STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056078	A. Building B. Wing	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta View Post Acute	831 S Lake Street Los Angeles, CA 90057

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview and record review, the facility failed to identify and ensure one of four sampled residents (Resident 2), who was at risk for pain and distress related to amputations on both lower legs (surgical removal) and had hypertension (high blood pressure, a condition when the force of the blood against the artery wall is too high), received care and services in accordance with professional standards of practice and the comprehensive person-centered care plan by failing to: -Implement Resident 2's Physician's Order to administer pain medication hydrocodone/acetaminophen 10/325 mg (Norco - a controlled substance used to relieve moderate to severe pain), as needed every six hours for severe pain. -Recognize and assess Resident 2's pain every shift, related to the resident's amputations. -Implement Resident 2's care plan for limitations in joint mobility and monitor for pain every shift. This deficient practice caused Resident 2 to experience severe untreated pain (rated 8 or 9 out of 10 on a pain scale from 0-10 where 10 is the worst possible pain) between 12/2 - 12/5/2021 when the pain medication was not administered as ordered. Findings: A review of Resident 2's Admission Record (face sheet) indicated Resident 2 was originally admitted to the facility on [DATE] with diagnoses including acquired absence of left leg below knee (left leg amputation below the knee) and acquired absence of right leg above the knee (right leg amputation above the knee). A review of Resident 2's Order Summary Report (a document summarizing a resident's current physician's orders), dated 9/27/2021, indicated Resident 2 was to receive hydrocodone/acetaminophen 10/325 mg (Norco), one tablet by mouth every six hours as needed for severe pain (pain score 7-10.). On 9/29/2021, the Order Summary Report indicated the attending physician ordered Resident 2 to be assessed for pain every shift and indicated a score of 0 was no pain, 1-3 mild pain, 4-6 moderate pain, and 7-10 severe pain. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	A review of the care plan updated 9/2021 indicated Resident 2 had impaired physical mobility related to limited movement, with complications of unrelieved phantom pain (pain that feels like it is coming from a body part that is no longer there). The care plan indicated the contributing factor was Resident 2's left below the knee amputation and the right above the knee amputation. The care plan approach indicated to monitor for pain and notify the physician of any pain. There was no pain medication noted on the care plan. According to a review of the care plan updated 9/2021, Resident 2 had limitations in joint mobility with the approach to monitor for pain every shift. There was no pain medication noted on the care plan. A review of the care plan updated 9/2021 indicated Resident 2 was at risk for pain related to chronic pain syndrome with the goal to have pain under control with medication. The care plan approach indicated to administer analgesics as ordered, Norco 10-325 mg every six hours as need for severe pain, and to observe effectiveness of medications. A review of the annual Minimum Data Set (MDS - a comprehensive assessment and care-screening tool) dated 10/16/2021 indicated Resident 2 was able to make decisions and did not have a memory problem. The MDS indicated Resident 2 received as needed (PRN) pain medication and had pain within the last five days. A review of Resident 2's MAR for November 2021 indicated Resident 2 typically received one to three doses of the pain medication hydrocodone/acetaminophen 10/325 mg (Norco) per day for pain scores ranging from 7-9. A review of Resident 2's Controlled Drug Record for hydrocodone /acetaminophen 10/325 mg (Norco) was unavailable from 11/4 to 11/17/2021. According to a review of Resident 2's progress notes, dated 11/1/2021 to 12/6/2021, there was no record that licensed nursing staff assessed or monitored Resident 2 for pain during the administration of hydrocodone /acetaminophen 10/325 mg (Norco). A review of the Controlled Drug Record (a log signed by the nurse with the date and time each time a controlled substance is given to a resident) for Resident 2's hydrocodone /acetaminophen 10/325 mg, indicated Resident 2 did not receive any hydrocodone/ acetaminophen 10/325 mg between 12/1/2021 at 9:30 PM - 12/5/2021 at 10:13 PM (four days). During an observation of Medication Cart 2 on 12/4/2021 at 1:10 PM, with the Licensed Vocational Nurse (LVN 1), and a concurrent interview, LVN 1 stated Resident 2's hydrocodone/acetaminophen 10/325 mg was reordered from the pharmacy but had not yet arrived. LVN 1 stated there was currently no other hydrocodone/acetaminophen 10/325 mg available for Resident 2 in the facility. A review of Resident 2's Medication Administration Record (MAR - a record of all doses of medications administered to the resident) for December 2021 indicated Resident 2 received a dose of hydrocodone/acetaminophen 10/325 mg around 9:30 PM on 12/1/21 and did not receive another dose until 12/5/21 around 10:13 PM. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 2's progress notes dated 12/1 - 12/6/2021, indicated no record that licensed nursing staff assessed Resident 2 for pain between 12/1/2021 at 9:30 PM - 12/5/2021 at 10:13 PM. During an interview on 12/6/2021 at 4:10 PM Resident 2 stated he takes Norco for pain in his stumps since he had his legs amputated. Resident 2 stated he experienced 8 or 9 out of 10 pain throughout the time his pain medication was unavailable from 12/2/21 to 12/5/21. Resident 2 stated he did his best to take his mind off the pain and tried follow up with staff regarding his refill. Resident 2 stated he asked three charge nurses: LVN 2, LVN 3, and LVN 4 why his refill was late and got three different explanations. Resident 2 stated he did not receive the Norco or any other pain medication from the facility's emergency medication kit or any other source during that time. Resident 2 stated staff denied him medication from the emergency kit because they said it was not an emergency. Resident 2 stated he has been living at the facility for about fourteen months and this was the second time the facility failed to refill his hydrocodone/acetaminophen 10/325 mg on time. During an interview on 12/6/2021 at 4:55 PM, LVN 4 stated Resident 2 asked him about his pain medication on Sunday 12/5/2021. LVN 4 stated he called the pharmacy around 5 PM to follow up. LVN 4 stated the medication was delivered later that night and he administered a dose to Resident 2 around 10 PM. During an interview on 12/8/2021 at 11:38 AM, the Director of Nursing (DON) stated she was unable to find the missing Controlled Drug Records for Resident 2's hydrocodone /acetaminophen 10/325 mg between 11/1/2021 and 11/19/2021. The DON stated and confirmed Resident 2 was not offered any pain medication from the facility's emergency kit between 12/2/2011 and 12/5/2021 when his own supply of pain medication hydrocodone /acetaminophen 10/325 mg was unavailable, and that licensed staff failed to assess his pain during that time. The DON acknowledged the facility failed to refill Resident 2's hydrocodone/ acetaminophen 10/325 mg on time to ensure he did not go without treatment for severe pain. A review of the facility policy titled, Administering Medications, and dated April 2019, indicated medications are administered in accordance with prescriber orders, including any required time frame. A review of the facility's policy titled, Pain Assessment and Management, undated, indicated the purpose was to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs. The policy indicated the pain management program was based on a facility-wide commitment for appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. The policy indicated the steps in procedure was to review the medication administration record to determine how often the resident requests and receives PRN medication, and to what extent the administered medication relieves the resident's pain. A review of the facility's policy titled Medication Ordering and Receiving from Pharmacy, dated April 2008, indicated medications and related products were received from the dispensing pharmacy on a timely basis. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A review of the facility policy and procedure dated April 2017, titled, Documentation of Medication Administration, indicated the facility shall maintain a medication administration record to document all medication administered. Documentation must include, a minimum: name and strength, dosage, date and time, reason(s) why a medication was withheld, not administered, or refused (as applicable). Signature and title of the person administering the medication.

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(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 - 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** 40994 This is a repeat deficiency from 10/2021, intake 752526. Based on observation, interview, and record review, the facility failed to ensure hydrocodone/acetaminophen (Norco - a controlled substance, medication used to treat moderate to severe pain) 10/325 milligrams (mg - a unit of measure for mass) was reordered from the pharmacy in a timely manner for one of four sampled residents (Resident 2) receiving medications for severe pain between 12/2/21 and 12/5/21. This deficient practice caused Resident 2 to experience severe untreated pain (rated 8 or 9 out of 10 on a pain scale from 0-10 where 10 is the worst possible pain) between 12/2 - 12/5/2021 when the medication was unavailable. Findings: A review of Resident 2's Admission Record (face sheet) indicated Resident 2 was originally admitted to the facility on [DATE] with diagnoses including acquired absence of left leg below knee (left leg amputation below the knee) and acquired absence of right leg above the knee (right leg amputation above the knee). A review of Resident 2's Order Summary Report (a document summarizing a resident's current physician's orders), dated 12/6/2021, indicated on 9/27/2021 the attending physician ordered hydrocodone/acetaminophen 10/325 mg (Norco), one tablet by mouth every six hours as needed for severe pain (pain score 7-10.). On 9/29/2021, the Order Summary Report indicated the attending physician ordered Resident 2 to be assessed for pain every shift and indicated a score of 0 was no pain, 1-3 mild pain, 4-6 moderate pain, and 7-10 severe pain. A review of Resident 2's Medication Administration Record (MAR - a record of all doses of medications administered to the resident) for November 2021 indicated Resident 2 typically received one to three doses of the pain medication hydrocodone/acetaminophen 10/325 mg (Norco) per day for pain scores ranging from 7-9. During an observation of Medication Cart 2 on 12/4/2021 at 1:10 PM, with the Licensed Vocational Nurse (LVN 1), an empty medication card (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the medication) for Resident 2's hydrocodone/acetaminophen 10/325 mg was observed in the cart. During a concurrent interview, LVN 1 stated Resident 2's hydrocodone/acetaminophen 10/325 mg was reordered from the pharmacy but had not yet arrived. LVN 1 stated there was currently no other hydrocodone/acetaminophen 10/325 mg available for Resident 2 in the facility. A review of the Controlled Drug Record (a log signed by the nurse with the date and time each time a controlled substance is given to a resident) for Resident 2's hydrocodone/acetaminophen 10/325 mg, indicated Resident 2 did not receive any hydrocodone/acetaminophen 10/325 mg between 12/1/2021 at 9:30 PM - 12/5/2021 at 10:13 PM (four days). (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 2's MAR for December 2021 indicated Resident 2 received a dose of hydrocodone/acetaminophen 10/325 mg around 9:30 PM on 12/1/2021 and did not receive another dose until 12/5/2021 around 10:13 PM. A review of Resident 2's progress notes dated 12/1 - 12/6/2021, indicated no record that licensed nursing staff assessed Resident 2 for pain between 12/1/2021 at 9:30 PM - 12/5/2021 at 10:13 PM. During an interview on 12/6/2021 at 4:10 PM Resident 2 stated he takes the Norco medication for pain in his stumps since he had his legs amputated. Resident 2 stated he experienced 8 or 9 out of 10 pain throughout the time his hydrocodone/acetaminophen 10/325 mg was unavailable from 12/2/21 to 12/5/21. Resident 2 stated he did his best to take his mind off the pain and tried follow up with staff regarding his refill. Resident 2 stated he asked three charge nurses: LVN 2, LVN 3, and LVN 4 why his refill was late and got three different explanations. Resident 2 stated he did not receive the Norco or any other pain medication from the facility's emergency medication kit or any other source during that time. Resident 2 stated staff denied him medication from the emergency kit because they said it was not an emergency. Resident 2 stated he has been living at the facility for about fourteen months and this was the second time the facility failed to refill his Norco on time. During an interview on 12/6/2021 at 4:50 PM, LVN 5 stated he was unable find a record of the refill request sent for Resident 2's hydrocodone/acetaminophen 10/325 mg via fax. LVN 5 stated sometimes refill requests were sent to the pharmacy directly through the computer system but he did not know how to access a record of that. During an interview on 12/6/2021 at 4:55 PM, LVN 4 stated Resident 2 asked him about his pain medication on Sunday 12/5/2021. LVN 4 stated he called the pharmacy around 5 PM to follow up and was told it would be delivered that night. LVN 4 stated he did not understand why the pharmacy delayed medication refills. LVN 4 stated the medication was delivered later that night and he administered a dose to Resident 2 around 10 PM. During a telephone interview on 12/7/2021 at 2:10 PM, the Registered Pharmacist (RPH) at Pharmacy 1 stated the facility first requested a refill for Resident 2's hydrocodone /acetaminophen 10/325 on 12/3/2021 at 11:24 AM via a phone call from LVN 6. The RPH stated Pharmacy 1 processed the refill on 12/4/2021 and delivered it to the facility on [DATE]. The RPH stated there was no other issues with filling the prescription on time that were apparent from the pharmacy's documentation. The RPH stated the pharmacy always requests at least two to three days of advanced notice to process refills and that if the facility was out of Resident 2's hydrocodone/acetaminophen 10/325 mg, they could have called the pharmacy to request access to the hydrocodone/acetaminophen 10/325 mg available in the facility's emergency medication kit. The RPH stated there was no record of any request from the facility to access the facility's emergency kit between 12/3/2021 and 12/5/2021. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	During an interview on 12/8/2021 at 11:38 AM, the Director of Nursing (DON) stated the facility's policy was to reorder any medication that was active when a five-day supply or less of the medication remained. The DON confirmed the first time the facility requested a refill for Resident 2's hydrocodone/acetaminophen 10/325 mg was when LVN 6 called Pharmacy 1 for a refill on 12/3/2021, two days after the last dose was administered. The DON stated and confirmed Resident 2 was not offered any pain medication from the facility's emergency kit between 12/2/21 and 12/5/21 when his own supply of pain medication hydrocodone /acetaminophen 10/325 mg was unavailable, and that licensed staff failed to assess his pain during that time. The DON acknowledged the facility failed to refill Resident 2's hydrocodone/acetaminophen 10/325 mg on time to ensure he did not go without treatment for severe pain. A review of the facility's policy titled, Medication Ordering and Receiving from Pharmacy, dated April 2008, indicated medications and related products were received from the dispensing pharmacy on a timely basis. The policy indicated to reorder medication five days in advance of need to assure an adequate supply was on hand. A review of the facility's policy and procedure revised in April 2019, titled, Controlled Substances, indicated controlled substances are reconciled upon receipt, administration, disposition. The nurse administering the medication was responsible for recording time, quantity of the medication remaining. A review of the facility's policy and procedure titled, Medication Orders and Receipt Record, dated 1/2021 indicated the facility shall document all medications that it orders and receives. The Charge Nurse will maintain medication order and receipt records. The medication order/receipt record shall contain: Order date; Name and title of person placing the order. The date and quantity received; and Name and title of the person receiving the order. The Director of Nursing Services will designate individuals to be responsible for completing medication order/receipt forms. Medications should be ordered in advance, based on the dispensing pharmacy's required lead time.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on interview and record review, the facility failed to monitor and record pain scores (an assessment of pain on a scale from 0-10 where 0 is no pain and 10 is the worst possible pain) for ten doses of as needed pain medication administered to three of four sampled residents (Residents 1, 2, and 3) between 11/1/2021 - 12/1/2021. The deficient practice increased the risk that Residents 1, 2, and 3 could have been given medication when it was unnecessary, per the physician's order or that their pain may have been inadequately treated resulting in health complications and diminished quality of life. Findings: a. A review of Resident 1's Admission Record indicated he was admitted to the facility on [DATE] with diagnoses including chronic pain syndrome (chronic pain that affects physical and mental well-being.) A review of Resident 1's Order Summary Report (a document summarizing a resident's current physician's orders), dated 12/6/2011, indicated on 9/4/2021 the attending physician ordered oxycodone/acetaminophen 10/325 mg to take one tablet by mouth every six hours as needed for severe pain (pain score of 7-10.) During a comparison of Resident 1's MAR for November 2021 and the Controlled Drug Record for oxycodone/acetaminophen 10/325 mg, the records indicated the following doses signed on the Controlled Drug Record were not entered into Resident 1's MAR: 11/2/2021 at 9:54 PM, 11/10/2021 at 3:30 PM, 11/10/2021 at 9:42 PM, 11/17/2021 at 3:50 PM, and 11/17/2021 at 10 PM. A review of Resident 1's progress notes, dated 11/1/2021 to 12/6/2021, indicated no record the licensed nursing staff assessed or monitored Resident 1 for pain during the administration of oxycodone/acetaminophen 10/325 mg on the dates and times listed above. b. A review of Resident 2's Admission Record, dated 12/6/2021, indicated Resident 2 was originally admitted to the facility on [DATE] with diagnoses including acquired absence of left leg below knee (left leg amputation below the knee) and acquired absence of right leg above the knee (right leg amputation above the knee). A review of Resident 2's Order Summary Report, dated 12/6/2021, indicated on 9/27/2021 the attending physician ordered hydrocodone/acetaminophen 10/325 mg to take one tablet by mouth every six hours as needed for severe pain (pain score 7-10.) During a comparison of Resident 2's MAR for November 2021 and the Controlled Drug Record for hydrocodone/acetaminophen 10/325 mg, the records indicated the following doses signed on the Controlled Drug Record were not entered into Resident 2's MAR: 11/1/2021 at 9 PM and 11/18/2021 at 6 PM. A review of Resident 2's Controlled Drug Record for hydrocodone/acetaminophen 10/325 mg was unavailable from 11/4 to 11/17/2021. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 2's progress notes, dated 11/1/2021 to 12/6/2021, no record that licensed nursing staff assessed or monitored Resident 2 for pain during the administration of hydrocodone/acetaminophen 10/325 mg on the dates and times listed above. c. A review of Resident 3's Admission Record, dated 12/6/2021, indicated he was admitted to the facility on [DATE] with diagnoses including chronic pain syndrome and low back pain. A review of Resident 3's Order Summary Report, dated 12/6/2021, indicated on 9/27/2021 the attending physician ordered hydrocodone/acetaminophen 10/325 mg to take one tablet by mouth every four hours as needed for severe pain (pain score 7-10.) During a comparison of Resident 3's MAR for November and December 2021 and the Controlled Drug Record for hydrocodone/acetaminophen 10/325 mg, the records indicated the following doses signed on the Controlled Drug Record were not entered into Resident 3's MAR: 11/22/2021 at 6 PM, 11/23/2021 at 4:30 AM, and 12/1/2021 at 10:50 PM. A review of Resident 3's Controlled Drug Record for hydrocodone/acetaminophen 10/325 mg was unavailable from 11/1 to 11/19/2021. A review of Resident 3's progress notes, dated 11/1/2021 to 12/6/2021, indicated no record that licensed nursing staff assessed or monitored Resident 3 for pain during the administration of hydrocodone/acetaminophen 10/325 mg on the dates and times listed above. During an interview on 12/6/2021 at 2:10 PM with the former administrator (FADM), the FADM stated the facility's electronic MAR system was new to them and acknowledged some staff have missed documenting the administration of some controlled substances in the MAR immediately after administration. The FADM stated the registered nurse supervisor was supposed to check the administration of as needed controlled drugs at the end of each shift to ensure the documentation was performed correctly in the MAR. During an interview on 12/6/21 at 3:50 PM, licensed vocational nurse (LVN 7) stated he failed to document doses of oxycodone/acetaminophen 10/325 mg given to Resident 1 on 11/10/2021 at 3:30 PM and 9:42 PM and on 11/17 at 3:50 PM and 10 PM. LVN 7 stated the medication was administered to the resident per the Controlled Drug Record, but he failed to record it in the MAR or perform monitoring or documentation for the resident's pain level before and after the dose. LVN 7 stated that the proper protocol was to record the pain score and the administration of as needed pain medication right after the dose is given and to return about an hour later to document the effectiveness. LVN 7 stated it was important to properly monitor medications and record the results to ensure they were effective, that the residents do not receive more doses than prescribed, and the residents do not experience adverse effects which could lead to health complications. During an interview on 12/8/2021 at 11:38 AM, the Director of Nursing (DON) stated she was unable to find the missing Controlled Drug Records for Resident 2 and 3's hydrocodone /acetaminophen 10/325 mg between 11/1/21 and 11/19/21. A review of the facility's policy titled, Administering Medications, revised January 2021, indicated the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy titled, Controlled Substances, revised January 2021, indicated upon administration: the nurse administering the medication is responsible for recording name, strength, and dose of the medications and time of administration. A review of the facility's policy titled, Charting Errors and/or Omissions, revised January 2021, indicated accurate medication records shall be maintained by this facility.