STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555397	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Los Angeles	340 South Alvarado Street Los Angeles, CA 90057

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 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. 36395 Based on interview and record review the facility failed to administer medication as per physician ' s order for one of two sampled residents (Resident 1). By failing to: 1. Follow physician order to administer Filgrastim (medication that helps the body make more neutrophils [blood cells that helps the body fight infections] 300 micrograms/0.5 milliliter (mcg. /ml., unit of measurement) to Resident 1. The Filgrastim 300 mcg. /0.5 ml was not given to Resident 1 on 6/22/24 at 9 a.m. or on 7/11/24 at 9 a.m. 2. Ensure there was an adequate supply of the Filgrastim 300 mcg. /0.5 ml. readily available for Resident 1. 3. Notify Resident 1 ' s primary physician or oncologist (a doctor who had special training in diagnosing and treating cancer) when the Filgrastim 300 mcg. /0.5 ml. was not available, and Resident 1 missed the doses of Filgrastim on 6/22/24 at 9 a.m. and 7/11/24 at 9 a.m. These deficient practices had the potential for Resident 1 to have increased risk of contracting infection. Findings: A review of Resident 1 ' s Admission Record indicated the facility admitted Resident 1 on 3/22/24 with diagnoses including diffuse large B-cell lymphoma (cancer of the cells that are part of the body ' s immune system [body system that protects that helps the body fight infections and other diseases] and muscle weakness. A review of Resident 1 ' s care plan initiated on 3/26/24 indicated Resident 1 had chemotherapy related to diffuse large B cell lymphoma. The Care Plan goal indicated Resident 1 will remain free of complications related to chemotherapy side effects through the review date. Interventions included to give medications and treatments as ordered. During a review of the Physician Order dated 6/17/24 at 2:48 p.m., indicated an order to give Resident 1, Filgrastim 300 mcg. /0.5 ml. (inject one ml.) subcutaneously (SQ, under the skin) one time a day for neutropenia. The Physician Order indicated to administer the Filgrastim two days after chemotherapy to start on 6/19/24 for five days until 6/23/24. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s Medication Administration Record (MAR) for June 2024, indicated Resident 1 was given Filgrastim 300mcg/0.5 ml on 6/19/24 at 9 a.m., 6/20/24 at 9 a.m., 6/21/24 at 9 a.m. and was not given the Filgrastim on 6/22/24 at 9 a.m. A review of Resident 1 ' s Minimum Data Set (MDS, standardized screening and health screening tool) dated 6/27/24 indicated Resident 1 had moderately impaired cognitive skills (ability to think, read, learn, remember, reason, express thoughts, and make decisions) and was dependent (helper does all the effort) with personal hygiene, shower, toileting hygiene, substantial assistance (helper does more than half the effort) with putting on/taking off footwear, lower body dressing and moderate assistance (helper does less than half the effort) with oral hygiene, eating and upper body dressing. The MDS indicated Resident 1 was on chemotherapy. During a review of the Physician Order dated 7/8/24 at 5:42 p.m., indicated an order to give Resident 1 Filgrastim 300 mcg/0.5 ml (inject two ml.) SQ, one time a day for neutropenia two days after chemotherapy for five days to start on 7/10/24 until 7/15/24. A review of Resident 1 ' s MAR for July 2024, indicated Resident 1 was given Filgrastim 300mcg/0.5 ml on 7/10/24 at 9 a.m. and missed the dose on 7/11/24 at 9 a.m. The MAR indicated Resident 1 continued to receive the Filgrastim 300 mcg/0.5 ml. on 7/12/24 at 9 am, 7/13/24 at 9 a.m., 7/14/24 at 9 a.m. and 7/15/24 at 9 a.m. A review of Resident 1 ' s Medication Administration Note dated 7/11/24 at 10:45 a.m., indicated the Filgrastim was .was not available in cart . During a concurrent interview and record review on 7/16/24 at 11:22 a.m., Resident 1 ' s MARs for 6/22/24 and 7/11/24 were reviewed with the registered nurse supervisor (RNS 1). RNS 1 stated on 6/22/24 at 9 a.m., and on 7/11/24 at 9 a.m., the Filgrastim was not administered because the Filgrastim was not available. RNS 1 stated when Filgrastim was not available the physician and the oncologist should have been notified. RNS 1 stated Filgrastim was a medication given to increase the neutrophils and if Resident 1 did not receive the Filgrastim Resident 1 was a high risk of getting infection. During an interview on 7/16/24 at 1:02 p.m., the Director of Nursing (DON) stated Filgrastim was not given to Resident 1 on 6/22/24 at 9 a.m. because Filgrastim was a special medication that was supplied from the general acute hospital (GACH 1). The DON confirmed by stating the Filgrastim was not given on 7/11/24 at 9 a.m. The DON stated when the Filgrastim was not available, the primary physician should have been notified to get an order and/or ask what the primary physician wanted to do. A review of the facility ' s Policy and Procedures (P&P) titled Medication Administration-General Guidelines reviewed on 2/21/24, indicated medications were to be administered as prescribed in accordance with good nursing principles and practices. The P&P indicated the medications were to be administered in accordance with written orders of the prescriber. A review of the facility ' s P&P titled Medication Ordering and Receiving from Pharmacy reviewed on 2/21/24, indicated medications and related products were received from the dispensing pharmacy on a timely basis. The P&P indicated medications were to be reordered four days in advance as directed by the pharmacy order and delivery schedule to assure an adequate supply of hand. The P&P indicated medications that required special processing order were to be ordered seven days in advance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 36395 Based on observation, interview, and record review the facility failed to follow their policy and procedure titled Resident Isolation- Categories of Transmission Based Precautions with a review date of 2/21/24 for one of two sampled residents (Resident 1) who was on contact isolation (prevent transmission of infectious agent which are spread by direct or indirect contact with the resident and the resident ' s environment). On 7/16/24 at 9 a.m., certified nursing assistant 1 (CNA 1) did not use a protective gown while taking Resident 1 ' s vital signs (measure the basic function of the body that included temperature and blood pressure). This deficient practice had the potential to spread infection to staff and residents. Findings: A review of Resident 1 ' s Admission Record indicated the facility admitted Resident 1 on 3/22/24 with diagnoses including diffuse large B-cell lymphoma (cancer of the cells that are part of the body ' s immune system [body system that protects that helps the body fight infections and other diseases] and muscle weakness. A review of Resident 1 ' s Minimum Data Set (MDS, standardized screening and health screening tool) dated 6/27/24, indicated Resident 1 had moderately impaired cognitive skills (ability to think, read, learn, remember, reason, express thoughts, and make decisions) and was dependent (helper does all the effort) with personal hygiene, shower, toileting hygiene, substantial assistance (helper does more than half the effort) with putting on/taking off footwear, lower body dressing and moderate assistance (helper does less than half the effort) with oral hygiene, eating and upper body dressing. The MDS indicated Resident 1 was on chemotherapy. A review of Resident 1 ' s care plan initiated on 7/14/24, indicated Resident 1 was on isolation/contact precautions related to Extended Spectrum Beta-Lactamase (ESBL, enzymes produced by some bacteria that may make them resistant to antibiotics and can spread to surfaces that are touched by someone who has the bacteria) in the urine. The care plan goal indicated Resident 1 ' s infection would resolve by the next review date. Interventions included maintain contact precautions as indicated, provide instructions/education to resident/family/visitor and staff regarding contact precautions needed and proper use of personal protective equipment (PPE, specialized clothing or equipment worn for protection against infectious material that includes gloves, protective gown, masks) needed when in direct contact with resident and materials used by Resident 1. During observation on 7/16/24 at 7:47 a.m. a sign was posted outside Resident 1 ' s room (Room A) indicating stop, contact precautions. The sign indicated providers and staff were required to put on a protective gown before room entry and discard the protective gown before room exit. CNA 1 was observed inside Resident 1 ' s room without a protective gown. CNA 1 was observed taking vital signs of Resident 1 and then proceeded to take the vital signs for Resident 1 ' s two other roommates. During interview on 7/16/24 at 7:50 a.m., CNA 1 stated no one is on isolation in room A. CNA 1 stated she did not have to wear a protective gown because she was only taking vital signs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/16/24 at 9:36 a.m., the infection preventionist (IP) stated Resident 1 was on contact isolation for ESBL in the urine. The IP stated a sign was posted outside Resident 1 ' s room instructing those that entered to wear personal protective equipment (PPE) that included protective gown and gloves. The IP stated CNA 1 should have been wearing a protective gown when taking vital signs to protect herself and other residents from the potential spread of infection. A review of the facility ' s Policy and Procedures (P&P) titled Resident Isolation- Categories of Transmission Based Precautions with a review date of 2/21/24, indicated contact precautions were implemented for residents known or suspected to be infected or colonized (no obvious signs of the disease but can spread microorganisms into the environment through normal day-to-day activities) with microorganism that were transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident ' s environment. The P&P indicated a clean, non-sterile gown was to be worn for interactions that could involve contact with the resident or potentially contaminated items in the resident ' s environment.