		AND HUMAN SERVICES & MEDICAID SERVICES	POC 3653	accepted 3/	<b>╱//</b> FOR	D: 02/21/2017 M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DA	(X3) DATE SURVEY COMPLETED		
		555099	B. WING	<u> </u>	0.	2/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	Zi i I Firiti	l l	REET ADDRESS, CITY, STATE,	ZIP CODE		
LAKEWO	OD HEALTHCARE C	ENTER	1	023 LAKEWOOD BLVD. DWNEY, CA 90242			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AO CROS <b>S</b> -REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	rs .	F 0001	Preparation and/or this Plan of Correc constitute admission	tion does not	:	
	The following reflects the findings of the California Department of Public Health during the investigation of an entity reported incidents (ERI) during an Abbreviated Standard Survey.  ERI number: CA00520463 - Substantiated  Representing the Department of Public Health:  Health Facilities Evaluator Nurse ID: 36526  The inspection was limited to the specific ERI investigated and does not represent the findings of a full inspection of the facility.  Two deficiencies were issued for ERI CA00520463  483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary			Provider of the trut alleged or conclusion the Statement of This Plan of Coprepared and/or exbecause it's requiprovisions of Healt Code Section 1280 a 483."	h of the facts as set forth on Deficiencies. Correction is secuted solely ired by the h and Safety	facts h on cies. i is olely the	
			F 329	This Plan of constitutes Healthcare credible compliance for deficient practices. F: 329 Drug Regimunnecessary drugs	the alleged		
	drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used		Corrective actions practice:	for deficient			
	(1) In excessive do therapy); or	ose (including duplicate drug		Skin sweep was per wing on 01/29/20 residents were in			
	<ul><li>(2) For excessive duration; or</li><li>(3) Without adequate monitoring; or</li><li>(4) Without adequate indications for its use; or</li></ul>			rashes. On 01/30/2017, Elimite was ordered for 14 identified residents. Remaining residents in west wing were treated for prophylactic measures on 01/31/2017.			
			T.				
		e of adverse consequences dose should be reduced or		Housekeeping deep wing 1/30/17, 1/31 respective dates. For	cleaned west /17 and 2/1/17		
LABORATOF	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	Administrator	<i>O</i>	(×6) DATE	

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.

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	555099		B. WING			C 02/17/2017	
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	·	
LAKEWOOD HEALTHCARE CENTER					23 LAKEWOOD BLVD. WNEY, CA 90242		
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ΒE	(X5) COMPLETION DATE
F 329	Continued From page 1  (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:  Based on observation, interview and record review, the facility failed to ensure 24 of 24 sampled residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, & 24) who received topical Elimite (an anti-parasitic used for treatment of scabies [a contagious skin infestation by the mite Sarcoptes scabiei resulting in severe itchiness] cream and Ivermectin (an-antiparasitic used to treat infections caused by parasites) had the medical indication for its used.  This deficient practice had the potential for residents to have side effects from the unnecessary used of Elimite and Ivermectin medications, and potential for the residents'		 		residents second treatment was performed on 02/06/17. There were 2 residents identified in east wing of the facility with rashes. Skin sweep was performed on east wing. I resident was treated with Elimite and roommate was treated for prophylactic measures. Another resident who was identified with similar symptoms, was discharged to acute hospital prior to skin sweep. Acute hospital was notified regarding the incident and resident was treated in the hospital.  Identification of other residents with the potential of being affected by same practice and implemented corrective measures:		
	the infection control review of the facility were treated with I stated that the der Ivermectin and Elia (condition that marash.  According to the E provided by the IC received topical are	a.m., during an interview with ol nurse (ICN), and record y's line listing of residents who Elimite and Ivermectin, ICN matologist had prescribed mite for the residents' eczema kes the skin itchy and red) and permatologist's orders and a list N the following residents oplication of the Elimite cream and given an oral (by mouth)			11-0	r of skin Iand were etion etion o all I the New the	

Ivermectin medications on the following dates:

#### PRINTED: 02/21/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ C 555099 **B WING** 02/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12023 LAKEWOOD BLVD. LAKEWOOD HEALTHCARE CENTER **DOWNEY, CA 90242** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Measures in place to ensure F 329 | Continued From page 2 F 329 practice does not recur: Resident 1 topical Elimite cream and Ivermectin Skin assessment will be performed on 1/12/17. by C.N.A's on O shift. Any unusual Resident 2 topical Elimite cream on 1/12/17, and findings will be reported to the Ivermectin on 1/30/17. charge nurse on each wing. DON Resident 3 topical Elimite cream on 1/12/17, and Ivermectin on 1/30/17. will be notified for further follow up Resident 4, topical Elimite cream on 1/12/17. or as needed. Treatment Nurse will do weekly skin check. In services Resident 5, topical Elimite cream on 1/12/17. for infection control and hand washing skills will be provided to Resident 6, topical Elimite cream on 1/12/17. new hires and on quarterly basis and Resident 7, topical Elimite cream on 1/12/17 as needed. ICN will make the daily Resident 8, topical Elimite cream on 1/30/17. rounds on each unit and will Resident 9, topical Elimite cream on 1/30/17. coordinate with charge nurses and Resident 10, topical Elimite cream on 1/30/17. DON/designee. Facility Medical Resident 11, topical Elimite cream on 1/30/17. Director will be notified if found Resident 12, topical Elimite cream on 1/30/17. similar findings. Resident 13, topical Elimite cream on 1/30/17. Resident 14, topical Elimite cream on 1/30/17. Monitoring system to make sure Resident 15, topical Elimite cream on 1/30/17. solutions are sustained. Resident 16, topical Elimite cream on 1/30/17. Resident 17, topical Elimite cream on 1/30/17. ICN nurse will discuss the findings Resident 18, topical Elimite cream on 1/30/17. from daily rounds with OA Resident 19, topical Elimite cream on 1/30/17. Resident 20, topical Elimite cream on 1/30/17. committee on monthly and quarterly Resident 21, topical Elimite cream on 1/31/17.

only treated 14 residents for suspected scables

Resident 22, topical Elimite cream on 1/30/17. Resident 23, topical Elimite cream on 1/30/17.

Resident 24, topical Elimite cream on 1/30/17.

and eight (8) residents were treated prophylactically.

A review of an online article, by Medline Plus,

meetings for recommendations.

Completion Date- 03/15/2017

#### PRINTED: 02/21/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 555099 B. WING 02/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12023 LAKEWOOD BLVD. LAKEWOOD HEALTHCARE CENTER DOWNEY, CA 90242 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 329 | Continued From page 3 F 329 titled, Permethrin Topical, indicated Elimite use can cause numbness or tingling of the skin; rash; and some side effects can be serious, such as, trouble breathing; continued irritation of the skin or scalp area: infected or pus filled areas of the skin or scalp area at https://www.nlm.nih.gov/medlineplus/druginfo/me ds/a698037.html According to an online article RxList dated 10/28/2016. Stromectol (Ivermectin) common side effects includes headache, dizziness, muscle pain, nausea, diarrhea, swelling of hands/ankles/feet, swelling or tenderness of your lymph nodes, itching, skin rash, or feeling of something is in your eve(s). F 500 | 483.70(g)(1)(2)(i)(ii) OUTSIDE PROFESSIONAL F 500 500 Outside Professional SS=E | RESOURCES-ARRANGE/AGRMNT resources - arrangement (g) Use of outside resources. Corrective actions for deficient practice: (1) If the facility does not employ a qualified professional person to furnish a specific service services stopped the Facility to be provided by the facility, the facility must

(2) of this section.

responsibility for-

have that service furnished to residents by a person or agency outside the facility under an

(2) Arrangements as described in section

specify in writing that the facility assumes

arrangement described in section 1861(w) of the

Act or an agreement described in paragraph (q)

1861(w) of the Act or agreements pertaining to

services furnished by outside resources must

(i) Obtaining services that meet professional standards and principles that apply to

immediately

with

Dermatologist. New Dermatologist

evaluated the residents with rashes

and treating medication was ordered

Identification of other residents

with the potential of being

affected by same practice and

implemented corrective measures:

from contracted pharmacy.

original

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
				A. BUILDING			С	
		555099	B. WING			02/17/2017		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
LAKEWOOD HEALTHCARE CENTER					23 LAKEWOOD BLVD.			
				DC	OWNEY, CA 90242		<del></del> _	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE/ICIENCY)	D BE	(X5) COMPLETION DATE	
F 500	(ii) The timeliness This REQUIREME by: Based on interview failed to ensure that (Residents 1, 2, 3, 14, 15, 16, 17, 18, not received media that has no written provide any types This deficient pracresidents received for treatment of so infestation by the in severe itchiness (an-antiparasitic uby parasites) media dermatologist with responsibilities for and this has a pot Findings:  On 2/1/17, at 3:35 director of nursing dermatologist insilvermectin to be opharmacy. The D written contract w	of the services.  NT is not met as evidenced  w and record review, the facility at 24 of 24 sampled residents' 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 19, 20, 21, 22, 23, and 24) did cations from an outside vendor agreement with the facility to		500	Administration reached out to Dermatologist to follow up or residents. Dermatologist came evaluate the residents symptoms of rash on 02/11/17 evaluated total of 55 resid Medical Director was out of conduring this time and on call Dowas notified regarding this matupon return Medical Director also notified regarding the chand treatment.  Measures in place to enspractice does not recur:  Licensed nurses will be in serve by DON or designee regardusing the contracted Pharmacy any new treatment. Licensed nursed on or be 03/15/2017. Licensed Nurse(s) ensure any new treatment on must go through contract pharmacy. Weekly reports will faxed to Medical Director by for the Dermatologist visit further recommendations if needs.  Monitoring system to make solutions are sustained.  ICN will discuss the findings findermatology report with	n 24 e to with and ents. intry octor atter. was ange sure iced ding for rses fore will ders cted be CN for ed. ure		
	A review of Resid	lents 1, 2, and 3's Treatment ecord (TAR) indicated that the d Elimite cream on 1/12/17 and			committee on monthly and quart meetings for recommendations.  Completion Date- 03/15/2017			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/21/2017 FORM APPROVED OMB NO. 0938-0391

		WIND OF WOLD				NIO INC	. 0330-0331
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		555099	B. WING			02	C / <b>17/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	71172011
LAKEWO	OD HEALTHCARE C	ENTER		ì	23 LAKEWOOD BLVD. WNEY, CA 90242		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETION DATE
F 500	Continued From pa	ige 5		500			
1 000	Ivermectin on 1/30		· F;	500;			
		and 7's TAR indicated that the Elimite cream on 1/12/17.	1	1			i .
!	19, 20, 21, 22, 23,	11, 12, 13, 14, 15, 16, 17, 18, and 24's TAR indicated that ved Elimite cream on 1/30/17.					
	license vocational (LVN/TxN) indicate orders of the derm with the Elimite and medical diagnosis.	ten declaration provided by the nurse/treatment nurse detected that the LVN questions the atologist to treat the residents detected the livermectin without a The declaration further orders were the dermatologist rocedures.					
	interview the admir no policy and proce medications from a Administrator furth	43 a.m., during a telephone nistrator stated the facility has edures regarding acquiring a non-contracted pharmacy, er stated he was aware that hould have been obtained from lity's pharmacy.	:				
				;			