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	02/14/2025

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

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505 Based on interviews and record review, the facility failed to create a baseline care plan (a care plan developed within 48 hours of admission that included minimum healthcare information necessary to properly care for each resident immediately upon their admission) for diabetes (DM-a disease that result in too much sugar in the blood) for one of three sampled residents, (Resident 1). This failure had a potential to cause Resident 1 to not have the appropriate interventions for diabetes. Findings During a review of Resident 1's Admission Record, dated 2/14/2025, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses including endocarditis (an infection that causes the swelling of the lining of the heart valves and chambers), type 2 DM and chronic kidney disease, stage 3A (a disease with progressive loss of kidney function, with mild to moderate loss of kidney function). During a review of Resident 1's History and Physical (H&P), dated 3/5/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 3/8/2024, the MDS indicated Resident 1 was able to understand and be understood by others. The MDS indicated Resident 1 had moderate cognitive impairment. The MDS indicated Resident 1 required moderate assistance from staff for activities of daily living such as toileting hygiene, upper and lower body dressing, and putting on and taking off footwear. The MDS indicated Resident 1 required supervision from staff for oral hygiene and was independent for eating and moderate assistance staff for sitting to lying, lying to sitting on edge of bed, sitting to standing, chair to bed transfer, and walking 10 feet and supervision for rolling left and right. During a review of Resident 1's order summary report, dated 2/14/2025, the order summary report indicated an order for insulin NPH (medication for DM) two times a day for high blood sugar and insulin lispro (medication for DM) one time a day for high blood sugar. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's progress note titled, IDT (Interdisciplinary Team) note , dated 3/7/2024, the note indicated the IDT discussed Resident 1's plan of care with Resident 1's responsible party. During a review of Resident 1's care plan titled, The resident has a diagnosis of diabetes: Insulin Dependent, dated 3/10/2024, the interventions included to assess and record blood glucose levels as ordered, monitor for signs and symptoms of hyper/hypoglycemia (high/low blood sugar), report abnormal findings to physician and notify physician of glucose levels (with unknown parameters). During a concurrent interview and record review on 2/20/2025 at 1:35 p.m. with the Director of Nursing (DON), Resident 1's care plan, dated 3/10/2024, was reviewed. The DON stated the care plan was created and initiated on 3/10/2024. The DON stated Resident 1 was admitted to the facility on [DATE] with the diagnosis of diabetes. The DON stated the baseline care plan should have been created within 48 hours of admission and the baseline care plan should contain the minimum, needed for the care of the resident. The DON stated there should have beena baseline care plan created for diabetes. The DON stated the purpose of the care plan was to guide the care of the resident and if there was no care plan, then the staff would have no guideline for the resident's care. During a review of the facility's policy and procedure (P&P) titled, Care Plan-Baseline, dated 8/25/2021, the P&P indicated the baseline care plan should be developed within 48 hours of resident's admission and the baseline care plan includes the minimum information necessary to properly care for a resident including initial goal based on admission orders and physician orders.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46505 Based on interviews and record review, the facility failed to follow professional standards of practice for one of three sampled residents (Resident 1), who was receiving insulin (a medication to lower blood sugar) injections, by not ensuring a physician order for blood sugar monitoring was obtained and monitored, as indicated in the resident's care plan. This deficient practice had the potential for Resident 1's blood sugar not being adequately monitored and managed. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including endocarditis (an infection that causes the swelling of the lining of the heart valves and chambers), type 2 diabetes mellitus (DM-a long term condition in which the body has trouble controlling blood sugar and using it for energy), and chronic kidney disease, stage 3A (kidney failure). During a review of Resident 1's History and Physical (H&P), dated 3/5/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 3/8/2024, the MDS indicatedResident 1 was able to understand and be understood by others. The MDS indicated Resident 1 had moderate cognitive impairment. The MDS indicated Resident 1 required moderate assistance from staff for activities of daily living such as toileting hygiene, upper and lower body dressing, and putting on and taking off footwear. The MDS indicated Resident 1 required supervision for oral hygiene and was independent for eating. The MDS indicated Resident 1 required moderate assistance for sitting to lying, lying to sitting on edge of bed, sitting to standing, chair to bed transfer, and walking 10 feet and supervision for rolling left and right. During a review of Resident 1's order summary report, dated 2/14/2025, the order summary report indicated an order for insulin NPH (medication for DM), four units two times a day for high blood sugar and insulin lispro (medication for DM) four units, onse a day for high blood sugar. The order summary report did not indicate blood sugar level parameters for the insulin administration. During a review of Resident 1's change in condition (COC) evaluation, dated 3/10/2024, the COC evaluation indicated on 3/10/2024, while Resident 1 was sitting in the wheelchair, Resident 1 was observed pale and was unresponsive. The COC indicated, upon assessment, Resident 1's blood sugar level was 64 milligram/deciliter (mg/dL, a unit of measurement) and the oxygen saturation was low (normal level is 90-100%). The COC evaluation indicated Resident 1 was transferred to a general acute care hospital (GACH). During a review of Resident 1's care plan titled, The resident has a diagnosis of diabetes: Insulin Dependent, dated 3/10/2024, the interventions indicated to assess and record blood glucose levels as ordered, monitor for signs and symptoms of hyper/hypoglycemia (high/low blood sugar), report abnormal findings to the physician and notify physician of glucose level (with unknown parameters). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Medication Administration Record (MAR) for 3/2025, the MAR indicated Resident 1 received the scheduled insulin NPH and insulin lispro injections. The MAR did not indicate any blood sugar levels monitoring. During an interview on 2/20/2025 at 1:25 p.m. with the Director of Nursing (DON), the DON stated if a resident with insulin admitted to the facility, there should be blood glucose monitoring orders. The DON stated nurses need to check blood sugar levels to ensure residents won't become hypoglycemic (low blood sugar) or hyperglycemic (high blood sugar). The DON stated if blood glucose levels are not monitored, the resident could experience adverse effects. During a concurrent interview and record review on 2/20/2025 at 1:30 p.m. with the DON, Resident 1's physician's orders were reviewed. The DON stated Resident 1 had no orders for blood sugar monitoring. The DON stated Resident 1's order did not indicate blood sugar level parameters, as to when the insulin should be administered or when it needed to be held. During a concurrent interview and record review on 2/20/2025 at 2:00 p.m. with the DON, the facility's policy and procedure (P&P) titled Diabetes-Clinical Protocol, dated 11/2020 was reviewed. The DON stated, the P&P indicated the physician should order appropriate lab tests, for example, periodic finger sticks, and adjust treatments based on these results and other parameters. The DON stated, the P&P indicated the example for blood glucose monitoring for a resident receiving insulin, to monitor blood glucose levels twice a day. The DON stated Resident 1's initial assessment was not done. The DON stated Resident 1's initial assessment should have been done per P&P. The DON stated the doctor did not order blood sugar monitoring for Resident 1. During a review of the facility's P&P titled, Diabetes-Clinical Protocol, dated 11/2020, the P&P indicated for monitoring and follow-up, the physician should order desired parameters for monitoring and reporting information related to blood sugar management. The P&P indicated, the staff will incorporate such parameters into the Medication Administration Record and the care plan.