

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER Playa Del Rey Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36504</p> <p>Based in observation, interview and record review, the facility failed to ensure the Licensed Vocational Nurses (LVN) working in the facility were able to administer all the medications for two of five sampled residents (Residents 1 and 2), timely, as ordered by the physician and as per standards of practice.</p> <p>This deficient practice had the potential to cause these residents not to maintain the therapeutic level of the medication and to not receive the full benefit of the ordered medications.</p> <p>Findings:</p> <p>1). During a review of Resident 1 Admission Record, the admission record indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, chronic obstructive pulmonary disease and acute respiratory failure.</p> <p>During a review of Resident 1 ' s Minimum data Set ([MDS] a federally mandated resident assessment tool) dated 2/21/2025, the MDS indicated Resident 1 had the ability to make her needs known.</p> <p>During an interview on 2/28/2025 at 9 30 a.m., with Resident 1, Resident 1 stated that she never receives her medications on time. Resident 1 stated she had waited for two hours for her pain medication (not specified) and still did not receive it. Resident 1 stated she had to get up and walked to the nurses ' station to ask for her pain medication again before one of the staff gave it to her.</p> <p>2). During a review of Resident 2 Admission Record, the admission record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), atrial fibrillation ([A Fib] irregular rapid heart rate that commonly causes poor blood flow), anxiety disorder.</p> <p>During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 had the ability to make her needs known.</p> <p>(continued on next page)</p>

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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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During inspection on 2/28/2025 at 11:15 a.m., medication administration was observed on Resident 2 with Licensed Vocational Nurse (LVN) 1. LVN 1 pulled out three medications from their sachets, oxybutynin extended release (medicine for an overactive bladder) 10 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), Eliquis 2.5 mg (prophylaxis of deep vein thrombosis (DVT), which may lead to pulmonary embolism), and buspirone 5 mg (medicine for anxiety).</p> <p>During a review of Resident 2 ' s Medication Admin (Administration Audit Report schedule date: 12/1/2024-2/28/2025 indicated on 12/01/2024, Resident 2 received her scheduled 9:00 a.m. medications at 1:09 p.m.</p> <p>On the month of January 2025, 1/16/25, Resident 2 received her scheduled 9:00 a.m. medications at 1:18 p. m.</p> <p>On the month of February 2025, 2/19/2025, Resident 2 received her scheduled 9:00 a.m. medication at 2:45 p.m.</p> <p>During an interview on 2/28/2025 at 7:50 a.m., with LVN 2, LVN 2 stated Resident 1 complained to her that she did not get her pain medication on time last night (time not specified), but when she checked the MAR, it was documented that resident 1 received her pain medicine at 4 a.m.</p> <p>During an interview on 2/28/2025 at 1:00 p.m. with LVN 1, LVN 1 stated that she had 33 residents in her station, and it had been a struggle to meet up with the care the residents need. She stated that most of the time she was late in administering the residents ' medications because of the number of residents she has, and a lot of interruptions during medication pass. LVN 1 stated, she had to stop passing medications to the residents to respond to residents ' call light, assist the residents and family with their needs and talk to the doctors. LVN 1 stated all these (responding to residents ' call light, assisting the residents and family with their needs and talking to the doctors) delays the medication pass.</p> <p>During an interview on 2/28/2025 at 12:30 .pm. with LVN 3, LVN 3 stated that she has 33 Residents on her station, and it had always been a challenge to meet up with the care the residents need. LVN 3 stated that overtime is not allowed and if you endorse some of the work to the next shift, you could not finish, it might not be done because they too, have their own work to complete.</p> <p>During an interview on 3/4/2025 at 3:05 p.m., with LVN 4, on medication administration to Residents 3 and 5. LVN 4 stated that she has 34 Residents to care for during her 8-hour shift. LVN 4 stated she normally gives her residents their medications between 8 am to 10 am but due to the number of residents she has and lots of distractions during med pass, like answering the phone, helping the Certified Nurse Assistants (CNA) with residents, it had resulted to some residents getting their 9 a.m. medications late. LVN 4 stated that some days she will give the residents their 9 a.m. medications on time, but document later, because she does not have enough time to document at the same time the medications were given. LVN 4 stated that she knew that scheduled medication should be given one hour before or after the scheduled time, but due to the number of the residents she has, it was a struggle to meet up with time.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/4/2025 at 3:30 p.m., with the Director of Nursing (DON), the DON stated that the staff has never complained to her that they could not meet up with residents care due to the number of residents they are assigned to. The DON stated that the facility allows overtime, but it has to be with an approval from the management.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled ,Staffing Sufficient and Competent Nursing, dated 8/2022, the P&P indicated the facility should provide sufficient number of nursing staff with the appropriate skill and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plan and the facility assessment.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36504</p> <p>Based on observation, interview and records review, the facility failed to ensure, 1 of 5 sampled residents ' (Resident 2) medications were administered, as ordered by the physician. The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. The facility staff did not crush Resident 2 ' s three medications together without physicians ' order. 2. The facility staff did not crush Resident 2 ' s extended-release medication (medications designed to release an active ingredient over a specific duration gradually) prior to its administration. <p>These deficient practices placed Resident 2 at risk for high level of the medication in her system, as crushing extended-release medication, converts it to immediate release (developed to dissolve without delaying or prolonging dissolution or absorption of the drug).</p> <p>Findings:</p> <p>During a review of Resident 2 ' s Admission Record, the admission record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), atrial fibrillation ([A Fib] irregular rapid heart rate that commonly causes poor blood flow), anxiety disorder.</p> <p>During a review of Resident ' s 2 Minimum data Set ([MDS] a federally mandated resident assessment and care-screening tool) dated 2/8/2025, the MDS indicated Resident 2 had the ability to make her needs known.</p> <p>During a review of Resident 2 ' s physician ' s Order Summary Report dated 2/28/2025, the order summary indicated the following:</p> <ol style="list-style-type: none"> 1) On 12/10/2024, the physician ordered to administer Buspirone (used to treat anxiety) 10 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount) 1 tablet by mouth two times a day for anxiety. 2) On 10/26/2024, the physician ordered to administer Eliquis (used to treat and prevent blood clots) 2.5 mg 1 tablet by mouth two times a day for A fib. 3) On 1/31/2025, the physician ordered to administer Oxybutynin chloride ER (Extended Release) 24-hour 10 mg 1 tablet by mouth one time a day for frequent urination. <p>During inspection on 2/28/2025 at 11:15 a.m., medication administration was observed on Resident 2 with Licensed Vocational Nurse (LVN 1), LVN 1 pulled out three medications from their sachets, oxybutynin extended release 10 mg, Eliquis 2.5 mg, and buspirone 5 mg that were scheduled for 9 a.m. LVN 1 crushed the three medications together, mixed them with apple, then administered to Resident 2 at 11:37 am.</p> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/28/2025 at 12:05 pm, with Resident 2, Resident 2 stated that she always got her morning medications at 11 a.m. and she liked them crushed. RN 2 stated it made it easy to swallow.</p> <p>During an interview on 2/28/2025 at 1:00 p.m. with LVN 1, LVN 1 stated she crushed Resident 2 ' s medications because Resident 2 wanted her meds to be crushed and made it easy for her to swallow.</p> <p>During a concurrent interview and record review on 2/8/2025 at 1:50 p.m. with LVN 1, the physician order summary report for Resident 2 were reviewed, there was no physician order to crush Resident 2 ' s medications and to mix with apple source. LVN 1 stated that she should have called the physician and obtained physician order to crush Resident 2 ' s medications before crushing it. LVN 1 stated the speech therapy should have evaluated Resident 2 for swallowing problem.</p> <p>During an interview on 3/4/25 at 12:16 p.m. with the facility pharmacy consultant (Pharm C), the Pharm C stated that one of Resident 2 ' s medications Oxybutynin Chloride extended release should not be crushed. By crushing it, the medication may act as immediate release and may result in resident going to bathroom more often. Pharm C stated that Resident ' s medications should be given as scheduled to maintain a therapeutic level and also to avoid overdosing when 2 doses are administered too soon to the resident.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Staffing Sufficient and Competent Nursing, dated 8/2022, the P&P indicated all nursing staff must meet the specific competency requirement of their respective Licensure and Certification. The P&P indicated staff must demonstrate the skill and techniques necessary to care for resident needs including but not limited to resident rights, basic nursing skills and medication management.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36504</p> <p>Based in observation, interview and records review, facility failed to:</p> <ol style="list-style-type: none"> 1. Provide medications, to four of five sampled residents (Residents 2,3,4, and 5), in a timely manner and as ordered by the physician. 2. Ensure Licensed staff did not crush Resident 2 ' s three medications and mixed with apple source before administering it to Resident 2. <p>This deficient practice had the potential to cause drug interaction when two medications could not be mixed together and could lead to staff not being able to identify each medicine in the case resident refused to take any of the medications.</p> <p>This deficient practice placed Resident 2 at risk for high level of the medication in her system, crushing extended-release (medications designed to release an active ingredient over a specific duration gradually) medication converts it to immediate release (developed to dissolve without delaying or prolonging dissolution or absorption of the drug).</p> <ol style="list-style-type: none"> 3. Ensure facility staff did not crush Resident 2 ' s extended-release medication that is not supposed to be crushed. This deficient practice had the potential to cause these residents not to maintain the therapeutic level of the medication and not to get the full benefit of these medications. <p>Findings:</p> <p>During observation on 2/28/2025 at 11:15 a.m., Licensed Vocational Nurse (LVN 1) was observed during medication administration for Resident 2 ' s 9 a.m. medications. LVN 1 pulled out three medications from the sachets, oxybutynin (medicine for frequent urination) extended release (ER) (medications designed to release an active ingredient over a specific duration gradually) 10 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), Eliquis 2.5 mg (medicine to treat and prevent blood clots), and buspirone 5 mg. (medicine for anxiety). LVN 1 crushed the three medications together, mixed them with apple source and administered to Resident 2 at 11:37 a.m.</p> <p>During an interview on 2/28/2025 at 12:05 p.m., with Resident 2, Resident 2 stated that she always got her 9 a.m. medications at 11 a.m. and she liked the medications crushed as it made it easier to swallow.</p> <p>During a review of Resident 2 ' s Admission Record, the admission record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), atrial fibrillation ([A Fib] irregular rapid heart rate that commonly causes poor blood flow), anxiety disorder.</p> <p>During a review of Resident ' s 2 Minimum data Set ([MDS] a federally mandated resident assessment and care-screening tool) dated 2/8/2025, the MDS indicated Resident 2 had the ability to make her needs known.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 2 ' s physician ' s order summary report dated 2/28/2025, the physician ' s order indicated the following:</p> <ol style="list-style-type: none"> On 12/10/2024, the physician ordered to administer Buspirone 10 mg., 1 tablet by mouth two times a day for anxiety. On 10/26/2024, the physician ordered to administer Eliquis 2.5 mg., 1 tablet by mouth two times a day for A fib. On 1/31/2025, the physician ordered to administered oxybutynin chloride ER 24-hour, 10 mg, 1 tablet by mouth one time a day for frequent urination. <p>During a review of Resident 2 ' s Medication Admin (Administration) Audit Report schedule dated 12/1/2024-2/28/2025, the Medication Admin Audit report indicated on 12/1/2024, Resident 2 received the following scheduled 9:00 am medications at 1:09 pm.:</p> <ol style="list-style-type: none"> Pepcid 20 mg for indigestion Metoprolol 25 mg for hypertension Eliquis 5 mg for Afib. Buspirone 5 mg for anxiety <p>On 1/16/2025, the same medications scheduled for 9:00 am were administered to Resident 2 at 1:18 pm.</p> <p>On 2/19/2025, the same medications scheduled for 9:00 am were administered to Resident 2 at 2:45 pm.</p> <p>During an interview on 2/28/2025 at 1:00 p.m. with LVN 1, LVN 1 stated that she had 33 residents in her station, and it had been a struggle to meet up with the care the residents need. She stated that most of the time she was late in administering the residents ' medications because of the number of residents she has, and a lot of interruptions during medication pass. LVN 1 stated, she had to stop passing medications to the residents to respond to residents ' call light, assist the residents and family with their needs and talk to the doctors. LVN 1 stated all these (responding to residents ' call light, assisting the residents and family with their needs and talking to the doctors) delays the medication pass.</p> <p>During a concurrent interview and record review on 2/8/2025 at 1:50 p.m. with LVN 1, the physician order summary report for Resident 2 was reviewed. The physician order summary report did not have a physician order to crush Resident 2 ' s medications and to mix with apple source. LVN 1 stated that she should have called the physician and obtained an order to crush Resident 2 ' s. LVN 1 stated the speech therapy should have evaluated Resident 2 of any swallowing problem.</p> <p>During a concurrent interview and record review on 2/28/25 at 3:30 p.m. with the Registered Nurse Supervisor (RNS), the Medication Administration Audit Report for Residents 2,3,4 and 5 were reviewed.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 3 Admission record, the admission record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including hypertension, chronic kidney disease.</p> <p>During a review of Resident 3 ' s MDS dated [DATE], the MDS indicated Resident 3 had the ability to make his needs known.</p> <p>During a review of Resident 3 ' s Medication Administration Audit Report on 1/5/2025, the following 9 am scheduled medications for Resident 3 were administered at 3:16 pm.</p> <ol style="list-style-type: none"> 1. Hydralazine 50 mg three times a day. 2. Metoprolol 25 mg two time a day. <p>During a review of Resident 4 Admission Record, the admission record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including Retinal Hemorrhage left eye.</p> <p>During a review of Resident ' s 4 MDS dated [DATE], the MDS indicated Resident 4 had the ability to make her needs known.</p> <p>During a review of Resident 4 ' s Medication Administration Audit Report on 2/1/2025, the following scheduled 9am medications for Resident 4 were administered at 1:59 pm</p> <ol style="list-style-type: none"> 1. Aspirin 81 mg one time a day for the prevention of Cerebrovascular accident (CVA- stroke). 2. Brimonidine solution, eye drop for Glaucoma (type of eye disease). <p>During a review of Resident 5 Admission record, the admission record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including Hypertension, Blindness left eye.</p> <p>During a review of Resident ' s MDS dated [DATE], the MDS indicated Resident 5 had the ability to make his needs known.</p> <p>During a review of Resident 5 ' s Medication Administration Audit Report on 2/15/2025, the following scheduled 9:00 am medications for Resident 5 were administered at 12:50 pm.</p> <ol style="list-style-type: none"> 1. Amlodipine 10 mg for Hypertension. 2. Timolol solution eye drop for glaucoma. <p>During a concurrent interview and record review with RNS, the RNS stated that Residents 2,3,4, and 5 ' s medications scheduled for 9:00 a.m. were not administered as scheduled based on the documentation on the medication administration audit report. The RNS stated that scheduled medications should be administered to the residents one hour before or one hour after the scheduled time.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/4/2025 at 12:16 p.m. with the facility pharmacy consultant (Pharm C), the Pharm C stated that one of Resident 2 ' s medications Oxybutynin Chloride extended release should not be crushed. By crushing it, the medication may act as immediate release (developed to dissolve without delaying or prolonging dissolution or absorption of the drug) and may result in resident going to bathroom more often. Pharm C stated that Resident ' s medications should be given as scheduled to maintain a therapeutic level and also to avoid overdosing when 2 doses are administered too soon to the resident.</p> <p>During an interview on 3/4/2025 at 3:05 p.m., with LVN 4, on medication administration to Resident 3 and 5, LVN 4 stated that she had 34 Residents to care for during her 8 hours shift. She normally gives the residents their medications between 8 am to 10 am but due to the number of residents she has and lots of distractions during med pass like answering the phone, helping the CNA with residents, some residents would get their 9 am medications late. LVN 4 stated that some days she will give the residents their 9 am medications on time but document later because she does not have enough time to document same time the medications were given. LVN 4 stated that she knew that scheduled medication should be given one hour before or after the scheduled time, but due to the number of the residents she had, it was a struggle to meet up with time.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Medication Administration Preparation and General Guidelines, dated 10/2017, the P&P indicated medications should be administered as prescribed by the physician. The P&P indicated the facility should have sufficient staff to allow administration of medication without unnecessary interruptions. The P&P indicated long-acting or enteric coated dosage forms should generally not be crushed, an alternative should be sought. Medications should be administered in accordance with written orders of the attending physician. The P&P indicated medications should be administered within 60 mins of scheduled time (1 hour before and 1 hour after).</p>