Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555700	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beverly Hills Rehabilitation Centre	580 S San Vicente Blvd. Los Angeles, CA 90048

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 - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on interview and record review, the facility failed to ensure one of five sample residents (Resident 1) was free from medication errors. This failure resulted in Resident 1 receiving a discontinued medication gabapentin (medication used for seizures or nerve pain) 100 mg (milligrams) that was not removed from the medication cart. Findings: A review of Resident 1 ' s Admission Record dated 3/27/24, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including aftercare following joint replacement surgery, primary osteoarthritis (protective cartilage around joint wears down causing, joint swelling, pain, tenderness bone spurs [extra bits of bone form around the joint]) of left knee, legal blindness, difficulty walking and muscle weakness. A review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/4/24 indicated Resident 1 had moderately impaired cognition (ability to think, understand and make daily decisions) and required limited assistance from staff for bed mobility, transfer, dressing, toilet use and personal hygiene. A review of Resident 1 ' s physician ' s orders, dated 9/28/23, indicated, no order for gabapentin 100 mg. During an interview and a concurrent record review on 4/2/24 at 4:42 pm with the Director of Nursing (DON), Resident 1 ' s Change in Condition form dated 7/10/23, was reviewed. The form indicated per CN (Charge Nurse) she just gave pt (patient) gabapentin 100 mg, per MD (Medical Doctor) he already gave orders to d/c (discontinue) gabapentin, saw written orders dated 6/28, medication was d/c on the PCC (Point Click Care, electronic charting application), but medication was not removed on the med cart. The DON stated this was a mediation error because the medication was given that was still in the medication cart after it was discontinued in PCC. The DON further stated it is important to remove the discontinued medications from the medication cart to avoid giving it to the patient. A review of the facility ' s policy and procedures (P&P) titled, Administering Medications, reviewed August 2023, indicated Medications shall be administered in a safe and timely manner, and as prescribed.

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