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	01/09/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to exercise reasonable care for the protection of one of three sampled residents' (Resident 1) personal property by failing to: 1.Ensure Resident 1's Inventory of Personal Effects (personal belonging inventory list) was completed on admission to the facility. This failure had the potential to result in Resident 1's belongings getting lost or stolen and negatively affecting the resident's psychosocial well-being. 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 left artificial knee joint, anxiety disorder (excessive and persistent worry that interferes with life), and depression (mood disorder causing persistent sadness, loss of interest, and affecting how you feel, think, and act). During a review of Resident 1's California Standard admission Agreement, dated 12/17/2025, the Agreement indicated each resident must identify in writing their personal property inventory on the form provided by the facility to the resident.During a review of Resident 1's History and Physical (H&P), dated 12/18/2025, the H&P indicated Resident 1 had the capacity to understand and make medical decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/22/2025, the MDS indicated Resident 1 had no cognitive (ability to think and reason) impairment. The MDS indicated Resident 1 did not have a change in mental status and had no delusions or hallucinations. During a review of Resident 1's Progress Notes, dated for the month of 12/2025, the Notes did not indicate Resident 1 brought in personal belongings to the facility.During a review of Resident 1's Inventory of Personal Effects, dated 1/8/2026, the form indicated Resident had belongings including one grey jacket, one black robe, two shoes, one sweater, two small therapy compresses, two comforters/quilts/afghan (blankets), one wallet/purse, one laptop with mouse, one phone, one seated walker, and one wheelchair. Resident 1's Inventory of Personal Effects did not indicate the residents' personal belongings were inventoried upon admission on [DATE]. During a concurrent observation and interview on 1/8/2026 at 3:20 p.m., Resident 1 stated he arrived at the facility with bags of clothing that went missing during his stay in the facility. He could not find his favorite t-shirt, striped shorts, other t-shirts, pants, socks and jacket. No large plastic bags of clothing were observed in Resident 1's room or closet. Resident 1 stated staff did not label his clothing, provide a personal inventory form, or record his belongings when he was admitted to the facility. Resident 1 stated he is frustrated due to the missing belongings.During an interview on 1/9/2026 at 6:31 a.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated CNAs and licensed nurses were responsible for documenting residents' personal items on the Inventory of Personal Effects form when they arrive at the facility. CNA 1 stated all inventory changes must be recorded to avoid items going missing or getting stolen.During a concurrent interview and record review on 1/9/2026 at 9:50 a.m. with the Social Services Director (SSD), Resident 1's California Standard admission Agreement, dated (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/17/2025, Resident 1's Progress Notes, dated 12/17/2025, Resident 1's Inventory of Personal Effects, dated 1/8/2026, and Resident 1's physical chart for this admission were reviewed. The SSD stated there was no indication that Resident 1's inventory was recorded during admission to the facility. The SSD stated Resident 1's inventory should have been recorded, regardless of whether he arrived with belongings. The SSD stated she visited Resident 1's room on 12/18/2025, the morning after he was admitted . She observed Resident 1 with a personal phone, wheelchair, walker, and small red paper bag with toys at his bedside on the morning of 12/18/2025. The SSD stated she was notified about Resident 1's alleged missing belongings on 12/26/2025. The SSD stated she investigated Resident 1's alleged missing belongings but there was no inventory recorded upon admission to the facility. The SSD stated Resident 1 only had one inventory list, created 1/8/2026. The SSD stated the admission Agreement and Resident 1's rights were violated, which had the potential to result in Resident 1's items being lost or stolen.During an interview on 1/14/2026 at 7:30 a.m. with CNA 6, CNA 6 stated she admitted Resident 1 to the facility, CNA 6 stated those items should have been recorded on the Resident 1's Inventory of Personal Effects when he was admitted on [DATE]. CNA 6 stated she did not provide or assist with an inventory list during Resident 1's admission to the facility. CNA 6 stated Resident 1 arrived at the facility with a personal phone, walker, and wheelchair.During a review of the facility's P&P titled, Resident's Personal Property, dated 8/25/2021, the P&P indicated personnel will identify and record resident's belongings upon admission to the facility. The P&P's purpose was to protect the residents' rights to retain their personal belongings and preserve the resident's individuality and dignity.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet residents' needs for one of three sampled residents (Resident 1) by failing to:1.Ensure the alprazolam (medication to treat anxiety) was available to be administered according to the physician's order for Resident 1. This failure had the potential for Resident 1 to feel frustrated and result in worsening of the Resident's anxiety. 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 left artificial knee joint, anxiety disorder (excessive and persistent worry that interferes with life), and depression (mood disorder causing persistent sadness, loss of interest, and affecting how you feel, think, and act). During a review of Resident 1's History and Physical (H&P), dated 12/18/2025, the H&P indicated Resident 1 had the capacity to understand and make medical decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/22/2025, the MDS indicated Resident 1 had no cognitive (ability to think and reason) impairment. The MDS indicated Resident 1 did not have a change in mental status and had no delusions or hallucinations. During a review of Resident 1's Physician Orders, dated 12/17/2025, the Orders indicated Resident 1 was prescribed alprazolam 0.5 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount) once per day as needed (PRN) for anxiety manifested by episodes of inability to relax. The orders indicated nurses must monitor episodes of inability to relax every shift, document non-drug interventions used, and document the effectiveness of the interventions every shift.During a review of Resident 1's Progress Notes for the month of 12/2025, the Notes did not indicate licensed nurses contacted the pharmacy to obtain alprazolam for Resident 1 during the month of 12/2025. During a review of Resident 1's Medication Administration Record (MAR) for the month of 12/2025, the MAR did not indicate alprazolam was administered to Resident 1 from 12/17/2025 through 12/29/2025. During an interview with Resident 1 on 1/9/2026 at 3:20 p.m., Resident 1 stated he requested alprazolam several times between 12/17/2025 and 12/27/2025 for anxiety and an unnamed Licensed Vocational Nurse (LVN) informed the Resident that the medication was not available. Resident 1 stated staff offered non-pharmacological interventions (non-drug methods to prevent, treat or manage health issues or symptoms), but they were not always effective. Resident 1 stated not having the medication available, worsened his anxiety and he felt frustrated and discouraged about his missing medication.During an interview on 1/9/2026 at 11:36 a.m., with the facility's Pharmacist (Pharm 1), Pharm 1 stated physician orders for alprazolam had to be signed by hand with a pen, not electronically, before the medication could be sent to the facility. Pharm 1 stated she received Resident 1's alprazolam order on 12/19/2025. Pharm 1 stated she informed an unnamed licensed nurse that she could not dispense the medication on 12/19/2025 because it did not have the required physician's signature. Pharm 1 stated the facility staff did not contact the pharmacy regarding Resident 1's alprazolam order from 12/20/2025 through 12/28/2025. Pharm 1 stated she was not provided with a hand-written signature until 12/29/2025 and the medication was sent to the facility on the same day, on 12/29/2025. Pharm 1 stated there were no shortages of alprazolam at that time. Pharm 1 stated alprazolam was not in the facility's e-kit and thus no alprazolam was available at the facility for Resident 1 from 12/17/2025 through 12/28/2025.During a concurrent observation and interview on 1/9/2026 at 12:17 p.m. with Registered Nurse (RN 1), the facility's emergency kit (e-kit - a pre-stocked container of prescription medications to address resident's urgent needs) was not stocked, or supposed to be stocked with alprazolam. RN 1 stated there was no emergency alprazolam available and timely administration would not have (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been possible.During an interview with on 1/9/2026 at 1:00 p.m. with the Director of Nursing (DON), the DON stated Resident 1 did not have access to his alprazolam from 12/17/2025 through 12/28/2025 as ordered by the physician. The DON stated Resident 1 had the potential to have unmanaged and worsened anxiety because the medication was not available.During a concurrent interview and record review on 1/9/2026 at 1:45 p.m., with Registered Nurse (RN) 1, Resident 1's Physician Orders, dated 12/17/2025, Resident 1's MAR, for the month of 12/2025, and the facility's Policy and Procedure (P&P) titled, Administering Medications, dated 4/2019, was reviewed. RN 1 stated the licensed nurses should have all PRN medications in stock and available for resident's use within two days of admission. RN 1 stated the nurses should have contacted the pharmacy to obtain the medication (for Resident 1) to allow for timely administration of the medication, if needed. RN 1 stated Resident 1 had the potential to experience avoidable anxiety because the alprazolam was not available for the Resident. RN 1 stated the P&P could not be followed because timely administration of alprazolam was not possible from 12/17/2026 through 12/28/2026.During a review of the facility's P&P titled, Administering Medications, dated 4/2019, the P&P indicated medications were administered in a safe and timely manner, and as prescribed.