STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555668	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwalk Skilled Nursing & Wellness Centre, LLC	11510 Imperial Highway Norwalk, CA 90650

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 - Some	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** 44055 Based on interview and record review the facility failed to provide pharmaceutical services to meet the residents needs for two of three sampled residents (Resident 1 and 2) when: a. The facility failed to ensure Registered Nurse (RN) 1 did not document in Resident 1 ' s Medication Administration Record (MAR) that Methadone (strong medicine used to treat heroin [an illegal substance] dependence) was administered on 7/27/2024 to Resident 1 because it was not given to Resident 1. b. The facility failed to ensure Resident 1 ' s physician order for Methadone on 7/17/2024 at 12:29 p.m. indicated the medication should not be administered on the day Resident 1 will visit the methadone clinic on Mondays. c. The facility failed to ensure Licensed Vocational Nurse (LVN) 6 and 7 documented the administration of Norco (a combination medication of Hydromorphone and Acetaminophen used to manage moderate to severe pain) in Resident 1 and 2 ' s MAR. The deficient practice of Resident 1 ' s missed dose of Methadone on 7/27/2024 resulted in Resident 1 having an extra dose of methadone in the inventory and had the potential to result in Resident 1 experiencing drug withdrawals (negative physical and mental symptoms that occur after stopping or reducing intake of a drug). The deficient practice of the physician order not indicating to not give Resident 1 ' s Methadone dose on Mondays when Resident 1 goes to the Methadone clinic resulted in Resident 1 receiving 55 milligrams of Methadone on 7/29/2024 at 9 a.m. and Resident 1 received an extra dose of Methadone in the clinic on 7/29/2024 and had the potential to result in increased adverse drug reactions. The deficient practice of not having the Norco documented in Resident 1 and 2 ' s MAR placed Resident 1 and 2 at risk for mismanagement of their medication regimen which can negatively affect the residents ' health. Findings: (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
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including osteomyelitis (bone infection) of vertebra (back bone) and post laminectomy syndrome (pain after a prior back surgery). During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 7/22/2024, the MDS indicated Resident 1 had intact cognition (ability to think and reason). During a review of Resident 1 ' s physician order, dated 7/17/2024 at 12:29 p.m. the order indicated Methadone Hydrochloride 55 milligram one time a day for opioid (class of drugs that derive from, or mimic, natural substances found in the opium poppy plant) withdrawal, mix with 30 milliliters of water, Methadone Clinic will dispense medication to our SNF 1 to 2-week supply. During a review of Resident 1 ' s MAR for 7/2024, the MAR indicated Methadone Hydrochloride 55 milligram one time a day for opioid withdrawal, was administered on 7/27/2024 at 9 a.m. by RN 1 and again on 7/29/2024 at 9 a.m. by LVN 1. During a review of Resident 1 ' s Individual Narcotic (a drug or other substance that is tightly controlled by the government because it may be abused or cause addiction and may cause significant risk to patient safety) Record 10 for Methadone 55 milligrams, the record indicated on 7/27/2024 no methadone dose was removed from the inventory. During an interview with RN 1 on 8/7/2024 at 9:56 a.m., RN 1 stated he (RN 1) accidentally charted he gave Methadone 55 milligrams on 7/27/2024 to Resident 1 but RN 1 did not actually give it; that ' s why it was not removed from the Individual narcotic Record. RN 1 stated Resident 1 did not receive a methadone dose on 7/27/2024. RN 1 stated Resident 1 should have received the dose because Resident 1 might have a withdrawal if he does not receive it. During a record review and an interview with the Quality Assurance nurse (QA nurse) on 8/7/2024 at 10:55 a. m., Resident 1 ' s methadone order dated 7/17/2024 was reviewed. The order did not indicate to NOT administer the medications on Mondays when Resident 1 goes to the methadone clinic where Resident 1 receives a dose of Methadone. The QA nurse stated the order should have specified to hold the medications on Mondays so the nurse will not administer it. The QA nurse stated that ' s why the next methadone order was changed to indicate to give Methadone daily only from Tuesday to Sunday, the original order should have specified that. The order did not specify to hold the Methadone on Monday so, Resident 1 received a Methadone dose on 7/29/2024 at 9 a.m. and Resident 1 received another one in the clinic. During a review of Resident 1 ' s SBAR Communication Form 7/29/2024, the form indicated Resident 1 stated he received 2 doses of methadone, one dose at the facility in the morning and another one in the Methadone clinic. The form indicated Resident 1 does not get his Methadone dose every Monday at the facility because Resident 1 goes to the Methadone clinic to get his Monday Methadone Dose and his week supply of methadone. Resident 1 was observed and was clinically stable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 8/7/2024 at 11:10 a.m. the DON stated the missed dose of methadone can cause the resident to have withdrawals. The DON stated receiving double dose of methadone can be lethal, so the physician was informed, and the resident was monitored for three days. The DON stated Resident 1 should not have received the Methadone dose on Monday 7/29/2024. b. During a review of Resident 1 ' s Order Summary Report, active orders as of 8/7/2024, the report indicated an order for Norco oral tablet 5-325 milligrams, starting on 7/23/2024, one tablet by mouth every 6 hours as needed for moderate to severe pain. During a review of Resident 1 ' s Individual Narcotic Record 7, the record indicated LVN 6 removed one tablet of Norco 5/325 milligrams tablet on 7/20/2024 at 10:30 p.m. and on 8/5/2024 at 9:00 a.m. During a review of Resident 1 ' s MAR for July and for August 2024, the MARs indicated no documented evidence Norco 5/325 milligrams tablets were administered to Resident 1 on 7/20/2024 at 10:30 p.m. and on 8/5/2024 at 9:00 a.m. C. During a review of Resident 8 ' s Admission Record, the admission record indicated Resident 8 was admitted to the facility on [DATE] with diagnosis including low back pain and generalized osteoarthritis (occurs when the flexible, protective tissue at the ends of bones, called cartilage, wears down). During a review of Resident 8 ' s Minimum Data Set, dated dated [DATE], the MDS indicated Resident 8 ' s cognition was moderately impaired. During a review of Resident 8 ' s Order Summary Report, active orders as of 7/23/2024, the report indicated Resident 8 had an order for Norco tablet 5-325 milligrams one tablet by mouth every 6 hours as needed for severe pain. During a review of Resident 8 ' s Individual Narcotic Record 17, the record indicated LVN 6 removed one tablet of Norco 5/325 milligram tablet on 8/4/2024 at 4:30 p.m. and on 8/5/2024 at 5:30 p.m. The Record also indicated LVN 7 removed one tablet of Norco 5/325 milligrams tablet on 8/4/2024 at 11 p.m. and on 8/5/2024 at 11:30 p.m. During a review of Resident 8 ' s MAR for August 2024, the MARs did not indicate documented evidence Norco 5/325 milligrams tablets were administered to Resident 8 on 8/4/2024 at 4:30 p.m. and at 11 p.m. and on 8/5/2024 at 5:30 p.m. and at 11:30 p.m. During an interview and record review on 8/8/2024 at 7:44 a.m. with RN 2, Resident 8 ' s Narcotic Record 17 and Resident 8 ' s MAR for 8/2024 were reviewed. RN 2 confirmed documentation that one tablet of Norco 5/325 milligram was removed from the count on 8/4/2024 at 4:30 p.m. and 11 p.m., and on 8/5/2024 at 5:30 p.m. and 11:30 p.m. RN 2 confirmed Resident 8 ' s MAR does not reflect Norco was administered to Resident 8 on 8/4/2024 at 4:30 p.m. and 11 p.m., and on 8/5/2024 at 5:30 p.m. and 11:30 p.m. RN 2 stated the nurses should have documented in the MAR so subsequent nurse would know when the medication was administered so resident will not receive an extra dose. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 8/8/2024 at 10 a.m. with the QA nurse, Resident 1 ' s Narcotic Record 7 and MAR for 7/2024 and 8/2024 were reviewed. The QA nurse confirmed documentation that one tablet of Norco 5/325 milligrams was removed from the count on 7/20/2024 at 10:30 p.m. and on 8/5/2024 at 9 a.m. The QA nurse confirmed Resident 1 ' s MAR does not reflect Norco was administered to Resident 1 on 7/20/2024 at 10:30 p.m. and on 8/5/2024 at 9 a.m. The QA nurse stated LVN 6 should have documented in the MAR and not just the Individual Narcotic Record. During a phone interview on 8/8/2024 at 10:14 a.m., LVN 6 stated she remembers those shifts and remembers signing the narcotic record for Resident 1 and 2 and forgetting to document on the MAR. LVN 6 stated she will make sure to document in the MAR next time. During an interview and record review on 8/8/2024 at 11:11 a.m., with the DON, the DON stated administered medications need to be documented in the MAR because if it was not documented it was not done. The DON stated there was a risk of medication errors and that the resident might get under or over medicated if errors happen. During a review of the facility ' s Policy and Procedure (P/P) titled, Medication-Administration, revised 1/1/2012, the P/P indicated the P/P was to ensure accurate medication administration for residents in the facility. The P/P indicated medication will be administered directed by a Licensed Nurse and upon the order of a physician or licensed independent practitioner. Medications will be administered as prescribed to ensure compliance with dose guidelines. The nursing staff will keep in mind the seven rights of medications when administering the medication. One of the seven rights include the right time and right amount. The P/P indicated the time, the date and dose of the drug administered to the patient will be recorded in the patient's individual medication record by the person who administers the drug. Based on interview and record review the facility failed to provide pharmaceutical services to meet the residents needs for two of three sampled residents (Resident 1 and 2) when: a. The facility failed to ensure Registered Nurse (RN) 1 did not document in Resident 1's Medication Administration Record (MAR) that Methadone (strong medicine used to treat heroin [an illegal substance] dependence) was administered on 7/27/2024 to Resident 1 because it was not given to Resident 1. b. The facility failed to ensure Resident 1's physician order for Methadone on 7/17/2024 at 12:29 p.m. indicated the medication should not be administered on the day Resident 1 will visit the methadone clinic on Mondays c. The facility failed to ensure Licensed Vocational Nurse (LVN) 6 and 7 documented the administration of Norco (a combination medication of Hydromorphone and Acetaminophen used to manage moderate to severe pain) in Resident 1 and 2's MAR. The deficient practice of Resident 1's missed dose of Methadone on 7/27/2024 resulted in Resident 1 having an extra dose of methadone in the inventory and had the potential to result in Resident 1 experiencing drug withdrawals (negative physical and mental symptoms that occur after stopping or reducing intake of a drug). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The deficient practice of the physician order not indicating to not give Resident 1's Methadone dose on Mondays when Resident 1 goes to the Methadone clinic resulted in Resident 1 receiving 55 milligrams of Methadone on 7/29/2024 at 9 a.m. and Resident 1 received an extra dose of Methadone in the clinic on 7/29/2024 and had the potential to result in increased adverse drug reactions. The deficient practice of not having the Norco documented in Resident 1 and 2's MAR placed Resident 1 and 2 at risk for mismanagement of their medication regimen which can negatively affect the residents' health. Findings: a. During a review of Resident 1's Admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including osteomyelitis (bone infection) of vertebra (back bone) and post laminectomy syndrome (pain after a prior back surgery). During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 7/22/2024, the MDS indicated Resident 1 had intact cognition (ability to think and reason). During a review of Resident 1's physician order, dated 7/17/2024 at 12:29 p.m. the order indicated Methadone Hydrochloride 55 milligram one time a day for opioid (class of drugs that derive from, or mimic, natural substances found in the opium poppy plant) withdrawal, mix with 30 milliliters of water, Methadone Clinic will dispense medication to our SNF 1 to 2-week supply. During a review of Resident 1's MAR for 7/2024, the MAR indicated Methadone Hydrochloride 55 milligram one time a day for opioid withdrawal, was administered on 7/27/2024 at 9 a.m. by RN 1 and again on 7/29/2024 at 9 a.m. by LVN 1. During a review of Resident 1's Individual Narcotic (a drug or other substance that is tightly controlled by the government because it may be abused or cause addiction and may cause significant risk to patient safety) Record 10 for Methadone 55 milligrams, the record indicated on 7/27/2024 no methadone dose was removed from the inventory. During an interview with RN 1 on 8/7/2024 at 9:56 a.m., RN 1 stated he (RN 1) accidentally charted he gave Methadone 55 milligrams on 7/27/2024 to Resident 1 but RN 1 did not actually give it; that's why it was not removed from the Individual narcotic Record. RN 1 stated Resident 1 did not receive a methadone dose on 7/27/2024. RN 1 stated Resident 1 should have received the dose because Resident 1 might have a withdrawal if he does not receive it. During a record review and an interview with the Quality Assurance nurse (QA nurse) on 8/7/2024 at 10:55 a.m., Resident 1's methadone order dated 7/17/2024 was reviewed. The order did not indicate to NOT administer the medications on Mondays when Resident 1 goes to the methadone clinic where Resident 1 receives a dose of Methadone. The QA nurse stated the order should have specified to hold the medications on Mondays so the nurse will not administer it. The QA nurse stated that's why the next methadone order was changed to indicate to give Methadone daily only from Tuesday to Sunday, the original order should have specified that. The order did not specify to hold the Methadone on Monday so, Resident 1 received a Methadone dose on 7/29/2024 at 9 a.m. and Resident 1 received another one in the clinic. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555668	A. Building B. Wing	08/08/2024

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Norwalk Skilled Nursing & Wellness Centre, LLC	11510 Imperial Highway Norwalk, CA 90650

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's SBAR Communication Form 7/29/2024, the form indicated Resident 1 stated he received 2 doses of methadone, one dose at the facility in the morning and another one in the Methadone clinic. The form indicated Resident 1 does not get his Methadone dose every Monday at the facility because Resident 1 goes to the Methadone clinic to get his Monday Methadone Dose and his week supply of methadone. Resident 1 was observed and was clinically stable. During an interview with the Director of Nursing (DON) on 8/7/2024 at 11:10 a.m. the DON stated the missed dose of methadone can cause the resident to have withdrawals. The DON stated receiving double dose of methadone can be lethal, so the physician was informed, and the resident was monitored for three days. The DON stated Resident 1 should not have received the Methadone dose on Monday 7/29/2024. b. During a review of Resident 1's Order Summary Report, active orders as of 8/7/2024, the report indicated an order for Norco oral tablet 5-325 milligrams, starting on 7/23/2024, one tablet by mouth every 6 hours as needed for moderate to severe pain. During a review of Resident 1's Individual Narcotic Record 7, the record indicated LVN 6 removed one tablet of Norco 5/325 milligrams tablet on 7/20/2024 at 10:30 p.m. and on 8/5/2024 at 9:00 a.m. During a review of Resident 1's MAR for July and for August 2024, the MARs indicated no documented evidence Norco 5/325 milligrams tablets were administered to Resident 1 on 7/20/2024 at 10:30 p.m. and on 8/5/2024 at 9:00 a.m. C. During a review of Resident 8's Admission Record, the admission record indicated Resident 8 was admitted to the facility on [DATE] with diagnosis including low back pain and generalized osteoarthritis (occurs when the flexible, protective tissue at the ends of bones, called cartilage, wears down). During a review of Resident 8's Minimum Data Set, dated dated [DATE], the MDS indicated Resident 8's cognition was moderately impaired. During a review of Resident 8's Order Summary Report, active orders as of 7/23/2024, the report indicated Resident 8 had an order for Norco tablet 5-325 milligrams one tablet by mouth every 6 hours as needed for severe pain. During a review of Resident 8's Individual Narcotic Record 17, the record indicated LVN 6 removed one tablet of Norco 5/325 milligram tablet on 8/4/2024 at 4:30 p.m. and on 8/5/2024 at 5:30 p.m. The Record also indicated LVN 7 removed one tablet of Norco 5/325 milligrams tablet on 8/4/2024 at 11 p.m. and on 8/5/2024 at 11:30 p.m. During a review of Resident 8's MAR for August 2024, the MARs did not indicate documented evidence Norco 5/325 milligrams tablets were administered to Resident 8 on 8/4/2024 at 4:30 p.m. and at 11 p.m. and on 8/5/2024 at 5:30 p.m. and at 11:30 p.m. (continued on next page)

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	555668	A. Building B. Wing	08/08/2024

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 8/8/2024 at 7:44 a.m. with RN 2, Resident 8's Narcotic Record 17 and Resident 8's MAR for 8/2024 were reviewed. RN 2 confirmed documentation that one tablet of Norco 5/325 milligram was removed from the count on 8/4/2024 at 4:30 p.m. and 11 p.m., and on 8/5/2024 at 5:30 p.m. and 11:30 p.m. RN 2 confirmed Resident 8's MAR does not reflect Norco was administered to Resident 8 on 8/4/2024 at 4:30 p.m. and 11 p.m., and on 8/5/2024 at 5:30 p.m. and 11:30 p.m. RN 2 stated the nurses should have documented in the MAR so subsequent nurse would know when the medication was administered so resident will not receive an extra dose. During an interview and record review on 8/8/2024 at 10 a.m. with the QA nurse, Resident 1's Narcotic Record 7 and MAR for 7/2024 and 8/2024 were reviewed. The QA nurse confirmed documentation that one tablet of Norco 5/325 milligrams was removed from the count on 7/20/2024 at 10:30 p.m. and on 8/5/2024 at 9 a.m. The QA nurse confirmed Resident 1's MAR does not reflect Norco was administered to Resident 1 on 7/20/2024 at 10:30 p.m. and on 8/5/2024 at 9 a.m. The QA nurse stated LVN 6 should have documented in the MAR and not just the Individual Narcotic Record. During a phone interview on 8/8/2024 at 10:14 a.m., LVN 6 stated she remembers those shifts and remembers signing the narcotic record for Resident 1 and 2 and forgetting to document on the MAR. LVN 6 stated she will make sure to document in the MAR next time. During an interview and record review on 8/8/2024 at 11:11 a.m., with the DON, the DON stated administered medications need to be documented in the MAR because if it was not documented it was not done. The DON stated there was a risk of medication errors and that the resident might get under or over medicated if errors happen. During a review of the facility's Policy and Procedure (P/P) titled, Medication-Administration, revised 1/1/2012, the P/P indicated the P/P was to ensure accurate medication administration for residents in the facility. The P/P indicated medication will be administered directed by a Licensed Nurse and upon the order of a physician or licensed independent practitioner. Medications will be administered as prescribed to ensure compliance with dose guidelines. The nursing staff will keep in mind the seven rights of medications when administering the medication. One of the seven rights include the right time and right amount. The P/P indicated the time, the date and dose of the drug administered to the patient will be recorded in the patient's individual medication record by the person who administers the drug.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) was free from significant medication error when: a. The facility failed to ensure Resident 1 received Methadone (strong medicine used to treat heroin [an illegal substance] dependence) 55 milligrams on 7/27/2024 at 9 a.m. as ordered. b. The facility failed to ensure Resident 1 ' s physician order for Methadone on 7/17/2024 at 12:29 p.m. indicated the medication should not be administered on the day Resident 1 will visit the methadone clinic on Mondays because Resident 1 will receive a dose in the clinic. The deficient practice of not receiving the methadone on 7/27/2024 placed Resident 1 at risk for drug withdrawals (negative physical and mental symptoms that occur after stopping or reducing intake of a drug). The deficient practice of the physician order not indicating to not give Resident 1 ' s Methadone dose on Mondays when Resident 1 goes to the Methadone clinic resulted in Resident 1 receiving 55 milligrams of Methadone on 7/29/2024 at 9 a.m. and Resident 1 received an extra dose of Methadone in the clinic on 7/29/2024 and had the potential to result in increased adverse drug reactions. Findings: During a review of Resident 1 ' s Admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including osteomyelitis (bone infection) of vertebra (back bone) and post laminectomy syndrome (pain after a prior back surgery). During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 7/22/2024, the MDS indicated Resident 1 had intact cognition (ability to think and reason). During a review of Resident 1 ' s physician order, dated 7/17/2024 at 12:29 p.m. the order indicated Methadone Hydrochloride 55 milligram one time a day for opioid (class of drugs that derive from, or mimic, natural substances found in the opium poppy plant) withdrawal, mix with 30 milliliters of water, Methadone Clinic will dispense medication to our Skilled Nursing Facility 1 to 2-week supply. During a review of Resident 1 ' s MAR for 7/2024, the MAR indicated Methadone Hydrochloride 55 milligram one time a day for opioid withdrawal, was administered on 7/27/2024 at 9 a.m. by RN 1 and again on 7/29/2024 at 9 a.m. by Licensed Vocational Nurse (LVN) 1. During a review of Resident 1 ' s Individual Narcotic (a drug or other substance that is tightly controlled by the government because it may be abused or cause addiction and may cause significant risk to patient safety) Record 10 for Methadone 55 milligrams, the record indicated on 7/27/2024 no methadone dose was removed from the inventory. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s SBAR Communication Form 7/29/2024, the form indicated Resident 1 stated he received 2 doses of methadone, one dose at the facility in the morning and another one in the Methadone clinic. The form indicated Resident 1 does not get his Methadone dose every Monday at the facility because Resident 1 goes to the Methadone clinic to get his Monday Methadone Dose and his week supply of methadone. Resident 1 was observed and was clinically stable. During an interview with Registered Nurse (RN) 1 on 8/7/2024 at 9:56 a.m., RN 1 stated he (RN 1) accidentally charted he gave Methadone 55 milligrams on 7/27/2024 to Resident 1 but RN 1 did not actually give it; that ' s why it was not removed from the Individual narcotic Record. RN 1 stated Resident 1 did not receive a methadone dose on 7/27/2024. RN 1 stated Resident 1 should have received the dose because Resident 1 might have drug withdrawals if Resident 1 does not receive it. During a record review and an interview with the Quality Assurance nurse (QA nurse) on 8/7/2024 at 10:55 a. m., Resident 1 ' s methadone order dated 7/17/2024 was reviewed. The order did not indicate to NOT administer the medications on Mondays when Resident 1 goes to the methadone clinic where Resident 1 receives a dose of Methadone. The QA nurse stated the order should have specified to hold the medications on Mondays so the nurse will not administer it. The QA nurse stated that ' s why the next methadone order was changed to indicate to give Methadone daily only from Tuesday to Sunday, the original order should have specified that. The order did not specify to hold the Methadone on Monday so Resident 1 received a Methadone dose on 7/29/2024 at 9 a.m. and Resident 1 received another Methadone dose in the clinic. During an interview with the Director of Nursing (DON) on 8/7/2024 at 11:10 a.m. the DON stated the missed dose of methadone can cause the resident to have withdrawals. The DON stated receiving double dose of methadone can be lethal, so the physician was informed, and the resident was monitored for three days. The DON stated Resident 1 should not have received the Methadone dose on Monday 7/29/2024. During a review of the facility ' s Policy and Procedure (P/P) titled, Medication-Administration, revised 1/1/2012, the P/P indicated medication will be administered directed by a Licensed Nurse and upon the order of a physician or licensed independent practitioner. Medications will be administered as prescribed to ensure compliance with dose guidelines. The nursing staff will keep in mind the seven rights of medications when administering the medication. One of the seven rights include the right time and right amount. Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) was free from significant medication error when: a. The facility failed to ensure Resident 1 received Methadone (strong medicine used to treat heroin [an illegal substance] dependence) 55 milligrams on 7/27/2024 at 9 a.m. as ordered. b. The facility failed to ensure Resident 1's physician order for Methadone on 7/17/2024 at 12:29 p.m. indicated the medication should not be administered on the day Resident 1 will visit the methadone clinic on Mondays because Resident 1 will receive a dose in the clinic. The deficient practice of not receiving the methadone on 7/27/2024 placed Resident 1 at risk for drug withdrawals (negative physical and mental symptoms that occur after stopping or reducing intake of a drug). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555668	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwalk Skilled Nursing & Wellness Centre, LLC	11510 Imperial Highway Norwalk, CA 90650

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The deficient practice of the physician order not indicating to not give Resident 1's Methadone dose on Mondays when Resident 1 goes to the Methadone clinic resulted in Resident 1 receiving 55 milligrams of Methadone on 7/29/2024 at 9 a.m. and Resident 1 received an extra dose of Methadone in the clinic on 7/29/2024 and had the potential to result in increased adverse drug reactions. Findings: During a review of Resident 1's Admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including osteomyelitis (bone infection) of vertebra (back bone) and post laminectomy syndrome (pain after a prior back surgery). During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 7/22/2024, the MDS indicated Resident 1 had intact cognition (ability to think and reason). During a review of Resident 1's physician order, dated 7/17/2024 at 12:29 p.m. the order indicated Methadone Hydrochloride 55 milligram one time a day for opioid (class of drugs that derive from, or mimic, natural substances found in the opium poppy plant) withdrawal, mix with 30 milliliters of water, Methadone Clinic will dispense medication to our Skilled Nursing Facility 1 to 2-week supply. During a review of Resident 1's MAR for 7/2024, the MAR indicated Methadone Hydrochloride 55 milligram one time a day for opioid withdrawal, was administered on 7/27/2024 at 9 a.m. by RN 1 and again on 7/29/2024 at 9 a.m. by Licensed Vocational Nurse (LVN) 1. During a review of Resident 1's Individual Narcotic (a drug or other substance that is tightly controlled by the government because it may be abused or cause addiction and may cause significant risk to patient safety) Record 10 for Methadone 55 milligrams, the record indicated on 7/27/2024 no methadone dose was removed from the inventory. During a review of Resident 1's SBAR Communication Form 7/29/2024, the form indicated Resident 1 stated he received 2 doses of methadone, one dose at the facility in the morning and another one in the Methadone clinic. The form indicated Resident 1 does not get his Methadone dose every Monday at the facility because Resident 1 goes to the Methadone clinic to get his Monday Methadone Dose and his week supply of methadone. Resident 1 was observed and was clinically stable. During an interview with Registered Nurse (RN) 1 on 8/7/2024 at 9:56 a.m., RN 1 stated he (RN 1) accidentally charted he gave Methadone 55 milligrams on 7/27/2024 to Resident 1 but RN 1 did not actually give it; that's why it was not removed from the Individual narcotic Record. RN 1 stated Resident 1 did not receive a methadone dose on 7/27/2024. RN 1 stated Resident 1 should have received the dose because Resident 1 might have drug withdrawals if Resident 1 does not receive it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555668	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwalk Skilled Nursing & Wellness Centre, LLC	11510 Imperial Highway Norwalk, CA 90650

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review and an interview with the Quality Assurance nurse (QA nurse) on 8/7/2024 at 10:55 a.m., Resident 1's methadone order dated 7/17/2024 was reviewed. The order did not indicate to NOT administer the medications on Mondays when Resident 1 goes to the methadone clinic where Resident 1 receives a dose of Methadone. The QA nurse stated the order should have specified to hold the medications on Mondays so the nurse will not administer it. The QA nurse stated that's why the next methadone order was changed to indicate to give Methadone daily only from Tuesday to Sunday, the original order should have specified that. The order did not specify to hold the Methadone on Monday so Resident 1 received a Methadone dose on 7/29/2024 at 9 a.m. and Resident 1 received another Methadone dose in the clinic. During an interview with the Director of Nursing (DON) on 8/7/2024 at 11:10 a.m. the DON stated the missed dose of methadone can cause the resident to have withdrawals. The DON stated receiving double dose of methadone can be lethal, so the physician was informed, and the resident was monitored for three days. The DON stated Resident 1 should not have received the Methadone dose on Monday 7/29/2024. During a review of the facility's Policy and Procedure (P/P) titled, Medication-Administration, revised 1/1/2012, the P/P indicated medication will be administered directed by a Licensed Nurse and upon the order of a physician or licensed independent practitioner. Medications will be administered as prescribed to ensure compliance with dose guidelines. The nursing staff will keep in mind the seven rights of medications when administering the medication. One of the seven rights include the right time and right amount.