STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555057	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Flores Convalescent Hospital	14165 Purche Ave. Gardena, CA 90249

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48778 Based on interview and record review, the facility failed to allow one of three sampled residents, (Resident 2), to exercise the right to refuse treatment, as indicated in the facility's operational manual, titled Resident Rights: Refusal of Treatment. This failure had the potential to cause Resident 2 to experience psychosocial harm. Findings: During a review of Resident 2 ' s Admission Record indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes Mellitus ([DM], a disorder characterized by difficulty in blood sugar control and poor wound healing) without complications, hypertension (HTN-high blood pressure) and hoarding disorder. During a review of Resident 2 ' s History and Physical (H&P), dated 10/07/2024, the H&P indicated Resident 2 had the capacity (the ability to hold) to understand and make decisions. During a review of Resident 2 ' s Minimum Data Set (Minimum Data Set [MDS] a federally mandated resident assessment tool), the MDS dated [DATE], indicated Resident 2 was cognitively (the ability to think and reason) intact. The MDS indicated Resident 2 was independent (did not require help) with activities such as oral hygiene, upper and lower body dressing, and putting on/taking off footwear. During a review of Resident 2 ' s complaint filed to the California Department of Public Health (CDPH) on 10/24/2024, the allegation indicated on 10/24/2024 at 12:50 p.m., the Licensed Vocational Nurse (LVN-unidentified) held her and forced her to take her insulin. During a review of Resident 2 ' s Medication Administration Record (MAR) dated, 10/24/2024, Resident 2 had an insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) administered per sliding scale (a scale used to determine the amount of insulin to be given based off of a blood sugar value). The MAR indicated Resident 2 ' s blood sugar level at 11:30 a.m. was 355 milligrams per deciliter (mg/dl- unit of measurement [normal blood sugar level is 70-100 mg/dl). The MAR indicated Resident 2 would require five (5) units of insulin as ordered by the physician. The MAR indicated Resident 2 received the 5 units of insulin. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555057	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/1/2024 at 3:09 p.m. with the Director of Nursing (DON), the DON stated she interviewed LVN 3 regarding Resident 2 ' s allegation of being forced to take insulin on 10/24/2024, around noontime. The DON stated per LVN 3, LVN 3 provided education to Resident 2 when she refused the insulin because of the high blood sugar level. The DON stated LVN 3 reported that she did not want to leave Resident 2 with high blood sugar level so LVN 3 reeducated Resident 2, gently moved the arm and administered the insulin. The DON stated, LVN 3 should have waited for Resident 2 to agree on taking the insulin. The DON stated Resident 2 had the right to refuse the insulin medication. During an interview on 11/1/2024 at 3:26 p.m. with LVN 3, LVN 3 stated, if a resident refused medication, staff should educate the resident and attempt to offer three times. LVN 3 stated, residents still have the right to refuse medication even after risks were explained. LVN 3 stated, the medication was administered to Resident 2 without consent. LVN 3 stated it went against patient ' s right and was not acceptable. During a review of the facility ' s policy and procedure (P&P) titled, Operational Manual - Resident Rights: Refusal of Treatment, dated 5/1/2023, the P&P indicated, the facility should honor a resident ' s request not to receive medical treatment as prescribed by the Attending Physician, as well as services outlined on the resident ' s assessment and care plan. The P&P indicated, residents should not be forced to accept any medical treatment and may refuse or request to discontinue a specific treatment even though it is prescribed by the Attending Physician. The P&P indicated, when a resident refused a treatment, the Charge Nurse or Director of Nursing (DON) should interview the resident to determine why the resident is refusing the treatment.