STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055559	A. BUILDING _____ B. WING _____	**05/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAY CREST CARE CENTER	**3750 GARNET STREET TORRANCE, CA 90503**

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 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's nursing staff failed to ensure a clinical rationale was provided after declining a pharmacist recommendation for one selected resident (Resident A). This deficient practice placed the resident at risk for administration of unnecessary medication. Findings: A review of Resident A's Admission Records indicated Resident A was readmitted to the facility on [DATE], with a [DIAGNOSES REDACTED]. According to physician's orders [REDACTED]. A review of a Consultation Report by the facility's Pharmacist Consultant dated 2/1[DATE]9, indicated Resident A has experienced a recent fall and receives the following medication which may cause or contribute to falls: [MEDICATION NAME] 15 milligrams (mg) at bed time. Recommendation: Please evaluate this medication as possibly causing or contributing to falls in this individual. Minimize or discontinue any of these therapies if possible, in order to minimize the risk of falls due to adverse drug effects. If this therapy is to continue it is recommended that: a) The prescriber document an assessment of risk versus benefits indicating that the medication is not believed to be contributing to falls in this individual. b) The facility interdisciplinary team ensures ongoing monitoring for effectiveness and potential adverse consequences. Continued review of the consultation report indicated the physician checked the following response: I have re-evaluated this therapy and DO NOT wish to implement any changes due to the reasons below. Rationale: Continue Treatment. On 3/[DATE]9 at 4:50 p.m., during an interview, the Director of Nursing (DON) stated she was not aware of the physician's response to the recommendation but would bring it to his attention for correction. The facility's policy and procedure titled, Medication Regimen review dated 11/2016, indicated if the attending physician decided to make no changes in the medication, the attending physician should document the rational in the health record.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) 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.