STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555057	A. BUILDING _____ B. WING _____	**03/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAS FLORES CONVALESCENT HOSPITAL	**14165 PURCHE AVE. GARDENA, CA 90249**

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop an individualized plan of care with measurable objectives, timeframes, and interventions to meet a resident's medical, nursing, mental, and psychosocial needs for one of six sampled residents (Resident 1), who had an order to go out on pass, returned to the facility intoxicated. This deficient practice resulted in Resident 1 leaving the facility, drinking, getting drunk and returning to the facility with alcoholic drinks. A review of Resident 1's Admission Face sheet indicated Resident 1 was admitted to the facility on [DATE] with a most recent admission on 8/27/19. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's history and physical (H & P) report, dated 9/5/19 indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS) an assessment and care screening tool dated 12/[DATE]9, indicated Resident 1 had the ability to understand and be understood others. The MDS indicated Resident 1 required supervision with bed mobility, transferring, moving from one location of the facility to another and in toilet use. The MDS indicated Resident required a one person's assistance dressing, and in personal hygiene. The MDS also indicated Resident 1 used a cane for crutch for mobility and was receiving antidepressants (medications to treat depression) and hypnotics (medication to induce sleep). A review of Progress Notes dated [DATE] and timed at 6:21 p.m., indicated Resident 1 was not in the facility and all due medications were held. A review of an incomplete Release of Responsibility for Leave of Absence form indicated Resident 1 went out on pass four (4) times in December 2019, and eight (8) times in January 2020. No times were indicated for Resident 1 to return to the facility. A review of Progress Notes dated [DATE] and timed at 2:05 p.m., indicated Resident 1 was not in the facility for the 7a.m.-3 p.m., shift (a total of 8 hours). On 2/3/2020 at 4:39 p.m., during a concurrent interview and review of Resident 1' physician's orders [REDACTED]. [REDACTED]. RN 1stated Resident 1 left the facility without signing out and sometimes was gone for over 4 hours. According to RN 1, all the staff had to do was document when Resident 1 returned. RN 1 stated there was no care plan with interventions on how to care for Resident 1 each time the resident returned to the facility drunk, intoxicated and with alcohol. RN 1 stated the charge nurse should search Resident 1 for alcohol though the resident might still sneak alcohol into his room. RN 1 stated Resident 1 should not have orders to leave the facility because the resident returned drunk especially on weekends. RN 1 added that there should have been a care plan with interventions like searching Resident 1's belongings for alcohol to ensure the resident did not drink in the facility. A review of the facility's policy titled Care Planning with a revised date of 5/1/2018, indicated a person-centered care plan would be developed for each resident with specific goals on the resident's medical, nursing, mental and psychosocial needs. A review of the facility's policy titled Obtaining a Pass of the Facility with a revised date of 1/1/2012, indicated when a resident returned to the facility after an out on pass, the licensed nurse would re-assess the resident to determine the resident's status during the pass and upon return.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents with orders to go out on pass, were supervised, did not bring alcohol to the facility, did not drink alcohol and, were not given medications that interact with alcohol for one of three sampled residents (Resident 1). This deficient practice resulted in Resident 1 drinking, getting drunk and shaking his roommate's (Resident 2) hand and bed. It also had a potential for Resident 1 to be physically abusing towards other residents. Findings: A review of Resident 1's Admission Face sheet indicated Resident 1 was admitted to the facility on [DATE] with a most recent admission on 8/27/19. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's history and physical (H & P) report, dated 9/5/19 indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS) an assessment and care screening tool dated 12/[DATE]9, indicated Resident 1 had the ability to understand and be understood others. The MDS indicated Resident 1 required supervision with bed mobility, transferring, moving from one location of the facility to another and in toilet use. The MDS indicated Resident required a one person's assistance dressing, and in personal hygiene. The MDS also indicated Resident 1 used a cane for crutch for mobility and was receiving antidepressants (medications to treat depression) and hypnotics (medication to induce sleep). A review of Resident 1's physician's orders [REDACTED]. A review of Resident 1's physician's orders [REDACTED]. A review of another physician's orders [REDACTED]. A review of a Progress Note' dated [DATE] and timed at 8:35 a.m., indicated Resident 1 was awake all night pacing the hallways and patio intoxicated and drunk, with very slurred speech, staggering gait, holding on the side rails holding on to side rails while pacing and laughing in an unusual manner. A review of Resident 1's Controlled Drug Record indicated Resident 1 received [MEDICATION NAME] on 12/14-15/2019. A review of a Medication Administration Record [REDACTED]. A review of a 24-hour Report of Patient Condition and Unit Activities form dated 1/30/2020, indicated Resident 1 was intoxicated and all his medications were held (sic). A review of Resident 1's progress note dated 1/31/2020 and timed at 8:30 a.m., indicated on 1/31/2020 at 7:56 a.m., Resident 1 was yelling at the Social Services Director (SSD) because a nurse found a bottle of vodka in Resident 1's room that did not belong to the resident. A review of Resident 1's Controlled Drug Record indicated Resident 1 received [MEDICATION NAME] on 1/30-31/2020. A review of Resident 1's MAR indicated [REDACTED]. A review of a progress note dated 1/30/2020 and timed at 6:07 p.m., indicated Resident 1 was intoxicated and his medications were held (sic). A review of a progress note dated 1/30/2020 and timed at 11 p.m., indicated Resident 1 had an unsteady gait with slurred speech and that his medications were not administered because Resident 1 was intoxicated. A review of a progress note dated 1/31/2020 and timed at 8:30 a.m., indicated on 1/31/2020 at 7:56 a.m., Resident 1 was yelling at the Social Services Director (SSD) because a nurse found a bottle of vodka in Resident 1's room that did not belong to the resident. A review of a progress note dated 1/31/2020 and timed at 10:39 a.m., indicated on 1/31/2020 at 10:28 a.m., Resident 1told the SSD he had slapped a staff on the face. The progress note indicated Resident 1 appeared intoxicated and the SSD informed Resident 1 that alcohol consumption was not allowed in the facility. A review of a progress note dated 2/1/2020 and timed at 8:11 a.m., indicated Resident 1 was observed by a CNA drinking alcohol in his room. This note indicated upon entering the room, a charge nurse smelled alcohol but did not see Resident 1 drinking. A review of a progress note dated 2/6/2020 and timed at 2:08 p.m., indicated a bottled of Vodka was recovered from Resident 1's room. On 2/1/2020, at 8:10 a.m., during a concurrent observation and interview, Resident 1 who was awake in bed, with alcohol on his breath, stated that a few nights ago, a Certified Nursing Assistant (CNA 1) pushed him on the forehead and took a bottle of Vodka (liquor) from Resident 1's bag. Resident 1 was observed with

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.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) another empty bottle of Vodka in a brown bag on the resident's bed. On 2/1/2020 at 8:15 a.m., Resident 1's family member (FM 1) stated Resident 1 went out on pass on 1/31/2020, drank Vodka and was drunk, before returning to the facility. FM 1 stated on 2/1/2020, Resident 1 was drinking Vodka at 7 a.m. On 2/1/2020 at 8:51 a.m., during an interview, a Licensed Vocational Nurse (LVN 1) stated on 2/1/2020 at 6:30 a.m., CNA 2 reported that he observed Resident 1 drinking Vodka. LVN 1 stated no interventions were initiated because she did not see Resident 1 drinking and that Resident 1 was unpredictable and abusive towards the staff when confronted. On 2/3/2020 at 2:44 p.m., during an interview, the Director of Nursing (DON) stated she was not aware Resident 1 had vodka and was drinking. The DON stated an IDT will be held with Resident 1. The Don stated Resident 1 did not have orders to drink vodka. On 2/3/2020 at 3:12 p.m., during an interview, LVN 2 stated Resident 1 was medicated on 2/1/2020 at 8 a.m., because he was not aware Resident 1 had been drinking. On 2/3/2020, during a concurrent interview and review of Resident 1's progress notes, a Registered Nurse (RN 1) stated Resident 1 did not have orders to drink alcohol but had an out on pass order. RN 1 stated Resident 1 sometimes went out without notifying the staff and returned intoxicated especially during weekends. RN 1 stated Resident 1 was aggressive towards the staff especially when drunk. RN 1 also stated Resident 1 should not have an out on pass order because he would drink and get drunk when out of the facility. According to RN 1, Resident 1 received [MEDICATION NAME] almost every day including on 12/15/2019 when the resident returned to the facility intoxicated. RN 1 added that [MEDICATION NAME] should not have been administered to Resident 1 while intoxicated because it could cause falls and injuries. A review of the facilities policy and procedure titled, Resident Drug and [MEDICAL CONDITION], with a revised dated of 5/1/2018, indicated the facility did not tolerate alcohol without physician's orders [REDACTED]. A review of another policy titled Obtaining a Pass of the Facility with a revised date of 1/1/2012, indicated nursing staff would assess the resident prior to leaving on a pass to ensure the resident was properly dressed for current weather conditions and the resident had medication supply for the period out on pass. This policy also indicated when the resident returned to the facility, the licensed nurse would re-assess the resident to determine the resident's status during the pass and upon return.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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** Based on interview, and record review, the facility failed to ensure a drug regimen review and gradual dose reduction was made with considerations on nurses' progress notes regarding residents' sleep and behavior patterns for one of three sampled residents (Resident 1) who was drinking alcohol and had been on [MEDICATION NAME] (medication used to induce sleep) for more than six months. This deficient practice had the potential to result in ineffective medication therapy falls and injuries. Findings: A review of Resident 1's Admission Face sheet indicated Resident 1 was admitted to the facility on [DATE] with a most recent admission on 8/27/19. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's history and physical (H & P) report, dated 9/5/2019 indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS) an assessment and care screening tool dated 12/4/2019, indicated Resident 1 had the ability to understand and be understood others. The MDS indicated Resident 1 required supervision with bed mobility, transferring, moving from one location of the facility to another and in toilet use. The MDS indicated Resident required a one person's assistance dressing, and in personal hygiene. The MDS also indicated Resident 1 used a cane for crutch for mobility and was receiving antidepressants (medications to treat depression) and hypnotics (medication to induce sleep). A review of a physician's orders [REDACTED]. A review of a physician's orders [REDACTED]. A review of a physician's orders [REDACTED]. A review of a physician's orders [REDACTED]. A review of a physician's orders [REDACTED]. A review of a physician's orders [REDACTED]. A review of a [MEDICAL CONDITION] Summary Sheet dated 8/27-31/2019, 9/1-30-2019, 10/1-31/2019, 11/1-30/2019, and 12/1-31/2019, indicated Resident 1 was receiving [MEDICATION NAME] 15 mg at bed time, regularly for [MEDICAL CONDITION]. This [MEDICAL CONDITION] summary sheet did not however indicate any attempt for a gradual dose reduction (GDR) of [MEDICATION NAME] for Resident 1. A review of a literature from an online source indicated [MEDICATION NAME] was used to induce sleep by causing drowsiness which helped patients fall asleep. The literature indicated the sedative effects of [MEDICATION NAME] may last longer in older adults, cause falls and injuries. According to this literature, drinking alcohol was forbidden when taking [MEDICATION NAME] because it could cause anxiety, depression and suicidal thoughts. This literature also indicated [MEDICATION NAME] should be used only for a short time to treat [MEDICAL CONDITION]. A review of Resident 1's Medication Administration Record (MAR) indicated for the month of December 2019 Resident 1 received 15 mg of [MEDICATION NAME] every day except for 12/1-5/2019 and 1[DATE]19. A review of Resident 1's MAR for January 2020 indicated Resident 1 received [MEDICATION NAME] 15 mg from 12/9-12/2019, and the rest of December excluding 1/7/2020, 1/9-16/2020, 1/18-20/2020, 1/22-23/2020 and 1/26-29/2020. On 2/1/2020 at 10:12 a.m., during an interview, CNA 3 stated Resident 1 used to drink alcohol in the facility, stopped and started drinking again. CNA 3 stated Resident 1 always walked to the liquor store across the street from the facility to buy alcoholic drinks. On 2/3/2020 at 1:48 p.m., during an interview CNA 1 stated on 1/30/2020 at 5:45 p.m., Resident 1 who was known to drink in the facility was observed with a three quarter (3/4) bottle full of Vodka. CNA 1 stated that after taking the bottle away from Resident 1, the resident slapped CNA 1 on the right face. On 2/3/2020 at 4:39 p.m., during a concurrent interview and review of Resident 1's medical records a Registered Nurse (RN 1) stated Resident 1 had a long history of drinking, getting drunk and verbally abusing the staff. On [DATE]20 at 10:37 during a telephone interview, the facility's pharmacy consultant (PharmD) stated that Resident 1's [MEDICATION NAME]'s order was reviewed monthly but no recommendations made because the resident's psychiatrist and psychologist indicated Resident 1 needed the medication for sleeplessness. PharmD stated she was not aware Resident 1 would drink alcoholic drinks and get drunk. According to PharmD, Resident 1 should not receive [MEDICATION NAME], blood thinners or any medication to treat depression for safety and fall risk. PharmD stated she would make a note regarding Resident 1's alcohol consumption and re-evaluate the resident's medical records. On [DATE]20 during an interview, PharmD stated that during drug regimen review for Resident 1, the MAR, nurses progress notes, psychiatrist's notes and narcotic count sheets were used as needed. The PharmD stated that there was no indication that Resident 1 was consuming alcohol while receiving [MEDICATION NAME] and that any discrepancies in the MAR and narcotic count sheet were reported to the DON. A review of the facilities policy and procedure titled, Resident Drug and [MEDICAL CONDITION], with a revised dated of 5/1/2018, indicated the purpose of the policy was to provide a safe and drug-free environment for residents in the facility. This policy indicated the facility did not tolerate alcohol without physician's orders [REDACTED].