STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555117	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE HEALTHCARE CENTER - LA	3032 ROWENA AVE LOS ANGELES, CA 90039

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint Number: CA00891740 Representing the Department: Health Facilities Evaluator Nurse: 46445 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was identified for the complaint number: CA00891740 (F760).	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Skyline Healthcare Center-LA does not admit that the deficiency listed on this form exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts and conclusions that form the basis for the deficiency."	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the medications of two of three sampled residents (Resident 2 and Resident 3) were administered according to the physician's orders. The facility failed to: a. Administer Resident 2's valproic acid solution (an anticonvulsant medication used to control seizures [a sudden, uncontrolled burst of electrical activity in the brain]) at the scheduled time on multiple dates.	F 760	**F 760** **Immediate corrective action(s) for the said deficient practice:** Resident 2's valproic acid level was checked by the RN Supervisor per MDs order on 4/10/24 and within normal range of 64.1 mcg/ml (ref. Range 50.0-100.0). Resident 3's skin assessment was done by Treatment Nurse on 4/4/24 and 4/8/24 and no further skin breakdown was noticed. Licensed Nurses involved were re-educated by DON on 4/8/24 and 4/12/24 in regards to facility's policy and procedure titled, "Medication Administration" and "Medication Error" in conjunction with State and Federal regulations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 4/16/24

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.

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F 760	Continued From page 1 b. Administer Resident 3's pro-stat sugar free oral liquid (a medication used to increase protein in low volume) at the scheduled time on multiple dates. These deficient practices placed Resident 2 at risk for seizures and placed Resident 3 at risk for decreased protein in the body. c. Ensure Resident 2 and Resident 3's medications were not left at the bedside unattended. This deficient practice placed other wandering residents in the facility at risk for accidental ingestion of the unattended medications of Resident 2 and Resident 3. Findings: a. A review of Resident 2's Admission Record indicated the facility admitted the resident on 8/5/2021 with diagnoses including encephalopathy (refers to brain disease, damage, or malfunction), chronic obstructive pulmonary disease (COPD - a group of disease that cause airflow blockage and breathing-related problems), and epilepsy (a group of disorders marked by problems in the normal functioning of the brain). A review of Resident 2's physician orders, dated 2/23/2022, indicated the resident had an order to take five milliliters (ml - unit of measurement) of valproic acid solution 250 milligrams (mg - unit of measurement) in five ml, three times a day for seizure disorder. A review of Resident 2's History and Physical Exam, dated 11/26/2022, indicated the resident	F 760	**Plan/Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken:** All residents had the potential to be affected. However, during the random audit of the RN Supervisor on 4/4/24. No residents were found to be affected. **Facility measures and systemic changes to ensure the deficient practice does not recur:** Re-education was provided by the Director of Nursing on 4/4/24, 4/5/24, 4/8/24, 4/9/24, 4/11/24, 4/12/24 and ongoing to Licensed Nurses in regards to facility's policy and procedure titled, "Medication Administration" and "Medication Error" in conjunction with State and Federal regulations. RN Supervisors and/or Desk Nurses will be conducting a daily audit during nursing rounds of each shift in regards to medication pass. Any findings will be corrected immediately. Department Managers, DON, and Administrator will conduct daily compliance rounds to check if there's a medication left unattended in resident's bedside table. Any findings will be corrected immediately.	

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F 760	Continued From page 2 had seizure disorder and did not have the capacity to understand and make decisions. A review of Resident 2's Care Plan on epilepsy, initiated on 1/11/2023, indicated the interventions to administer medication as ordered and monitor for side effects, monitor for seizure activity every shift, and maintain a safe environment for the resident. A review of Resident 2's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 2/9/2024, indicated the resident's cognition (involving conscious intellectual activity such as thinking, reasoning, or remembering) was severely impaired. Resident 2 was dependent on the facility staff on eating, oral hygiene, toileting hygiene, shower or bath, and personal hygiene. A review of Resident 2's Medication Administration Record on valproic acid solution 250 mg per 5 ml, dated 3/25/2024 to 4/4/2024, indicated the resident received the scheduled medication late on the following dates and times: a. On 3/25/2024 at 6:52 p.m., b. On 3/26/2024 at 11:17 a.m., 2:07 p.m., and 7:53 p.m., c. On 3/27/2024 at 10:54 a.m. and 7 p.m., d. On 3/28/2024 at 8:17 p.m., e. On 3/29/2024 at 11:11 a.m. and 7:01 p.m., f. On 3/30/2024 at 6:23 p.m.,	F 760	**Facility plan to monitor corrective actions and sustain compliance; integrate QA Process:** The Director of Nursing and/or Designee will report the findings of the audits and pertinent updates at the monthly Quality Assurance and Performance Improvement (QAPI) Committee meeting. To ensure compliance the Director of Nursing and/or Designee will be responsible for results of the audit. Any findings will be corrected immediately. The Administrator will report monthly to QAPI for further review and corrective actions in the next 3 months or until the goals achieved. **Date of Compliance: April 16, 2024**	

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F 760	Continued From page 3 g. On 3/31/2024 at 10:25 a.m. and 7:32 p.m., h. On 4/1/2024 at 10:31 a.m., i. On 4/2/2024 at 10:37 a.m. and 8:17 p.m., j. On 4/3/2024 at 11:54 a.m. and 11:32 p.m. Resident 2's 9 a.m. and 1 p.m. scheduled valproic acid solution were both given at 2:26 p.m. on 3/25/2024 and at 12:25 p.m. on 3/28/2024. On 4/1/2024, Resident 2's valproic acid solution was scheduled for 1 p.m. and 5 p.m. but were given at 3:06 p.m. and 4:01 p.m., 53 minutes apart. On 4/4/2024, Resident 2's valproic acid solution was scheduled for 9 a.m. and 1 p.m. but were given at 11:50 a.m. and 12:36 p.m., 46 minutes apart. On 4/4/2024 at 9:57 a.m., during a concurrent observation and interview, observed a red liquid in a medication cup on Resident 2's bedside table. Licensed Vocational Nurse 1 (LVN 1) stated that the red liquid in a cup on Resident 2's table was the resident's valproic acid medication. LVN 1 stated that valproic acid was used for Resident 2's seizures. LVN 1 stated that she saw Resident 2 at 8 a.m. but she did not notice the medication on the table. LVN 1 stated that Resident 2's medication should be administered to the resident after it was prepared and should not be left unattended. LVN 1 stated that medications left unattended had the potential for other residents to accidentally take it or be thrown away. On 4/4/2024 at 10:13 a.m., during a concurrent observation and interview, observed a red liquid in a medication cup on Resident 2's bedside table. Certified Nursing Assistant 1 (CNA 1)	F 760		

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F 760	Continued From page 4 stated that she saw the medication on Resident 2's table but she did not inform the nurses because it was not her job. CNA 1 stated that leaving medications at the residents' bedside table was a practice that was happening in the facility. CNA 1 stated that she used to inform the nurses there were resident medications left unattended at the residents' bedside, but the practice was still happening. CNA 1 stated that the nurse should be informed if the medications were left at bedside. On 4/4/2024 at 12:48 p.m. during a concurrent interview and record review, Resident 2's Medication Administration Record was reviewed with the Director of Nursing (DON) which indicated Resident 2 received the valproic acid at 11:50 a.m. on 4/4/2024. The DON stated that Resident 2's valproic acid was scheduled at 9 a.m. but was given one hour and 50 minutes late. The DON stated that the attending physician was not notified for the late administration of Resident 2's medication. The DON stated that Resident 2 had the potential for seizures because the medication was given late. The DON stated that the facility failed to follow the medication administration policies and procedures. A review of the facility's policy and procedure titled, "Medication Administration," dated 1/25/2024, indicated the purpose to ensure the accurate administration of medications for residents in the facility. The policy indicated that the licensed nurse would prepare medications within one hour of administration and medications may be administered one hour before or after the scheduled medication administration time. A review of the facility's policy and procedure	F 760		

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F 760	Continued From page 5	F 760		

titled, "Medication Error," dated 1/25/2024, indicated the purpose to ensure the prompt reporting of errors in the administration of medications and treatments to residents. The policy indicated that all errors related to the administration of medications or treatments will be reported to the DON, the Attending Physician, and the Administrator (ADM) immediately. The policy indicated that the licensed nurse will make an immediate assessment of the resident in relation to the nature of the error and continue to monitor the resident closely for any adverse effects from the medication error.

b. A review of Resident 3's Admission Record indicated the facility admitted the resident on 4/30/2018 with diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), muscle weakness, and muscle wasting (weakening, shrinking, and loss of muscle caused by disease or lack of use) and atrophy (thinning of muscle mass).

A review of Resident 3's physician orders, dated 9/26/2023, indicated the resident had an order to take 30 milliliters (ml - unit of measurement) of pro-stat sugar free oral liquid three time a day for protein supplement.

A review of Resident 3's History and Physical Exam, dated 10/21/2023, indicated the resident was blind and did not have the capacity to understand and make decisions.

A review of Resident 3's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 10/29/2023, indicated the resident's cognition (involving conscious intellectual activity

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F 760	Continued From page 6	F 760		

such as thinking, reasoning, or remembering) was severely impaired. Resident 3 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) on eating, oral hygiene, toileting hygiene, shower or bath, and personal hygiene.

A review of resident 3's Care Plan on skin, initiated on 5/21/2022, indicated the resident was at risk for skin break or ulcer (wound) formation because of impaired mobility, incontinence, and cognitive impairment. The care plan interventions included to administer medication and treatment as ordered and monitor for effectiveness.

A review of Resident 3's Medication Administration Record on pro-stat sugar free oral liquid, dated 3/22/2024 to 4/4/2024, indicated the resident received the scheduled medication late on the following dates and times:

a. On 3/22/2024 at 7:34 p.m.,

b. On 3/25/2024 at 6:52 p.m.,

c. On 3/26/2024 at 11:18 a.m. and 7:52 p.m.,

d. On 3/27/2024 at 10:53 a.m. and 9:38 p.m.,

e. On 3/28/2024 at 8:17 p.m.,

f. On 3/29/2024 at 11:32 a.m. and 7:02 p.m.,

g. On 3/30/2024 at 6:23 p.m.,

h. On 3/31/2024 at 10:28 a.m. and 7:35 p.m.,

i. On 4/1/2024 at 10:45 a.m. and 3:19 p.m.,

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F 760	Continued From page 7 j. On 4/2/2024 at 10:38 a.m. and 8:26 p.m., k. On 4/3/2024 at 1:50 a.m. and 11:41 p.m. Resident 3's 9 a.m. and 1 p.m. scheduled pro-stat sugar free oral liquid were both given at 2:30 p.m. on 3/25/2024. On 4/1/2024, Resident 3's pro-stat sugar free oral liquid was scheduled for 1 p.m. and 5 p.m. but were given at 3:19 p.m. and 4:01 p.m., 42 minutes apart. On 4/4/2024, Resident 3's pro-stat sugar free oral liquid was scheduled for 9 a.m. and 1 p.m. but were given at 11:49 a.m. and 12:36 p.m., 47 minutes apart. On 4/4/2024 at 9:57 a.m., during a concurrent observation and interview, observed a yellow liquid in a medication cup on Resident 3's bedside table. Licensed Vocational Nurse 1 (LVN 1) stated that the yellow liquid in a cup on Resident 3's table was the resident's pro-stat medication. LVN 1 stated that pro-stat was used for Resident 3's protein supplement. LVN 1 stated that she saw Resident 3 at 8 a.m. but she did not notice the medication on the table. LVN 1 stated that Resident 3's medication should be administered to the resident after it was prepared and should not be left unattended. LVN 1 stated that medications left unattended had the potential for other residents to accidentally take it or be thrown away. On 4/4/2024 at 10:13 a.m., during a concurrent observation and interview, observed a yellow liquid in a medication cup on Resident 3's bedside table. Certified Nursing Assistant 1 (CNA 1) stated that she saw the medication on Resident 3's table but she did not inform the nurses because it was not her job. CNA 1 stated that leaving medications at the residents' bedside	F 760		

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F 760	Continued From page 8	F 760		

table was a practice that was happening in the facility. CNA 1 stated that she used to inform the nurses there were resident medications left unattended at the residents' bedside, but the practice was still happening. CNA 1 stated that the nurse should be informed if the medications were left at bedside.

On 4/4/2024 at 12:48 p.m. during an interview, the Director of Nursing (DON) stated that the attending physician was not notified for the late administration of Resident 3's medication. The DON stated that the facility failed to follow the medication administration policies and procedures.

A review of the facility's policy and procedure titled, "Medication Administration," dated 1/25/2024, indicated the purpose to ensure the accurate administration of medications for residents in the facility. The policy indicated that the licensed nurse would prepare medications within one hour of administration and medications may be administered one hour before or after the scheduled medication administration time.

A review of the facility's policy and procedure titled, "Medication Error," dated 1/25/2024, indicated the purpose to ensure the prompt reporting of errors in the administration of medications and treatments to residents. The policy indicated that all errors related to the administration of medications or treatments will be reported to the DON, the Attending Physician, and the Administrator (ADM) immediately. The policy indicated that the licensed nurse will make an immediate assessment of the resident in relation to the nature of the error and continue to monitor the resident closely for any adverse

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F 760	Continued From page 9 effects from the medication error.	F 760		