

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  05/30/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to:</p> <p>1. Ensure one of seven sampled residents (Resident 4) had timely documentation of his medications.</p> <p>This deficient practice had the potential to result in a duplicate dose of the medication being given due to no indication the resident received it.</p> <p>Findings:</p> <p>During a review of Resident 4 ' s admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE], with a readmission on [DATE]. Resident 4 ' s diagnoses included cerebral infarction ([stroke]- a condition where brain tissue dies due to a lack of blood flow), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 4 ' s Minimum Data Set (MDS - a resident assessment tool), dated 4/24/2025, the MDS indicated Resident 4 ' s cognition (ability to think and reason) was moderately impaired. Resident 4 was dependent on staff for toileting, showering, and dressing.</p> <p>During a concurrent interview and record review on 5/28/2025 at 2:35 p.m. with Licensed Vocational Nurse (LVN) 2 Resident 4 ' s Medication Administration (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) screen was reviewed. The MAR indicated seven medications scheduled for 9:00 a.m. was showing in red. LVN2 stated red on the MAR indicated the medications were late or not given. LVN2 stated the medications were given but she did not document it. LVN2 stated she did not document because she was busy. LVN2 stated medications should be documented at the time of administration. If you don ' t document, no will know the medication was given. This can result in the resident receiving a duplicate dose. If you get a double dose of insulin this can cause the blood sugar to go too low and this could become an emergency.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Administering Medications, (no date), the P&amp;P indicated the individual administering the medication initials the resident ' s medication administration record on the appropriate line after giving each medication and before administering the next ones.</p> <p>Based on interview and record review, the facility failed to:</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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NAME OF PROVIDER OR SUPPLIER  Playa Del Rey Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7716 Manchester Avenue Playa Del Rey, CA 90293	
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Ensure one of seven sampled residents (Resident 4) had timely documentation of his medications.</p> <p>This deficient practice had the potential to result in a duplicate dose of the medication being given due to no indication the resident received it.</p> <p>Findings:</p> <p>During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE], with a readmission on [DATE]. Resident 4's diagnoses included cerebral infarction ([stroke]- a condition where brain tissue dies due to a lack of blood flow), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 4/24/2025, the MDS indicated Resident 4's cognition (ability to think and reason) was moderately impaired. Resident 4 was dependent on staff for toileting, showering, and dressing.</p> <p>During a concurrent interview and record review on 5/28/2025 at 2:35 p.m. with Licensed Vocational Nurse (LVN) 2 Resident 4's Medication Administration (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) screen was reviewed. The MAR indicated seven medications scheduled for 9:00 a.m. was showing in red. LVN2 stated red on the MAR indicated the medications were late or not given. LVN2 stated the medications were given but she did not document it. LVN2 stated she did not document because she was busy. LVN2 stated medications should be documented at the time of administration. If you don't document, no will know the medication was given. This can result in the resident receiving a duplicate dose. If you get a double dose of insulin this can cause the blood sugar to go too low and this could become an emergency.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Administering Medications , (no date), the P&amp;P indicated the individual administering the medication initials the resident's medication administration record on the appropriate line after giving each medication and before administering the next ones.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Ensure one of seven sampled residents (Resident 4) received their scheduled dose of Lispro ([insulin]- a fast-acting medication that lowers the blood sugar) on time.</li> </ol> <p>This deficient practice had the potential to result in Resident 4 having a dangerously high blood sugar requiring medical attention.</p> <p>Findings:</p> <p>During a review of Resident 4 ' s admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE], with a readmission on [DATE]. Resident 4 ' s diagnoses included cerebral infarction ([stroke]- a condition where brain tissue dies due to a lack of blood flow), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 4 ' s Minimum Data Set (MDS &amp;ndash; a resident assessment tool), dated 4/24/2025, the MDS indicated Resident 4 ' s cognition (ability to think and reason) was moderately impaired. Resident 4 was dependent on staff for toileting, showering, and dressing.</p> <p>During a review of Resident 4 ' s care plan, dated 8/9/2023, the care plan indicated Resident 4 had a diagnosis of diabetes and was insulin dependent. The interventions indicated the facility would administer hypoglycemic medications as ordered.</p> <p>During a concurrent interview and record review on 5/28/2025 at 2:35 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 4 ' s Medication Administration (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) screen was reviewed. The MAR indicated Resident 4 had Lispro scheduled for 1:00 p.m. The Lispro was showing in red. LVN2 stated red indicated a medication was late or not given. LVN2 stated she did not give the Lispro because she was busy. LVN2 stated the latest the medication should be given is 2:00 pm, otherwise it ' s late. LVN further stated this is a medication error. If you don ' t give the Lispro on time the blood sugar can go too high and cause the resident to be confused. This could become an emergency.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Administering Medications, (no date), the P&amp;P indicated medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one hour of their prescribed time.</p>		