STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555700	A. BUILDING _____ B. WING _____	**06/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE REHABILITATION CENTRE OF BEVERLY HILLS	**580 SOUTH 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 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 observation, interview, and record review, the facility failed to ensure that two licensed vocational nurses (LVN 1 and LVN 2) reordered medications five days in advance in order to ensure that medications were available for one of three sampled residents (Resident 1). This deficient practice resulted to Resident 1 missing two consecutive doses of Anoro Ellipta (an inhaled medication used to treat breathing problems) scheduled for 9 AM on 6/13/20 and 6/14/20 because of the medication's unavailability. Findings: A review of Resident 1's Admission Record, dated 6/17/20, indicated the facility admitted her on 3/10/20 with [DIAGNOSES REDACTED].) A review of Resident 1's Minimum Data Set ((MDS) - an assessment and screening tool), dated 3/16/20, indicated Resident 1 had a severe cognitive (thought process) impairment. A review of Resident 1's physician order, dated 3/10/20, indicated she was prescribed umeclidinium-vilanterol aerosol powder (the generic name for Anovo Ellipta) to inhale one puff by mouth one time a day for [MEDICAL CONDITION]. A review of the facility's nursing assignment sheets indicated, for the 7 AM to 3 PM shifts, the facility assigned LVN 1 to administer medications to Resident 1 on 6/12/20 and LVN 2 on 6/13/20 and 6/14/20. A review of Resident 1's Medication Administration Record [REDACTED]. A review of the pharmacy refill request form, dated 6/13/20, indicated the pharmacy received through fax on 6/13/20 at 1:51 PM LVN 2's request to refill Resident 1's Anoro Ellipta. A review of RN 1's Progress Notes, dated 6/14/20, indicated Resident 1's inhaler (ANORO) was out of supply and was not given on 6/13/20 and 6/14/20. The Progress Notes indicated the pharmacy was called on 6/13/20 for a refill. On 6/16/20 at 5:25 PM, during a telephone interview, Resident 1's family member (FM 1) stated she called Resident 1 at the facility around 12:30 PM on 6/14/20. FM 1 stated that Resident 1 expressed a concern to her about waiting for something. FM 1 stated that Resident 1 was difficult to understand at times due to her recent stroke. FM 1 stated that she called the facility back around 12:45 PM on 6/14/20 to discuss Resident 1's concern and was informed that one of her medications was out of stock in the facility and had already been reordered. FM 1 stated she then attempted to reach Resident 1's attending physician, but was unsuccessful. FM 1 stated she called again the facility around 2:00 PM on 6/14/20 and spoke with the Registered Nurse Supervisor (RN 1). FM 1 stated RN 1 informed her that the facility had reordered Resident 1's Anoro Ellipta inhaler from the pharmacy, but it was currently unavailable in the facility and they did not administer it to Resident 1 as prescribed on 6/13/20 and 6/14/20. FM 1 stated that she received a call back from the facility around 7:40 PM on 6/14/20 to inform her that Resident 1's Anoro Ellipta inhaler had arrived from the pharmacy. FM 1 stated the facility attempted to administer a dose; however, Resident 1 refused the dose at that time because, if given in the evening, the medication makes it difficult for her to sleep. FM 1 stated that facility gave the next dose to Resident 1 around 8:00 AM on 6/15/20. On 6/17/20 at 10:15 AM, during an observation of Level 2 Medication Cart 2, the Anoro Ellipta inhaler for Resident 1 was found in the medication cart with four doses left. During a concurrent interview, LVN 1 stated this version of the Anoro Ellipta inhaler only contains a seven-day supply when full and she was required to reorder medications three days before they run out. LVN 1 stated that if any medication was not available for a resident, she would notify the RN supervisor, communicate with pharmacy, let the attending physician know that a dose of medication was missed or will be late. On 6/17/20 at 10:27 AM, during an interview, the Assistant Director of Nursing (ADON) stated LVN 2 faxed the refill request for Resident 1's Anoro Ellipta to the pharmacy on 6/13/20. The ADON stated she could not find the record of reorder from the facility to the pharmacy, but would call the pharmacy to obtain the time they received the request. The ADON stated the nursing staff should order refills for all residents' regularly scheduled medications three to five days in advance to allow ample time for the pharmacy to deliver before the medication runs out. On 6/17/20 at 10:36 AM, during a telephone interview, RN 1 stated Certified Nursing Assistant (CNA) said that Resident 1, around 10:30 AM to 11:00 AM on 6/14/20, was asking why LVN 2 did not administer her dose of Anoro Ellipta as scheduled. RN 1 stated that LVN 2 found the Anoro Ellipta inhaler empty on 6/13/20 and LVN 2 had requested a refill from the pharmacy on that day. RN 1 stated she then called the pharmacy to expedite the order because this medication is important and she should not miss it. RN 1 stated she spoke to the physician on call on 6/14/20 and received an order to give Resident 1 a dose as soon as it was available. RN 1 stated she spoke with FM 1 on 6/14/20 who was upset regarding the missed doses of the medication. RN 1 stated the nursing staff were required to order refills for all residents' regularly scheduled medications about five days ahead to prevent residents from running out. RN 1 stated that by failing to provide Resident 1's treatment for [REDACTED]. On 6/17/20 at 10:46 AM, during a telephone interview, LVN 2 stated the facility assigned her to administer medications in the morning for Resident 1 on 6/13/20 and 6/14/20. LVN 2 stated she found the Anoro Ellipta inhaler in the medication cart and checked the dose counter (numerical indicator on the inhaler that displays how many doses are left.) LVN 2 stated that the dose counted read zero. LVN 2 stated she told Resident 1 that the inhaler was out of doses and would not be able to give it. LVN 2 stated she did not notify her supervisor (RN 1) that the inhaler was out of stock and that Resident 1 would miss her scheduled dose. LVN 2 stated she later removed the refill sticker from the box, placed it on the reorder form, and faxed the reorder form to the pharmacy along with the stickers from other medications that needed to be refilled. LVN 2 stated on 6/13/20, around 3:50 PM, she called the pharmacy to communicate that the need for the Anoro Ellipta was urgent. LVN 2 stated the pharmacy informed her they would deliver it as soon as possible. On 6/17/20 at 11:02 AM, during an interview, LVN 1 stated that she administered a dose of Anoro Ellipta to Resident 1 around 9:00 AM on 6/12/20. LVN 1 stated that she thought there were three doses left in the inhaler but that it was possible she may not have checked the dose counter after giving the dose and put the inhaler back into the med cart empty. LVN 1 stated that even with only three doses left, she should have reordered the inhaler from the pharmacy right away per the facility's policy. LVN 1 stated that she did not reorder the inhaler at that time because she could not find the sticker on the box used to place refill orders with the pharmacy. LVN 1 stated that, because she could not find the reorder sticker, she assumed another nurse might have already reordered it. LVN 1 stated that it was important to order medications on time to ensure that residents' medications were available to treat their medical conditions. LVN 1 stated that if medications were not available, residents' health conditions were at risk of worsening. On 6/17/20 at 11:39 AM, during an interview, the Director of Nursing (DON) stated pharmacy refills should be ordered three to five days before the resident runs out and that nursing staff can order medications stat to get a two-hour delivery by calling the pharmacy directly. The DON stated if a medication was missing from the medication cart and the resident will miss a dose, it was considered a medication error. The DON stated that in the event of a medication error, nursing staff were required to notify their supervisor, the physician, the family member of the resident and, if the medication is missing, reorder the medication as stat or emergency from the pharmacy. The DON stated, according to the documentation in the MAR, the facility failed to administer doses of Anoro Ellipta to Resident 1 on 6/13/20 and 6/14/20 as ordered by the physician. The DON stated that LVN 1 and LVN 2 failed to follow the facility's policies and procedures regarding reordering

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

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) medications from the pharmacy and handling medication errors. The DON stated that she had provided retraining and disciplinary action to nursing staff in order to correct the issue. A review of the facility's policy and procedure titled, Medication Ordering and Receiving from Pharmacy: Ordering and Receiving Medications from the Dispensing Pharmacy, with effective date on April 2008, indicated the facility to Reorder medication five days in advance of need to assure an adequate supply is on hand If needed before the next regular delivery, inform the pharmacy of the need for prompt delivery 'Stat' and emergency medications are ordered as follows: . Afterhours medications ordered 'stat' are to be delivered and administered within 2 hours. Cross-referenced with F760
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** Based on observation, interview, and record review, the facility failed to ensure two doses of Anoro Ellipta (an inhaled medication used to treat breathing problems) on 6/13/20 and 6/14/20 were not missed for one of three sampled residents (Resident 1.) This deficient practice increased the risk for Resident 1 to experience adverse effects related to not receiving her breathing treatment including difficulty of breathing and shortness of breath. Findings: A review of Resident 1's Admission Record, dated 6/17/20, indicated the facility admitted her on 3/10/20 with [DIAGNOSES REDACTED].) A review of Resident 1's Minimum Data Set ((MDS) - an assessment and screening tool), dated 3/16/20, indicated Resident 1 had a severe cognitive (thought process) impairment. A review of Resident 1's physician order, dated 3/10/20, indicated she was prescribed umeclidinium-vilanterol aerosol powder (the generic name for Anovo Ellipta) to inhale one puff by mouth one time a day for [MEDICAL CONDITION]. A review of the facility's nursing assignment sheets indicated, for the 7 AM to 3 PM shifts, the facility assigned LVN 1 to administer medications to Resident 1 on 6/12/20 and LVN 2 on 6/13/20 and 6/14/20. A review of Resident 1's Medication Administration Record [REDACTED]. A review of RN 1's Progress Notes, dated 6/14/20, indicated Resident 1's inhaler (ANORO) was out of supply and was not given on 6/13/20 and 6/14/20. The Progress Notes indicated the pharmacy was called on 6/13/20 for a refill. On 6/16/20 at 5:25 PM, during a telephone interview, Resident 1's family member (FM 1) stated she called Resident 1 at the facility around 12:30 PM on 6/14/20. FM 1 stated that Resident 1 expressed a concern to her about waiting for something. FM 1 stated that Resident 1 was difficult to understand at times due to her recent stroke. FM 1 stated that she called the facility back around 12:45 PM on 6/14/20 to discuss Resident 1's concern and was informed that one of her medications was out of stock in the facility and had already been reordered. FM 1 stated she then attempted to reach Resident 1's attending physician, but was unsuccessful. FM 1 stated she called again the facility around 2:00 PM on 6/14/20 and spoke with the Registered Nurse Supervisor (RN 1). FM 1 stated RN 1 informed her that the facility had reordered Resident 1's Anoro Ellipta inhaler from the pharmacy, but it was currently unavailable in the facility and they did not administer it to Resident 1 as prescribed on 6/13/20 and 6/14/20. FM 1 stated that she received a call back from the facility around 7:40 PM on 6/14/20 to inform her that Resident 1's Anoro Ellipta inhaler had arrived from the pharmacy. FM 1 stated the facility attempted to administer a dose; however, Resident 1 refused the dose at that time because, if given in the evening, the medication makes it difficult for her to sleep. FM 1 stated that facility gave the next dose to Resident 1 around 8:00 AM on 6/15/20. On 6/17/20 at 10:36 AM, during a telephone interview, RN 1 stated Certified Nursing Assistant (CNA) said that Resident 1, around 10:30 AM to 11:00 AM on 6/14/20, was asking why LVN 2 did not administer her dose of Anoro Ellipta as scheduled. RN 1 stated that LVN 2 found the Anoro Ellipta inhaler empty on 6/13/20 and LVN 2 had requested a refill from the pharmacy on that day. RN 1 stated she then called the pharmacy to expedite the order because this medication is important and she should not miss it. RN 1 stated she spoke to the physician on call on 6/14/20 and received an order to give Resident 1 a dose as soon as it was available. RN 1 stated she spoke with FM 1 on 6/14/20 who was upset regarding the missed doses of the medication. RN 1 stated the nursing staff were required to order refills for all residents' regularly scheduled medications about five days ahead to prevent residents from running out. RN 1 stated that by failing to provide Resident 1's treatment for [REDACTED]. On 6/17/20 at 10:46 AM, during a telephone interview, LVN 2 stated the facility assigned her to administer medications in the morning for Resident 1 on 6/13/20 and 6/14/20. 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LVN 1 stated that if medications were not available, residents' health conditions were at risk of worsening. On 6/17/20 at 11:39 AM, during an interview, the Director of Nursing (DON) stated pharmacy refills should be ordered three to five days before the resident runs out and that nursing staff can order medications stat to get a two-hour delivery by calling the pharmacy directly. The DON stated if a medication was missing from the medication cart and the resident will miss a dose, it was considered a medication error. The DON stated that in the event of a medication error, nursing staff were required to notify their supervisor, the physician, the family member of the resident and, if the medication is missing, reorder the medication as stat or emergency from the pharmacy. The DON stated, according to the documentation in the MAR, the facility failed to administer doses of Anoro Ellipta to Resident 1 on 6/13/20 and 6/14/20 as ordered by the physician. The DON stated that LVN 1 and LVN 2 failed to follow the facility's policies and procedures regarding reordering medications from the pharmacy and handling medication errors. The DON stated that she had provided retraining and disciplinary action to nursing staff in order to correct the issue. A review of the facility's policy titled, Medication Administration: General, with revision date on 11/1/19, indicated To provide a safe, effective medication administration process If unable to provide the medication(s) or substitution(s) within one hour of prescribed time, refer to Medications Error policy. A review of the facility's policy titled, Medication Errors, with revision date on 11/1/2019, indicated to Report immediately to the Center Nurse Executive or designee. Notify physician/advanced practice provider, patient, and responsible party. Cross-referenced with F755