life - Dignity, dated 2/2020, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem .

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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** 47923 Based on interview and record review, the facility failed to provide pharmaceutical services to one of one sampled resident (Resident 1) by failing to: 1. Ensure the licensed nurses followed the facility's policy and procedure (P&P) titled, Administering Medications to administer medications within one hour of their prescribed time. This deficient practice placed Resident 1 at risk for mismanagement of medication regimen. Findings: During a review of Resident 1's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 1 was admitted to the facility on [DATE]. The Admission Record indicated Resident 1's diagnoses included rupture of other tendons (injuries to the soft tissues that connect muscles and joints), encounter for other orthopedic after care (the care that you need to take after having orthopedic surgery), and unspecified knee patellar tendinitis (an injury to the tendon connecting your kneecap to your shinbone. During a review of Resident 1's History and Physical (H&P), dated 11/11/2024, the H&P indicated, Resident 1 was alert, oriented x 3 (person, place, and time) and had appropriate mood and affect. During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool, dated 11/11/2024, the MDS indicated, Resident 1's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 1 required setup assistance (helper sets up, resident completes activity) on staff with eating, oral hygiene, and personal hygiene. During a review of Resident 1's Order Summary Report ([OSR] a document containing active physician orders), dated 11/26/2024, the OSR indicated, Resident 1 was to receive the following medications: 1. Aspirin 81milligrams (mg - unit of measurement, used for medication dosage and/or amount) twice a day for cerebrovascular accident ([CVA] stroke - a medical condition when there is a loss of blood flow to part of the brain). 2. Famotidine 20mg to give 1 tablet twice a day for acid indigestion (burning feeling in the stomach). 3. Atorvastatin 40mg to give 1 tablet at bedtime for hyperlipidemia (a condition in which there are high levels of fats in the blood). During a review of Resident 1's Medication Administration Records ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 11/2024, indicated Resident 1's doses of aspirin were scheduled at 9 a.m., and 5 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Medication Admin Audit Report ([MAAR] a document indicating the exact time medications were documented as administered), dated from 11/7/2024 to 11/27/2024, indicated aspirin was administered to Resident 1 as follows: 1. On 11/8/2024 - aspirin was scheduled to be administered at 5 p.m., however according to the MAAR aspirin was administered to Resident 1 at 9:04 p.m. (over 4 hours after the scheduled dose). 2. On 11/11/2024 - aspirin was scheduled to be administered at 9 a.m., however according to the MAAR aspirin was administered to Resident 1 at 12:30 p.m. (over 3 hours after the scheduled dose) 3. On 11/12/2024 - aspirin was scheduled to be administered at 9 a.m., however according to the MAAR aspirin was administered to Resident 1 at 3:37 p.m. (over 6 hours after the scheduled dose) 4. On 11/13/2024 - aspirin was scheduled to be administered at 9 a.m., however according to the MAAR aspirin was administered to Resident 1 at 12:15 p.m. (over 3 hours after the scheduled dose) 5. On 11/13/2024 - aspirin was scheduled to be administered at 5 p.m., however according to the MAAR aspirin was administered at 9:11 p.m. (over 4 hours after the scheduled dose) 6. On 11/15/2024 - aspirin was scheduled to be administered at 9 a.m., however according to the MAAR aspirin was administered at 11:22 a.m. (over 2 hours after the scheduled dose) 7. On 11/15/2024 - aspirin was scheduled to be administered at 5 p.m., however according to the MAAR aspirin was administered at 7:40 p.m. (over 2 hours after the scheduled dose) 8. On 11/17/2024 - aspirin was scheduled to be administered at 9 a.m., however according to the MAAR aspirin was administered at 11:06 a.m. (over 2 hours after the scheduled dose) 9. On 11/20/2024 - aspirin was scheduled to be administered at 9 a.m., however according to the MAAR aspirin was administered at 12:05 p.m. (over 3 hours after the scheduled dose) 10. On 11/20/2024 - aspirin was scheduled to be administered at 5 p.m., however according to the MAAR aspirin was administered at 7:02 p.m. (over 2 hours after the scheduled dose) 11. On 11/21/2024 - aspirin was scheduled to be administered at 5 p.m., however according to the MAAR aspirin was administered at 7:33 p.m. (over 2 hours after the scheduled dose) 12. On 11/23/2024 - aspirin was scheduled to be administered at 9 a.m., however according to the MAAR aspirin was administered at 12:41 p.m. (over 3 hours after the scheduled dose) 13. On 11/25/2024 - aspirin was scheduled to be administered at 5 p.m., however according to the MAAR aspirin was administered at 8:31 p.m. (over 3 hours after the scheduled dose) During a review of Resident 1's Medication Administration Records ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 11/2024, indicated Resident 1's doses of famotidine were scheduled at 9 a.m., and 5 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Medication Admin Audit Report ([MAAR] a document indicating the exact time medications were documented as administered), dated from 11/7/2024 to 11/27/2024, indicated famotidine was administered to Resident 1 as follows: 1. On 11/8/2024 - famotidine was scheduled to be administered at 5 p.m., however according to the MAAR famotidine was administered at 9:04 p.m. (over 4 hours after the scheduled dose) 2. On 11/11/2024 - famotidine was scheduled to be administered at 9 a.m., however according to the MAAR famotidine was administered at 12:30 p.m. (over 3 hours after the scheduled dose) 3. On 11/13/2024 - famotidine was scheduled to be administered at 9 a.m., however according to the MAAR famotidine was administered at 12:15 p.m. (over 3 hours after the scheduled dose) 4. On 11/13/2024 - famotidine was scheduled to be administered at 5 p.m., however according to the MAAR famotidine was administered at 9:11 p.m. (over 4 hours after the scheduled dose) 5. On 11/15/2024 - famotidine was scheduled to be administered at 9 a.m., however according to the MAAR famotidine was administered at 11:22 a.m. (over 2 hours after the scheduled dose) 6. On 11/15/2024 - famotidine was scheduled to be administered at 5 p.m., however according to the MAAR famotidine was administered at 7:40 p.m. (over 2 hours after the scheduled dose) 7. On 11/17/2024 - famotidine was scheduled to be administered at 9 a.m., however according to the MAAR famotidine was administered at 11:06 a.m. (over 2 hours after the scheduled dose) 8. On 11/19/2024 - famotidine was scheduled to be administered at 9 a.m., however according to the MAAR famotidine was administered at 11:57 a.m. (over 2 hours after the scheduled dose) 9. On 11/20/2024 - famotidine was scheduled to be administered at 9 a.m., however according to the MAAR famotidine was administered at 12:05 p.m. (over 3 hours after the scheduled dose) 10. On 11/20/2024 - famotidine was scheduled to be administered at 5 p.m., however according to the MAAR famotidine was administered at 7:03 p.m. (over 2 hours after the scheduled dose) 11. On 11/21/2024 - famotidine was scheduled to be administered at 5 p.m., however according to the MAAR famotidine was administered at 7:33 p.m. (over 2 hours after the scheduled dose) 12. On 11/23/2024 - famotidine was scheduled to be administered at 9 a.m., however according to the MAAR famotidine was administered at 12:41 p.m. (over 3 hours after the scheduled dose) 13. On 11/25/2024 - famotidine was scheduled to be administered at 5 p.m., however according to the MAAR famotidine was administered at 8:31 p.m. (over 3 hours after the scheduled dose) During a review of Resident 1's Medication Administration Records ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 11/2024, indicated Resident 1's dose of atorvastatin was scheduled at 9:00 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Medication Admin Audit Report ([MAAR] a document indicating the exact time medications were documented as administered), dated from 11/7/2024 to 11/27/2024, indicated atorvastatin was administered to Resident 1 as follows: 1. On 11/13/2024 - atorvastatin was scheduled to be administered at 9 p.m., however according to the MAAR atorvastatin was administered at 11:56 p.m. (over 2 hours after the scheduled dose) 2. On 11/23/2024 - atorvastatin was scheduled to be administered at 9 p.m., however according to the MAAR atorvastatin was administered at 11:36 p.m. (over 2 hours after the scheduled dose) 3. On 11/25/2024 - atorvastatin was scheduled to be administered at 9 p.m., however according to the MAAR atorvastatin was administered at 11:27 p.m. (over 2 hours after the scheduled dose) 4. On 11/26/2024 - atorvastatin was scheduled to be administered at 9 p.m., however according to the MAAR atorvastatin was administered at 11:31 p.m. (over 2 hours after the scheduled dose) During an interview on 11/26/2024 at 12:45 p.m., with Resident 1, Resident 1 stated licensed nurses were late in giving his medications. During an interview on 11/27/2024 at 10:00 a.m., with the Director of Nursing (DON), the DON stated she knows that Resident 1 was not getting his scheduled medications on several occasions based on the MAAR. The DON stated scheduled medication should be given 1 hour before and 1 hour after the scheduled time. The DON stated it was important to administer medications as scheduled to ensure effectiveness and minimize the side-effects. During a review of the facility's undated policy and procedure (P&P) titled, Administering Medications, , the P&P indicated, Medications are administered in a safe and timely manner, as prescribed . The P&P also indicated medications are administered within one (1) hour of their prescribed time, unless otherwise specified.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to: 1. Administer influenza vaccine (a vaccine that protects against the influenza virus) to one of one sampled resident (Resident 1). This deficient practice placed Resident 1 at risk for acquiring influenza virus. Findings: During a review of Resident 1's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated, Resident 1 was admitted to the facility on [DATE]. The Admission Record indicated Resident 1's diagnoses included rupture of other tendons (injuries to the soft tissues that connect muscles and joints), encounter for other orthopedic after care (the care that you need to take after having orthopedic surgery), and unspecified knee patellar tendinitis (an injury to the tendon connecting your kneecap to your shinbone. During a review of Resident 1's History and Physical (H&P), dated 11/11/2024, the H&P indicated, Resident 1 was alert, oriented x 3 (person, place, and time) and had appropriate mood and affect. During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool, dated 11/11/2024, the MDS indicated, Resident 1's cognitive (ability to think and reason) skills for daily decision making was intact. The MDS indicated, Resident 1 required setup assistance (helper sets up, resident completes activity) on staff with eating, oral hygiene, and personal hygiene. During an interview on 11/26/2024 at 12:45 p.m., with Resident 1, Resident 1 stated 1 he requested to get the flu vaccine on 11/7/2024. Resident 1 stated he does not want to get the flu virus. Resident 1 stated until now facility staff did not give him yet the flu vaccine. During a concurrent interview and record review on 11/26/2024 at 4:15 p.m., with the Director of Nursing (DON), Resident 1's Consent to Administer Influenza Vaccine, dated 11/7/2024, was reviewed. The Consent to Administer Influenza Vaccine indicated, Resident 1 requested to be given an influenza vaccine. The DON stated Resident 1's consent for influenza vaccine was considered as a physician order. The DON stated he did not find any documentation that facility staff communicated with pharmacy and ordered Resident 1's influenza vaccine. The DON acknowledged there was no documentation in Resident 1's clinical records that facility staff did administer Resident 1's influenza vaccine. The DON stated it was important for residents to have their influenza vaccine updated in order to prevent them from developing influenza infection. During a review of the facility's undated, policy and procedure (P&P) titled, Influenza Vaccine, the P&P indicated, All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza . The P&P also indicated administration of the influenza vaccine will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated P&P titled, Administering Medications, the P&P indicated, Medications are administered in a safe and timely manner, as prescribed .