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| 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 05/01/2025 |
| 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to report a change in behavior for one of three sampled residents (Resident 1).</p> <p>This failure had the potential for delay in identifying the underlying cause of change in behavior in Resident 1 and receiving treatment.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 4/30/2025 at 9:33 a.m. in Resident 1 ' s room, Resident 1 was in the room sitting on a wheelchair with a sitter (a healthcare professional, often a trained patient sitter or companion, who provides continuous supervision and support to patients who may be at risk due to their medical condition or psychological state). Resident 1 stated at the time of the incident with Resident 2, she assumed the wheelchair was for anyone to use and did not know the wheelchair belonged to Resident 2.</p> <p>During a telephone interview on 4/30/2025 at 11:48 a.m., with Certified Nursing Assistant (CNA) 3, CNA 3 stated on 4/23/2025 witnessed the altercation between Resident 1 and Resident 2. CNA 3 stated, a week prior, a Stop & Watch (notification of a change in a Resident ' s health or behavior) was placed because Resident 1 seemed more confused than usual. CNA 3 stated staff were expected to create a Stop & Watch when there was a change in a resident ' s condition (any significant deviation from a patient's baseline condition, often requiring immediate attention and reassessment). CNA 3 could not recall the actual date or time, when the Stop & Watch was placed, only that it was one week ago. CNA 3 stated she did not inform the charge nurse of the changes in behavior observed in Resident 1.</p> <p>During a record review of Resident 1 ' s the nurse ' s notes indicated Resident 1 was hospitalized for a UTI (UTI- an infection in the bladder/urinary tract) on 4/23/2025 at 9:00 p.m. and returned to the facility on 4/24/2025.</p> <p>During an interview on 4/30/2025 at 3:15 p.m., with the Social Services Director (SSD), the SSD stated staff she was not informed of any changes in behavior for Resident 1 and there was no Stop & Watch on Resident 1 ' s medical record. The SSD stated if there was a notification of any behavior changes, a referral to a psychologist or psychiatrist would be entered.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a concurrent interview and record review on 4/30/2025 at 2:50 p.m., with the Director of Nursing (DON), Resident 1 ' s medical records indicated the dashboard (a visual, data-driven tool used in healthcare to present and monitor key information from a patient ' s electronic health record) did not have a Stop & Watch notification for Resident 1. The DON stated, the charge nurse should be verbally notified when a Stop & Watch was entered for a resident. There were no nursing notes for a change of behavior for Resident 1. The DON stated there was a note dated 4/23/2025 at 9:00 p.m. indicating there was a change of behavior in Resident 1 and the Resident was sent to the hospital</p> <p>During a review of Resident 1 ' s admission Record (facesheet), the admission Record indicated the facility originally admitted Resident 1 on 10/4/2024 and was re-admitted on [DATE] with diagnoses including depression and anxiety disorder (mental health conditions characterized by excessive worry, fear, and anxiety that can significantly impact daily life).</p> <p>During a record review of the Care Plan Report, initiated on 4/18/2025, the care plan report indicated an intervention including to observe and evaluate types of changes in cognitive status, e.g., confusion, orientation, forgetfulness, decision making ability, ability to express self, ability to understand others, impulsivity, mental status and notify physician as needed.</p> <p>During a review of the facility ' s policy and procedures (P&P) titled, Notification of Change in Condition, dated 8/25/2021, the P&P indicated, A facility must immediately inform the resident, consult with the Resident ' s physician and/or NP (nurse practitioner), and notify, consistent with his/her authority, Resident Representative where there is a significant change in the Resident ' s physical, mental, or psychosocial status (that is a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications).</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** Based on observation, interview, and record review the facility failed to ensure licensed nurses had the competencies and skill sets necessary to safely administer medications as ordered for one of three sample residents (Residents 5 and 2) when:</p> <ol style="list-style-type: none"> 1. Licensed Vocational Nurse (LVN) 1 did not check Resident 5's blood pressure in a supine (lying flat on the person's back) position as indicated, prior to administering Droxidopa (medication to treat orthostatic hypotension [low blood pressure (BP) that happens when standing up from a sitting or lying position). 2. Resident 2 blood sugar was not checked on 4/21/2025 at 9:00 p.m. and 4/24/2025 at 6:30 a.m., who had an order to administer insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication). <p>These failures placed Resident 5 at risk for supine hypertension (high blood pressure when lying down which could lead to strokes, heart attacks and death) and Resident 2 at risk for hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar).</p> <p>Findings:</p> <p>a. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record indicated Resident 5's diagnoses included orthostatic hypotension, gastrostomy (G-tube- a surgical procedure that creates an opening into the stomach to allow for the insertion of a gastrostomy tube or feeding tube), diastolic heart failure (the heart's main pumping chamber, doesn't relax normally between beats, making it hard to fill with blood), and Parkinsonism (a progressive disease of the nervous system marked by tremor, rigidity, and slow movement).</p> <p>During a review of Resident 5's Minimum Data Set ([MDS]- a resident assessment tool), dated 2/19/2025 the MDS indicated Resident 5's was usually able to understand and understood by others. The MDS indicated Resident 5 was totally dependent (staff does all the effort. Resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) for Activities of Daily Living (ADLs) such as showering, toileting hygiene, and dressing.</p> <p>During a record review of Resident 5's Order Summary Report dated 3/1/2025, the Order Summary Report indicated, on 3/26/2025 the physician ordered to administer Droxidopa 300 milligram (mg- a unit of measurement) one capsule via G-tube three times a day for orthostatic hypotension, to Resident 5, hold if SBP is more than 140 mmHg (millimeters of mercury- a unit of pressure measurement used to express BP). The Report also indicated a black box warning (serious warning for drugs that may cause serious harm or death) for Droxidopa and to obtain the resident's BP in a supine position.</p> <p>During an observation on 5/1/2025 at 8:50a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 was observed checking Resident 5's BP on the right arm while the resident was in an upright position. Resident 5's BP (obtained by LVN 1) was 152/73 mmHg.</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 a concurrent interview and record review on 5/1/2025 at 9:37 a.m. with LVN 1, Resident 5's physicians order dated 3/26/2025 was reviewed. LVN 1 stated she had taken Resident 5's BP in an upright position and should have taken the resident's BP in a supine position.</p> <p>During a concurrent interview and record review on 5/1/2025 at 2:54 p.m. with the Director of Nursing (DON), Resident 5's physician order dated 3/26/2025 was reviewed. The DON stated LVN 1 should have placed Resident 5 in a supine position when she obtained the resident's BP and assessed to administer Droxidopa to the resident as ordered by the physician. The DON stated not placing Resident 5 in the correct position before administrating medication created a false negative (a test or assessment incorrectly indicates the absence of a condition or disease when it is present).</p> <p>b. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record indicated Resident 2's diagnoses included depression (a mood disorder characterized by persistent sadness and loss of interest or pleasure in daily activities), anxiety (a vague, uneasy feeling of discomfort or dread), and bradycardia (a slow heart rate less than 60 beats per minute).</p> <p>During a review of Resident 2's History and Physical (H&P), dated 11/2/2024, the H&P indicated Resident 2 had the capacity to understand and make decisions.</p> <p>During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 required setup clean-up assistance (staff sets up or cleans up; resident completes activity. Staff assists only prior to or following the activity) for ADLs such as showering, toileting hygiene, and dressing.</p> <p>During a review of Resident 2's Order Summary Report dated 3/1/2025, the Order Summary Report indicated on 2/25/2025 the physician ordered to administer Insulin Lispro (a rapid acting insulin) subcutaneously (applied under the skin) solution pen-injector 100 unit per milliliter (U/ml -a unit of fluid volume) as per sliding scale (refers to the increasing administrator of the pre-meal insulin dose based on the blood sugar level) before meals and at bedtime.</p> <p>During a review of Resident 2's Medication Administration Record (MAR) dated 4/2025, the MAR did not indicate Resident 2's blood sugar was checked on 4/21/2025 at 9:00 p.m. and 4/24/2025 at 6:30 a.m.</p> <p>During a concurrent interview and record review on 5/5/2025 at 2:20 p.m. with the DON, Resident 2's MAR dated 4/2025 was reviewed. The DON stated, there was no documentation to support Resident 2's blood sugar was checked on 4/21/2025 at 9:00 p.m. and 4/24/2025 at 6:30 a.m. The DON stated it was important for licensed nurses to have a good understanding of completing blood sugar checks. The DON stated not documenting Resident 2's blood sugar could cause the resident to receive the incorrect treatment.</p> <p>During a review of the facility's undated Policy and Procedure (P&P) titled, Competency of Nursing Staff, the P&P indicated all nursing staff must meet the specific competency requirement to demonstrate specific competencies and skill sets deemed necessary to care for the needs of the residents, as identified through resident assessments, and described in the plans of care. The P&P indicated the facility assessment includes an evaluation of the staff competencies that are necessary to provide the level and types of care specific to the resident population.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement its infection prevention and control measures for one of three sampled residents (Resident 5) by failing to perform hand hygiene washing hands or using an alcohol-based hand-sanitizer) after removing personal Protective Equipment (PPE- clothing and equipment worn or used to provide protection against hazardous substances and/or environments).</p> <p>This deficient practice had the potential for contamination (transfer of harmful bacteria or viruses from one place, object or person to another) and transmission of disease-causing organisms leading to illness to Resident 5.</p> <p>Findings:</p> <p>During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record indicated Resident 5's diagnoses included orthostatic hypotension (a significant drop in blood pressure that occurs when a person changes from a lying or sitting position to a standing position), gastrostomy ([G-tube]- a surgical procedure that creates an opening into the stomach to allow for the insertion of a gastrostomy tube or feeding tube), diastolic heart failure (the heart's main pumping chamber, doesn't relax normally between beats, making it hard to fill with blood), and Parkinsonism (a progressive disease of the nervous system marked by tremor, rigidity, and slow movement).</p> <p>During a review of Resident 5's Minimum Data Set ([MDS]- a resident assessment tool), dated 2/19/2025 the MDS indicated Resident 5's was usually able to understand and understood by others. The MDS indicated Resident 5 was totally dependent (staff does all of the effort. Resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) for Activities of Daily Living (ADLs) such as showering, toileting hygiene, and dressing.</p> <p>During an observation on 5/1/2025 at 9:19 a.m., at Resident 5's bedside, LVN 1 was observed doffing (removing) her gloves after administering medications to Resident 5 and donned (put on) another pair of gloves without performing hand washing and setting up the resident's food tray.</p> <p>During an interview on 5/1/2025 at 9:22 a.m. with LVN 1, LVN 1 stated I did not wash my hands when I changed my gloves. LVN 1 stated she should have sanitized her hands after she removed her gloves. LVN 1 stated it was important to wash her hands to prevent cross contamination and the spread of infection.</p> <p>During an interview on 5/1/2025 at 3:39 p.m. with the Director of Nursing (DON), the DON stated LVN 1 failed to wash her hands after giving medication (to Resident 5), doffing her gloves and prior to donning new gloves. The DON stated LVN 1 should have performed hand hygiene to prevent the spread of infection.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated 9/2023, the P&P indicated all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The P&P indicated to use an alcohol-based hand rub containing at least 62 percent alcohol before and after contact with the resident, after removing PPE, and before meals.</p> |