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	06/10/2022

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to ensure one of 12 sampled residents (Resident 12) was informed about the risks and benefits of Aricept (a medication used to treat memory loss) prior to prescribing and administering the medication. The deficient practice of failing to inform Resident 12 about the risks and benefits of medication therapy could have caused him to experience adverse effects (unwanted and dangerous side effects of drug therapy) leading to a diminished quality of life. Findings: During a telephone interview on 6/7/22 at 2:33 PM, the Facility Monitor (FM) stated he observed Resident 12 refusing to take Aricept from the Licensed Vocational Nurse (LVN 9) on 6/2/22 around 12:50 PM. The FM stated Resident 12 expressed he was not aware of what Aricept was for and received no education regarding the risks or benefits of taking the medication. The FM stated upon reviewing the clinical record, Aricept was prescribed for one episode of forgetfulness mentioned back in March 2022 during an Interdisciplinary Team (IDT - a team of facility staff with different areas of expertise who meet quarterly to discuss and plan a resident ' s care) meeting. The FM stated Resident 12 indicated he was not invited to join this IDT meeting to participate in his own care even though he was self-responsible (makes his own decisions regarding medical treatments and procedures.) The FM stated Resident 12 was self-aware and able to make his needs known, had no history of dementia, and no clinical record indicating a diagnoses or workup of any kind of dementia was done prior to prescribing Aricept. A review of Resident 12 ' s Admission Record, dated 6/9/22, indicated he was originally admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including unspecified dementia without behavioral disturbance (a group of medical conditions characterized by impairment of at least two brain functions such as memory and judgement.) A review of Resident 12 ' s Physician's Order dated 3/15/22, indicated Resident 12 ' s attending physician prescribed Aricept 5 milligrams (mg - a unit of measure for mass) by mouth once daily for dementia. Further review indicated the physician discontinued this order on 6/3/22. A review of Resident 12 ' s Minimum Data Set (MDS - a comprehensive assessment and care planning tool) dated 4/27/22, section I4800 (active diagnoses) listed Non-Alzheimer ' s Dementia as an active diagnosis for Resident 12. (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
	056078	A. Building B. Wing	06/10/2022

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the nurse progress notes dated from 6/2/22 and 6/3/22 indicated Resident 12 was refusing to take his Aricept, was being educated by licensed staff regarding the risks and benefits of refusing the medication, and the physician was contacted regarding his repeated refusals. A review of Resident 12 ' s Resident Care Conference Review, dated 3/4/22, indicated the resident recently started ' Aricept ' per episode of forgetfulness (per resident)/dementia. Further review of this document did not indicate, in the space provided, whether Resident 12 elected to attend the meeting or not. A review of Resident 12 ' s clinical record did not show any documentation or clinical work up from the physician or any other provider supporting a diagnosis of dementia such as any record of checking memory, language, visual perception, attention, problem-solving, movement, senses, balance, reflexes, or other neurological work up. During an observation and concurrent interview on 6/9/22 at 1:06 PM., in Resident 12 ' s room, Resident 12 was observed sitting up in his wheelchair in his room responding to questions and was alert and oriented to person, place, time, and activity. Resident 12 stated he was never invited to participate in any care conference concerning his care since after he was first admitted . Resident 12 stated he was not invited to attend the IDT team meeting regarding his care held on 3/4/22 which included the discussion of adding Aricept to his medication regimen. Resident 12 stated he did not ask for Aricept due to forgetfulness and doesn ' t even know what Aricept is. Resident 12 stated he was never evaluated by the physician in person or remotely concerning the diagnosis of dementia and to his knowledge no other medical workup was done regarding his episode of forgetfulness. Resident 12 stated that it was not uncommon at this facility for residents to be started on medications without having been properly educated or evaluated by medical staff regarding their use. Resident 12 stated neither MD nor any other facility staff educated him on the risks or benefits of taking Aricept before they started giving it to him. Resident 12 stated he may forget something occasionally but it ' s not uncommon for someone almost [AGE] years old to forget something from time to time. Resident 12 stated, I don ' t have dementia and don ' t have any trouble remembering who other people are, who I am, or where I am. During an interview on 6/10/22 at 10:59 AM., with Registered Nurse Supervisor (RN 1) stated prior to his care conference on 3/4/22, Resident 12 had an episode where he slid out of his wheelchair while out on pass to his methadone (a medication used to treat pain) clinic. RN 1 stated Resident 12 expressed that he was having moments of forgetfulness and requested medication for it. RN 1 stated MD was contacted regarding his request, and she added a diagnosis of dementia and prescribed Aricept over the phone. RN 1 stated she was unsure whether the resident was invited to participate in that care conference, but it is important to ensure the resident was informed about the risks and benefits of the treatment options to ensure he or she has the right to refuse the medication if he or she chose to. (continued on next page)

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	06/10/2022

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/22 at 11:14 AM., the Minimum Data Set Nurse 1 (MDSN) stated she was responsible for coordinating the resident care conferences. MDSN stated Resident 12 ' s IDT meeting on 3/4/22 was misdated. The MDSN stated this conference happened after the Aricept was already started on 3/15/22 as it discussed the ongoing Aricept therapy. The MDSN stated the resident opted out of attending this care conference, but he usually comes to them when they involve incidents. The MDSN stated the Aricept was started pursuant to a telephone order from the physician and the physician did not evaluate this resident in person for dementia prior to ordering this medication. The MDSN stated she could find no written record that this resident was educated on the risks and benefits of Aricept before the medication was prescribed or administered. During a telephone interview on 6/10/22 at 11:29 AM, the Physician stated she was the primary attending physician for Resident 12 and occasionally this resident was forgetful or confused, but, I don ' t think he has dementia. The Physician stated she did not prescribe Aricept for this resident and did not know why her name was on the order. The Physician stated, I thought maybe he received this from the [hospital] when he was discharged and stated she was made aware that the resident was refusing the Aricept in early June and then discontinued it because ,I don ' t think he needs it. A review of the facility ' s policy titled, Resident Rights, reviewed January 2022, indicated federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident ' s right to be informed about his or her rights and responsibilities, be informed of, and participate in, his or her care planning and treatment, choose an attending physician and participate in decision-making regarding his or her care.

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	06/10/2022

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to ensure one of 12 sampled residents (Resident 12) was not allowed or required to self-administer medications without the required prior approval. The deficient practice of allowing Resident 12 to self-administer his medications without the required prior approval increased the risk that Resident 12 and other residents could have incorrectly administered medications leading to possible medical complications and an overall diminished quality of life. Findings: During a telephone interview on 6/7/22 at 2:33 PM, the Facility Monitor (FM) stated he observed Resident 12 on 6/2/22 at approximately 12:28 PM on the facility ' s patio holding a plastic medication cup containing six medications (identified at Aricept [a medication used to treat memory loss], valsartan [a medication used to treat high blood pressure], Cymbalta [a medication used to treat nerve pain], finasteride [a medication used to treat frequent urination, Norco [a medication used to treat pain], and gabapentin [a medication used to treat nerve pain]). The FM stated Resident 12 indicated he had just received these medications from the Licensed Vocational Nurse (LVN 9) and had already taken the multivitamin (a vitamin supplement) and vitamin c (a vitamin supplement.) The FM stated, according to the June 2022 MAR, LVN 9 documented six medications as administered around 10:30 AM on 6/2/22 (Aricept, valsartan, Cymbalta, finasteride, multivitamin and vitamin c). The FM stated during his observation of Resident 12 earlier that day, Resident 12 was asleep at that time and LVN 9 documented gabapentin and Norco were administered around 12:18 PM and 12:20 PM, respectively that day. The FM stated those medications were still in the medication cup along with the others when FM observed Resident 12 on the patio at 12:28 PM. The FM stated he took a time-stamped photo of the medications in the cup at 12:28 PM. The FM stated he observed Resident 12 on the patio with his medications unsupervised by facility staff and he asked LVN 9 on 6/2/22 why she left the medications alone with the resident rather than administering them to him. The FM stated LVN 9 eventually responded she left them alone with Resident 12 because he was self-responsible. The FM stated it was a common practice in the facility for licensed staff to leave medications with residents unsupervised for self-administration without prior approval and LVN 9 offered no explanation for the inaccuracy in the documentation. The FM stated most likely LVN 9 prepared the medications around 10:30 AM, found that the resident was asleep, locked them in the drawer of the medication cart intending to give them to the resident later, and then documented in the MAR that the medications had been given at that time when in fact they had not. A review of Resident 12 ' s Admission Record, dated 6/9/22, indicated he was originally admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including essential hypertension (high blood pressure) and unspecified dementia without behavioral disturbance (a group of medical conditions characterized by impairment of at least two brain functions such as memory and judgement. A review of the Physician's Order Summary Report, dated 6/9/22, indicated all current orders were to be clinician administered and there was no separate physician order authorizing the self-administration of medications. (continued on next page)

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	06/10/2022

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 12 ' s Self-Administration of Medication Assessment Record, dated 3/15/22, indicated Prefers LN (licensed nurse) to administer medication at this time. A review of Resident 12 ' s clinical record indicated no documentation of an Interdisciplinary Team (IDT - a team of facility staff with different areas of expertise who meet quarterly to discuss and plan a resident ' s care) meeting authorizing self-administration of medication or a resident care plan regarding self-administration of medications. During an observation and concurrent interview on 6/9/22 at 1:06 PM with Resident 12 in is room, Resident 12 was observed sitting up in his wheelchair in his room. Resident 12 stated when the licensed nurses provide his medications, they commonly leave his medications in the dosage cup at his bedside. Resident 12 stated he knows the proper protocol for administering medications was to stay with him while he takes them but says the nurses were probably frustrated that I take a long time to swallow them due to my [other medical conditions] and I know they have a lot of work to do. Resident 12 stated on 6/2/22, LVN 9 brought his medications to him while he was on the patio and left without watching him taken them all. A review of the June 2022 nursing schedule indicated LVN 9 was not scheduled for the rest of the month as she resigned 6/6/22. LVN 9 did not answer the phone in an attempt to interview her and messages were unreturned at this time of this writing. During an interview on 6/10/22 at 10:59 AM, Registered Nurse Supervisor (RN 1) stated for a resident to self-administer medications, there would need to be an IDT approval and a physician order allowing self-administration in place prior to allowing the resident to self-administer. RN 1 stated Resident 12 did not have the approval to self-administer medications and his self-administration assessment, dated 3/15/22, indicated his medications must be given by a licensed nurse. RN 1 stated that all of Resident 12 ' s medication orders indicated they were to be clinician administered. RN 1 stated, when administering pills, the licensed nurse was required to verify, in person, that the resident takes all of the medications before documenting them in the MAR. RN 1 stated licensed nurses cannot leave the pills with the resident at bedside or anyplace else unsupervised. RN 1 stated that if medications were left at the bedside without prior approval, the medical record regarding medications taken may be inaccurate if the resident did not actually take them all. RN 1 stated the nurse administering the medication would not know if the resident refused any of the medication and would not be able to document accurately. A review of the facility ' s policy titled, Self-Administration of Medications, reviewed January 2022, indicated residents have the right to self-administer medication if the interdisciplinary team had determined that it was clinically appropriate and safe for the resident to do so. If it was deemed safe and appropriate for a resident to self-administer medications, this was documented in the medical record and the care plan.

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	06/10/2022

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on observation, interview, and record review, the facility failed to ensure the call light device was within reach for one sampled resident (Resident 20) and also failed to ensure the call light was answered in a timely manner. This deficient practice had the potential to affect the Resident's ability to call for assistance when needed and similarly resulted in the resident not being able to summon health care workers for help as needed. Findings: A review of Resident 20 ' s Admission Record (face sheet), indicated the resident was admitted to the facility on [DATE]with diagnoses including Torticollis (a condition where one ' s neck muscles go into spasm and pulls the head to one side), need for assistance with personal care, and anxiety disorder (frequent intense, excessive and persistent worry and fear about everyday situations). A review of Resident 20 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 4/7/2022 indicated the resident was totally dependent with full staff performance every time. During an observation and concurrent interview on 6/9/2022 at 1:14 p.m., Resident 20 was lying down in bed and the call light was observed on the floor, on the resident's left side of the bed, out of the resident ' s reach. Certified Nursing Assistant (CNA) 9 acknowledged and stated the call light was out of reach and that this would result in the resident being unable to call for assistance. During an observation and concurrent interview on 6/9/2022 at 3:19 p.m., Resident 20 activated his call light and stated that it sometimes takes up to an hour before someone responds to it. At 3:27 p.m., CNA 5 who was assisting to answer calls responded to the call light. She stated the expectation was answering the call light immediately or within five minutes and that the ramifications of not following through may result in accidents such as choking and incontinence. During an interview on 6/10/2022 at 9:50 am, LVN 1 stated that Room A ws the most neglected room in the unit and the call lights get answered an average of 30 minutes and was sometimes left sitting in his own wastes. A review of the facility policy and procedure titled, Call Light, revised 3/1/21 indicated when the resident was in bed or confined to a chair, be sure the call light was within easy reach of the resident. The policy indicated to answer the resident as soon as possible.

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	06/10/2022

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview and record review, the facility failed to provide a safe, clean, comfortable and homelike environment per facility policy for seven of seven sampled residents (Resident 4, 6, 17, 18, 20, 26 and 27) by failing to: -Ensure Residents 4, 6, 17, 26 and 27 were provided with a comfortable noise level. -Ensure Resident 18 had a remote control for the television (TV). -Ensure Resident 20 ' s belongings were not scattered over the floor. These deficient practices had the potential to negatively impact the psychosocial well-being of the residents, delayed provision of required services, and inability to meet residents ' needs for Resident 4, 6, 17, 18, 20, 26 and 27. Findings: 1a. A review of Resident 4 ' s Admission Record indicated resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Type II diabetes (DM-a chronic condition that affects the way the body processes blood sugar [glucose]) and chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe). A review of the Minimum Data Set (MDS - a comprehensive assessment and care screening tool), dated 4/14/2022, indicated Resident 4's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making was intact and required extensive assistance from staff for activities of daily living (ADL- transfer, dressing, toilet use and personal hygiene). During an interview on 6/9/2022 at 8:43 p.m., Resident 4 stated another resident (Resident 18) screamed and yelled loudly every night, that it wakes him up in the middle of the night. Resident 4 stated Resident 18 yelled so loud he could hear it from across the room and stated he complained about it to the staff. 1b. A review of Resident 6 ' s Admission Record indicated resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts), acute respiratory failure (occurs when fluid builds up in the air sacs in your lungs), Type II diabetes, and heart failure (a condition in which the heart does not pump blood as well as it should). A review of the MDS, dated [DATE], indicated Resident 6's cognitive skills for daily decision-making was intact and required total dependence from staff for ADLs- transfer and locomotion off unit. (continued on next page)

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	06/10/2022

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/8/2022 at 2:53 p.m., Resident 6 stated another resident (Resident 18) screamed and yelled loudly every night after midnight that it wakes her up and she was then unable to go back to sleep. Resident 6 stated she has sleep apnea so it was even more difficult for her to sleep once the loud yelling wakes her up every night. 1c. A review of Resident 17 ' s Admission Record indicated resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), sepsis (a life-threatening condition that arises when the body ' s response to infection causes injury to its own tissues and organs) and heart failure. A review of the MDS, dated [DATE], indicated Resident 17's cognitive skills for daily decision-making was intact and required total dependence from staff for ADL- transfer and toilet use. During an interview on 6/8/2022 at 2:57 p.m., Resident 17 stated another resident (Resident 18) screamed and yelled loudly every night that it wakes her up. Resident 17 stated staff were aware, but they do nothing about it. Resident 17 stated she refused to be moved to another room. A review of Resident 18 ' s Admission Record indicated resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including multiple sclerosis (a progressive disease involving cell damage of the brain, spinal cord which will leave numbness, impairment of speech, muscular coordination, blurred vision and extreme tiredness), schizophrenia (a disorder that affects a person ' s ability to think, feel, and behave clearly) and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). A review of the MDS dated [DATE], indicated Resident 18's skills for daily decision-making was intact and required total dependence from staff for ADLs (transfer, toilet use and locomotion on unit). During an observation of the facility on 6/10/2022 at 9:45 a.m., Resident 18 can be heard in the hallway screaming loudly and yelling at the staff. During an interview on 6/9/2022 at 6:14 a.m., Licensed Vocational Nurse 3 (LVN 3) stated Resident 18 had episodes of screaming and yelling in the room loudly during the night shift and other residents complained about it. LVN 3 further stated it had been going on for about two weeks now. During an interview on 6/9/2022 at 6:32 a.m., Certified Nursing Assistant 4 (CNA 4) stated she had taken care of Resident 18 and confirmed that Resident 18 had episodes of yelling and screaming loudly at night. CNA 4 stated she would check on Resident 18 and asked why she screamed, and Resident 18 replied she did not remember or know why she screamed. During an interview with Director of Nursing (DON) on 6/10/2022 at 10:24 a.m., the DON stated and confirmed Resident 18 had episodes of screaming and yelling at staff with an increase of behavioral issues from the last two weeks. The DON stated and confirmed, the loud screaming and yelling wakes up few residents in the facility and this puts residents for inadequate quality of life due to excessive noise and lack of sleep. (continued on next page)

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	06/10/2022

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility ' s policy and procedure (P&P) titled, Quality of Life - Homelike Environment, released 3/1/2021, indicated the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: comfortable noise levels. 1d. A review of Resident 26 ' s Admission Record indicated resident was originally admitted on [DATE] with diagnoses including right ankle and foot osteomyelitis (bone infection), obesity (a disorder involving excessive body fat that increases the risk of health problems) and Chronic Obstructive Pulmonary Disease (COPD). A review of the MDS, dated [DATE], indicated Resident 26 had an intact cognitive skill for daily decision making and needed extensive assistance for ADLs. During an observation on 6/8/2022 at 7:22 p.m., Resident 19 was in his room and screamed uncontrollably and loudly. During an observation on 6/9/2022 at 6:35 a.m., Resident 19 was in his room and screamed loudly. During an interview with Licensed Vocational Nurse 1 (LVN 1) on 6/10/2022 at 10:38 a.m., LVN 1 stated all residents should be provided with a comfortable noise level throughout the day. During an interview with Resident 26 on 6/10/2022 at 4:47 p.m., Resident 26 stated that someone kept on yelling and screaming from the hallway and it was hard for her to sleep. A review of facility ' s P&P, titled, Quality of Life-Homelike Environment, dated 3/1/2021, indicated the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include comfortable noise levels. 1e. A review of Resident 27 ' s Admission Record indicated resident was admitted on [DATE] with diagnoses including atrial fibrillation (AF-an irregular rapid heart rate that commonly causes poor blood flow), hypertension (high blood pressure) and abnormalities of gait and mobility. A review of the MDS, dated [DATE], indicated Resident 27 had an intact cognitive skill for decision making and needing limited assistance for ADLs. During an observation on 6/8/2022 at 7:22 p.m., Resident 19 was in his room and screamed uncontrollably and loudly. During an observation on 6/9/2022 at 6:35 a.m., Resident 19 was in him room and screamed loudly. During an interview with Licensed Vocational Nurse 1 (LVN 1) on 6/10/2022 at 10:38 a.m., LVN 1 stated all residents should be provided with a comfortable noise level throughout the day. During an interview with Resident 27 on 6/10/2022 at 4:50 p.m., Resident 27 stated that he heard the screaming constantly and feels bad for both the screamer and the rest of the residents in the facility. Resident 27 also stated that it gets very hard to sleep during the night. (continued on next page)

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	06/10/2022

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility ' s P&P, titled, Quality of Life-Homelike Environment, dated 3/1/2021, indicated that the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include comfortable noise levels. 2. A review of Resident 18 ' s Admission Record indicated the resident was admitted on [DATE] with diagnoses including generalized muscle weakness (muscle weakness throughout the body), abnormalities of gait and mobility (unable to walk in the usual way) and lack of coordination (loss of coordination). A review of Resident 18 ' s MDS, dated [DATE], indicated Resident 18 had intact cognitive skills for decision making and required extensive to total dependance for functional status and total dependance for transfer, toilet use and needed extensive assistance for bed mobility, dressing and personal hygiene. During an interview Resident 18 stated, My television does not work. I reported this and they did not fix it. I have to call out every time I need help. During an interview and concurrent observation with the Certified Nurse Assistance 7 (CNA7) on 6/10/2022 at 2:47 p.m., CNA 7 stated I cannot find the remote. During a concurrent interview and observation on 6/10/2022 at 2:57 p.m., Director of Maintenance (DM) acknowledged that the TV was not working and stated, I will bring her a remote. A review of facility ' s policy and procedure (P&P), titled, Maintenance Service, revised on 1/2022, indicated the maintenance Department was responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel include but are not limited to maintaining the paging system in good working order. 3.A review of Resident 20 ' s Admission Record, indicated the resident was admitted to the facility on [DATE] with diagnoses including Torticollis (a condition where one ' s neck muscles go into spasm and pulls the head to one side), need for assistance with personal care, and anxiety disorder (frequent intense, excessive and persistent worry and fear about everyday situations). A review of the MDS, dated [DATE], indicated Resident 20 was totally dependent with full staff performance every time. During an observation and concurrent interview on 6/9/2022 at 1:14 p.m., Resident 20 ' s belongings were observed to be on the floor as well as in a plastic container located to the left side of his bed. Resident 20 stated he requested to have a nightstand for his belongings on multiple occasions but had neither received it nor was updated on what the status was. During a concurrent interview, Certified Nursing Assistant 9 (CNA 9) stated the closet space was not enough and added, I can only work with what I ' ve got. During an interview on 6/9/2022 at 3 PM, the Maintenance Director (MD) stated Resident 20 requested to have his belongings exactly the way they were. The resident confirmed with the MD that he wanted to have a nightstand while surveyor was waiting outside the resident ' s door. (continued on next page)

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	06/10/2022

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility ' s P&P, titled, Quality of Life-Homelike Environment, dated 3/1/2021, indicated residents were provided with safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.

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	06/10/2022

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to provide required care and services according to current standards of practice by failing to ensure multiple licensed staff, including Licensed Vocational Nurses 1, 7 and 8 (LVN) measured blood sugar levels according to physician's orders and care plans for seven of 11 sampled residents receiving sliding scale (dose of insulin [a medication used to treat high blood sugar] dependent on blood sugar readings taken immediately before administration) insulin between 1/1/22 and 3/31/22. The deficient practice of failing to check blood sugar levels as required by the physician's order and care plan, prior to administering insulin, could have caused Resident 1, 2, 3, 4, 5, 6 and 7's (Residents 1 - 7) blood sugar levels to drop dangerously low, likely leading to overall diminished quality of life, hospitalization , or death. On 6/9/2022 at 11:11 AM, an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the facility's Administrator (ADM) and Director of Nursing (DON) regarding the facility's failure to ensure blood sugar levels were checked prior to administering insulin as required by the physician's order and failure to provide required care and services to Residents 1-7 by failing to check their blood sugar as required by their physician's orders and care plans. On 6/10/22 at 3:23 PM, while onsite at the facility, the IJ was removed after the facility submitted an acceptable removal plan (interventions to correct the deficient practices), which was verified and confirmed through observation, interview and record review. The IJ situation was removed in the presence of the ADM and the DON. The accepted removal plan included the following actions: 1. On 6/9/2022, the Nurse Consultant reeducated licensed staff regarding neglect, with emphasis on providing professional care and services to prevent physical harm by ensuring blood sugar levels were measured and not duplicated prior to administering insulin. 2. Facility staff identified a total of 17 residents currently in the facility with a physician's order to check blood sugar prior to administering sliding scale insulin, reviewed their Medication Administration Records (MAR) for duplicate blood sugar entries between 6/1/2022 and 6/9/2022, and found no additional duplicate blood sugar levels. 3. On 6/9/2022, the Pharmacist Consultant (PC) conducted educational training with licensed staff regarding the following topics: A. Obtaining a fingerstick glucose (sugar) level B. Importance of accuracy and integrity of medical records C. Importance of measuring blood sugar level per physician's order prior to administering insulin based on a sliding scale dosing regimen. (continued on next page)

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	06/10/2022

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. On 6/10/2022, the Pharmacy Nurse Consultant began to conduct direct observations of licensed staff to ensure competency in technique and documentation for five licensed staff per day with a target date of completion for the entire nursing staff by 6/15/2022. 5. On 6/9/2022, the Medical Director (MD) reviewed the blood sugar readings of all 17 residents with physician's orders to check blood sugar prior to administering sliding scale insulin. On 6/10/22, MD personally assessed residents affected by the duplication of blood sugar readings for any adverse effect. 6. On 6/9/2022, the DON and/or the Quality Assurance Nurse will audit eight residents three times weekly to ensure licensed staff were checking blood sugar levels prior to administering sliding scale insulin. 7. The DON and ADM to be responsible for the implementation of the plan and will review and monitor the effectiveness of the plan and present findings in quarterly quality assurance meetings. Findings: During a telephone interview on 6/7/2022 at 2:33 PM, the Facility Monitor (FM) stated Residents 1, 2, and 3 had multiple identical blood sugar readings documented for insulin administration between January and March 2022. The FM stated multiple nurses documented the same blood sugar readings multiple times throughout the day, on multiple days and for multiple residents. The FM stated many of the duplicate readings were used to determine the dose of sliding scale insulin and insulin was administered as a result. A review of Resident 1's Admission Record dated 6/9/2022, indicated he was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Type II diabetes mellitus (impairment in the way the body regulates and uses sugar [glucose] as a fuel). A review of the Physician's Order Summary Report, dated 6/9/2022, indicated the following active orders for Resident 1's insulin: -On 3/3/2022, insulin lispro (a fast-acting form of insulin) to inject three units (a unit of dosage for insulin) subcutaneously (under the skin) three times a day for Type II diabetes with instructions to hold if the blood sugar value was less than 120 milligrams ([ml] - a unit of measurement for mass) per deciliter ([dl] - a unit of measurement for volume). -On 3/3/22, insulin lispro to inject as per sliding scale: if blood sugar (BS) = 71-150, no coverage, 151-200 = 3 units, 201-250 = 5 units, 251-300 = 7 units, 301-350 = 9 units, 351-400 = 11 units, more than 400 = 13 units subcutaneously before meals and at bedtime for Type II diabetes. -On 4/21/22, insulin glargine (a slow-acting insulin) to inject 30 units subcutaneously in the morning for Type II diabetes. A review of Resident 1's Care Plan for diabetes, updated April 2022, indicated he was at risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) due to diabetes with an approach plan to Accucheck (take blood sugar measurement) as ordered QID (four times daily) AC (before meals) and QHS (at bedtime). (continued on next page)

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	06/10/2022

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident 1's MAR dated from January to March 2022, indicated the following examples of duplications of blood sugar readings in the record on 1/17/2022: -9 AM - 214 mg/dl - 3 units of lispro administered by Licensed Vocational Nurse (LVN 8) -1 PM - 214 mg/dl - 3 units of lispro administered by LVN 8 -5 PM - 214 mg/dl - 3 units of lispro administered by LVN 7 -11 PM - 214 mg/dl - 20 units of glargine administered by LVN 7. On 1/28/2022 at 9 AM - 254 mg/dl - 3 units lispro administered by LVN 8 -11:30 AM - 254 mg/dl - 7 units lispro administered per sliding scale by LVN 8 -1 PM - 254 mg/dl - 3 units lispro administered by LVN 8 -4:30 PM - 254 mg/dl - 7 units lispro administered per sliding scale by LVN 8 -5 PM - 254 mg/dl - 3 units lispro administered by LVN 7 -6 PM - 254 mg/dl - 14 units glargine administered by LVN 7 -11 PM - 254 mg/dl - 7 units lispro administered per sliding scale by LVN 7. On 2/1/2022 at 6 AM - 371 mg/dl - 14 units glargine administered -6:30 AM - 371 mg/dl - 11 units lispro administered per sliding scale -9 AM - 371 mg/dl - 3 units lispro administered by LVN 7 -11:30 AM - 371 mg/dl - 11 units lispro administered per sliding scale by LVN 7 -1 PM - 371 mg/dl - 3 units lispro administered by LVN 7 -4:30 PM - 371 mg/dl - 11 units lispro administered per sliding scale by LVN 7 -5 PM - 371 mg/dl - 3 units lispro administered by LVN 7 -6 PM - 371 mg/dl - 14 units glargine administered by LVN 7 -11 PM - 371 mg/dl - 11 units lispro administered per sliding scale by LVN 7. On 2/4/2022 at 6 AM - 397 mg/dl - 14 units glargine administered, -6:30 AM - 397 mg/dl - 11 units lispro administered per sliding scale -9 AM - 397 mg/dl - 3 units lispro administered by LVN 7 (continued on next page)

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	06/10/2022

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-11:30 AM - 397 mg/dl - 11 units lispro administered per sliding scale by LVN 7 -1 PM - 397 mg/dl - 3 units lispro administered by LVN 7 -4:30 PM - 397 mg/dl - 11 units lispro administered per sliding scale by LVN 7 -5 PM - 397 mg/dl - 3 units lispro administered by LVN 7 -6 PM - 397 mg/dl - 14 units glargine administered by LVN 7 -11 PM - 397 mg/dl - 11 units lispro administered per sliding scale by LVN 7. Further review of Resident 1's MAR dated between January and March 2022 indicated similar findings (duplications) on the following dates: 2/5/, 2/6, 2/8, 2/18/2022, and 3/4/2022 for a total of 134 duplicate blood sugar readings. A review of Resident 2's Admission Record, dated 6/9/2022, indicated she was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Type II diabetes mellitus. A review of the Physician's Order Summary Report, dated 6/9/2022, indicated the following active orders for Resident 2's insulin: -On 3/31/22, Humulin R (a type of insulin) to administer per sliding scale: for blood sugar reading 70-130 = 0 units, 131-180 = 2 units, 181-240 = 4 units, 241-300 = 6 units, 301-350 = 8 units, 351-399 = 10 units, greater than 400 = 12 units and contact physician, subcutaneously before meals and at bedtime for Type II diabetes. -On 3/10/2022, insulin glargine to inject 30 units subcutaneously at bedtime related to Type II diabetes. A review of the Care Plan for diabetes, updated April 2022, indicated Resident 2 was at risk for hypoglycemia and hyperglycemia related to a diagnosis of diabetes mellitus with an approach plan to Accucheck (take blood sugar measurement) as ordered. A review of Resident 2's MAR dated from January to March 2022 indicated the following example of duplications of blood sugar readings in the record on 2/22/2022 at 6:30 AM - 279 mg/dl - 6 units of Humulin R were administered per sliding scale, -11:30 AM - 279 mg/dl - 6 units of Humulin R were administered per sliding scale by LVN 7. -4:30 PM - 279 mg/dl - 6 units of Humulin R were administered per sliding scale by LVN 7. -11 PM - 279 mg/dl - 6 units of Humulin R were administered per sliding scale by LVN 7. Further review of Resident 2's MAR dated between January and March 2022 indicated similar findings (duplications) on the following dates: 1/7, 1/10, 1/11, 1/17, 1/18, 1/25/2022, and 3/24/2022 for a total of 51 duplicate blood sugar readings. (continued on next page)

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	06/10/2022

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident 3's Admission Record, dated 6/9/2022 indicated he was originally admitted to the facility on [DATE] with diagnoses including Type II diabetes mellitus. A review of Resident 3's Physician's Order dated 2/2/2022, indicated he was to receive Humulin R according to the following sliding scale: If blood sugar is 201-250 = 3 units, 251 - 300 = 4 units, 301-350 = 6 units, 351-400 = 9 units, above 400 = 12 units and report to the physician subcutaneously before meals and at bedtime for Type II diabetes. A review of Resident 3's Resident Care Plan for diabetes, updated May 2022, indicated Resident 3 was at risk for hypoglycemia and hyperglycemia related to a diagnosis of diabetes with an approach plan to Accucheck (take blood sugar measurement) as ordered. A review of Resident 2's MAR dated from February to March 2022, indicated the following example of duplications of blood sugar readings in the record on 3/24/2022 at 11:30 AM - 210 mg/dl - 3 units of Humulin R administered by sliding scale, -4:30 PM - 210 mg/dl - 3 units of Humulin R administered by sliding scale by LVN 7. -11 PM - 210 mg/dl - 3 units of Humulin R administered by sliding scale by LVN 7. Further review of Resident 3's MAR dated between February and March 2022, indicated similar findings (duplications) on the following dates: 2/4, 2/5, 2/6, 2/7, 2/8, 2/9, 2/15, 2/18, 2/25/2022, and 3/7/2022 for a total of 62 duplicate blood sugar readings. A review of Resident 4, 5, 6, and 7's MARs dated between January and March 2022 indicated similar findings (duplications) between 1/20/22 and 3/31/22 for a total of 303 total duplicate blood sugar readings for Residents 1 to 7 documented by multiple licensed staff. During an interview on 6/8/2022 at 5:47 PM with the DON and the ADM, the DON stated LVN 7 and 8 have resigned and were no longer working at this facility. The DON stated LVN 7 resigned on 3/29/2022 after having previously been suspended as disciplinary action for possible duplication or false entries for vital signs and blood sugar readings. The DON stated the FM had brought her attention to LVN 7 possibly duplicating vital signs and blood sugar readings around the end of March 2022. The DON stated, when she asked LVN 7 about entering duplicate blood sugar and vital sign values in the MAR without measuring them, LVN 7 denied doing so. The ADM stated she was unsure why LVN 8 resigned. The ADM stated when the FM advised them of the trend of duplicated blood sugar readings, the facility attempted to retrain their staff regarding proper documentation procedures at that time. The DON and ADM stated they also began conducting audits of the medical records of two residents per medication cart per week to search for duplicate entries. (continued on next page)

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	06/10/2022

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The ADM and DON stated they did not know why so many of their residents would have so many identical blood sugar readings and could not offer any plausible alternative explanation to an intentional fabrication of the medical record. The DON stated it was possible that the resident could have as many as nine identical blood sugar readings consecutively in a 24-hour period. The DON stated the staff cannot see the previous readings when they were documenting blood sugar and do not have time to look it up. The DON stated if the blood sugar readings were inaccurate, especially if it was higher than the true value, there was a chance that the dose of insulin given to the resident could have been too high based on the sliding scale order. The DON stated that if a resident received too much insulin it could cause them to crash by dropping the residents' blood sugar too low possibly resulting in hospitalization or death. A review of the Employee Notice of Discipline form, dated 3/25/2022, for LVN 7 indicated the DON suspended LVN 7 from work due to, On 3/24/22 there was a review of documentation indicated that there is a possibility of inaccurate blood sugar readings and V/S (vital signs) documented in E-MAR (electronic MAR). During an interview on 6/9/2022 at 1:59 PM, the Pharmacist Consultant (PC) stated if residents were given large doses of insulin when their blood sugar was too low, it may cause medical complications of hypoglycemia depending on how low the glucose level ultimately goes including: sweating, dizziness, irritability, and generally not feeling well for mild hypoglycemia to possible loss of consciousness resulting in hospitalization or death for major hypoglycemia. The PC stated hopefully the low blood sugar would be discovered and corrected by facility staff before it got to a life-threatening level or before hospitalization would be needed but that depends on the staff's ability to monitor residents properly or the residents' ability to communicate their change in status. The PC stated if a resident did not have the ability to communicate a change in their status, there was a higher risk that they may experience more severe effects of hypoglycemia as the episode may go longer without being detected. The PC stated that in his professional opinion, documenting the same blood sugar multiple times in a row for the same resident in the same day indicated the medical record regarding those blood sugar readings was inaccurate and most likely fabricated. The PC stated, even without giving insulin, blood sugar levels will naturally rise and fall throughout the day based on food consumed and activity level so it would be highly unlikely to have two consecutive identical blood sugar readings let alone multiple times across multiple residents on multiple dates. The PC stated the onset of action (how quickly the drug starts working) for lispro insulin was 15-30 minutes, so if 11 units of lispro were given at 4:30 PM and the blood sugar was measured again at 5 PM, as per the record for Resident 1, we would expect to see a lower blood sugar reading at 5 PM due to the insulin activity. The PC stated that if multiple doses of scheduled and sliding scale insulin were given at high doses throughout the day together, there could be a risk the resident develops a life-threatening hypoglycemic episode which would require medical intervention. The PC stated that it was important for the medical record to be accurate to ensure that providers and pharmacists had the correct information on which to base their treatment decisions and recommendations regarding medication therapy. The PC stated if the medical records were inaccurate, pharmacists and physicians may recommend or prescribe inaccurate doses of insulin which could possibly result in further medical complications. (continued on next page)

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	06/10/2022

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 6/10/2022 at 11:29 AM, the Medical Director (MD) stated, in her professional opinion, administering large doses of fast-acting insulin to a resident pursuant to false or fabricated high blood sugar readings could result in that resident experiencing a hypoglycemic event that could end in a diabetic coma or other serious medical complications causing hospitalization or death. The MD stated there was a higher chance that more vulnerable residents who were unable to communicate their needs or a change in their status would suffer, or be more likely to suffer, a more serious hypoglycemic event. The MD stated she regularly attends monthly quality assurance meetings in person, but many times the meetings were canceled due to emergencies or scheduling conflicts. The MD stated many times she must leave the meetings early to attend to other patient's medical needs or must excuse herself from the meetings to take phone calls while they are ongoing. The MD stated she was never made aware of the issue of duplicated blood sugar readings in residents receiving insulin until the DON informed her on 6/9/2022. The MD stated she did not recall any meeting since March or afterward where this issue was discussed in a quality assurance meeting when she was present. During a telephone interview on 6/10/2022 at 1:02 PM, LVN 7 stated he used a duplicate entry function within the MAR that copied the last entry on the order when documenting blood sugars and doses of sliding scale insulin for the residents under his care between January and March 2022. LVN 7 stated he and other licensed staff were having difficulty understanding the proper way to document the blood sugar readings in the MAR and accidentally used the duplicate entry function rather than entering his own blood sugar and vital sign readings. LVN 7 denied intentionally entering any false information into the MAR. LVN 7 stated he took his own blood sugar readings, documented them in the MAR, and only administered insulin to residents when appropriate based on the parameters. LVN 7 stated he did not know why his own readings were not available anywhere in the residents' records. LVN 7 stated he also accidentally duplicated records of sliding scale insulin administrations in the MAR. During an observation and concurrent interview on 6/10/2022 at 1:19 PM, LVN 1 was observed demonstrating how to record new blood sugar readings for a resident on the MAR data input screen. LVN 1 was observed selecting the medication cart number and a resident name to input a new reading. LVN 1 was observed entering a new blood sugar reading requiring the value to be manually typed in each time. No duplicate button or similar functionality was observed on the MAR data input screen. LVN 1 stated there used to be a repeat last entry functionality on the data entry screen in the MAR but it was disabled several months ago once the facility was informed about multiple duplicate entries on vital signs and blood sugar readings on multiple residents. LVN 1 stated it was too convenient for some nurses to input false information into the record by using this duplicate functionality. LVN 1 stated, If they wanted to lie, they should have just changed the number a little bit on a new entry. LVN 1 stated that once the repeat last entry functionality was used, for a nurse to change it, they would have to manually perform an edit to strike the previous value and record a new one by entering the value manually. (continued on next page)

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	06/10/2022

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LVN 1 stated it would be apparent on the MAR that the new reading would be indicated as the correct one after the correction was made. LVN 1 stated the MAR was the only place blood sugar readings or medication administration records can be documented. LVN 1 stated sometimes the nurses will use the progress notes to explain anomalous (deviating from what is standard, normal or expected) readings or add clarification to an action, but will not routinely record blood sugars, vital signs, or medication administration records anyplace other than the MAR. LVN 1 stated, If it's not in the MAR, it most likely means they didn't do it. A review of the facility's policy titled, Administering Medications, reviewed January 2022 indicated medication are administered in a safe and timely manner, and as prescribed, The following information is checked/verified for each resident prior to administering medications, Vital signs, if necessary, as required or indicated for a medication, the individual administering the medication records in the resident's medical record, and the dosage. A review of the facility's policy titled, Insulin Administration, reviewed January 2022, indicated to provide guidelines for the safe administration of insulin to residents and to check blood glucose by fingerstick. A review of the facility's policy titled, Obtaining a Fingerstick Glucose Level, reviewed January 2022, indicated the person performing this procedure should record the following information in the resident's medical record: the blood sugar results. Follow facility policies and procedure for appropriate nursing interventions regarding the blood sugar results (if resident is on sliding scale coverage, and/or physician intervention is needed to adjust insulin or oral medication dosages). A review of the facility's policy titled, Abuse and Neglect - Clinical Protocol, reviewed January 2022, indicated neglect means 'the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm,' and along with staff and management, the physician will help identify situations that might constitute or could be construed as neglect, and the staff, with the physician's input as needed, will investigate alleged neglect to clarify what happened and identify possible causes and the medical director will advise facility management and staff about ways to ensure that basic medical, functional, and psychosocial needs are being met and that potentially preventable or treatable conditions affecting function and quality of life are addressed properly.

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	06/10/2022

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure the assessment entries on the Minimum Data Set (MDS- an assessment and care screening tool) accurately reflected the resident ' s behavioral status for two of 31 sampled residents, Resident 18 and 21. This deficient practice resulted in incorrect data transmitted to Centers for Medicare and Medicaid Services (CMS) regarding resident's behavior status. Findings: a. A review of Resident 18 ' s Admission Record indicated resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including multiple sclerosis (a progressive disease involving cell damage of the brain, spinal cord which will leave numbness, impairment of speech, muscular coordination, blurred vision and extreme tiredness), schizophrenia (a disorder that affects a person ' s ability to think, feel, and behave clearly), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one ' s daily activities). A review of the MDS dated [DATE], indicated Resident 18's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making were intact and required total dependence from staff for activities of daily living (ADL- transfer, toilet use and locomotion on unit). The MDS Section E assessment (Behavior) indicated, None of the above for Potential Indicators of Psychosis and 0 - Behavior not exhibited - verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). During an observation of the facility on 6/10/2022 at 9:45 a.m., Resident 18 was seen and heard in the hallway screaming loudly and yelling at the staff. During an interview with Licensed Vocational Nurse 3 on 6/9/2022 at 6:14 a.m., LVN 3 stated Resident 18 had episodes of screaming and yelling in the room loudly during her night shift that other residents complained about it. LVN 3 further stated it had been going on for awhile now. A review of Psychiatric (medical specialty devoted to the diagnosis, prevention, and treatment of mental disorder) Follow-Up Note, dated 5/4/2022 indicated, episode of cursing and screaming at staff during ADLs plus sad intermittently. The Mental Status Examination indicated Resident 18 had a guarded behavior, suspicious interactions, blunted/constricted affect and irritable mood with intermittent sadness. A review of Resident 18 ' s Summary Order Report - active order as of 6/8/2022 indicated the following: -Zyprexa zydis (used to treat certain mental/mood disorders, including schizophrenia and bipolar disorder) tablet disintegrating 5 milligram (mg) - give 1 tablet by mouth every 12 hours related to Schizophrenia manifested by (m/b) rapid mood swing from calm to angry. (continued on next page)

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	06/10/2022

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Zyprexa: monitor episode of psychosis m/b rapid mood swings from calm to angry every shift for on psychotropic record Yes if behavior observed. During a concurrent interview and record review with Minimum Data Set Nurse 1 (MDSN 1) on 6/10/2022 at 12:07 p.m., she stated the MDS Section E did not reflect the correct assessment as indicated that Resident 18 did not have any behavioral issues. MDSN 1 stated she will do a correction on the system and send a correction to CMS. b.A review of Resident 21 ' s Admission Record indicated resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including pneumonia (lung infection that inflames air sacs with fluid or pus), bipolar disorder and anxiety disorder. A review of the MDS dated [DATE], indicated Resident 18's cognitive skills for daily decision-making was intact and required extensive assistance to total dependence from staff for ADL- bed mobility, dressing, toilet use and personal hygiene. A review of the MDS dated [DATE], Section E assessment (Behavior) indicated, None of the above for Potential Indicators of Psychosis and Behavior not exhibited - verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). During an observation of Resident 21 on 6/9/2022 at 1:48 p.m., Resident 21 was seen and heard in the hallway screaming loudly and yelling curse words at the Housekeeping Supervisor (HS) while cleaning the room and telling her to leave her room. During an interview with HS on 6/9/2022 at 1:55 p.m., she stated Resident 21 always yells and screams at staff and to her directly as she did not want her room to be cleaned. HS stated she explained that the room needs to be cleaned but Resident 21 still yells and curses at her. HS stated Resident 21 was aggreessive with staff for a very long time. During an interview with Licensed Vocational Nurse 1 (LVN 1) on 6/8/2022 at 2:44 p.m., she stated Resident 21 was very particular with what she wanted and how she wanted things done. LVN 1 stated, Resident 21 was bipolar and had mood swings. LVN 1 stated, Resident 21 can also be very aggressive to staff and curses at them and Resident 21 was on Ativan for her behavior issues. A review of Resident 21 ' s Summary Order Report - active order as of 6/8/2022 indicated the following: -Ativan tablet (medication is used to treat anxiety) 1 mg - give 1 tablet by mouth every 8 hours as needed for anxiety manifested by irritability, screaming without apparent reason. During a concurrent interview and record review with MDSN 1 on 6/10/2022 at 12:10 p.m., stated the MDS Section E did not reflect the correct assessment as indicated that Resident 21 did not have any behavioral issues. MDSN 1 stated they were aware of Resident 21 ' s aggressive behavior to staff as they hear and see her yell and curse at staff on a regular basis. MDSN 1 stated she will do a correction on the system and send a correction to CMS. (continued on next page)

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	06/10/2022

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Director of Nursing (DON) on 6/10/2022 at 10:32 a.m., the DON stated and confirmed Resident 18 and 21 were having episodes of screaming and yelling at staff with an increase of behavioral issues from the last two weeks. The DON stated and confirmed, Resident 18 and 21 ' s MDS Section E did not reflect the correct data sent to CMS. A review of facility ' s policy and procedure (P&P) titled, MDS Assessment Coordinator, reviewed January 2022, indicated, a Registered Nurse (RN) shall be responsible for conducting and coordinating the development and completion of the resident assessment (MDS). Any individual who willfully and knowingly certified (or causes another individual to certify) a material and false statement in a resident assessment is subject to disciplinary action and such incident must be promptly reported to the Administrator.

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	06/10/2022

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 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. 45524 Based on observation, interview, and record review, the facility failed to ensure nursing staff revised care plan on diabetes (High blood sugar) for one of three sampled residents (Resident 1). This deficient practice had the potential to increase the risks associated with complications of diabetes not limited to low and/or high blood sugar level for Resident 1. Findings: A review of the admission record (Face sheet) for Resident 1, indicated the facility admitted Resident 1 on 2/28/22 with a diagnoses not limited to, Encephalopathy (a disturbance of the brain's functioning that leads to problems like confusion and memory loss), Diabetes Mellitus type 2 and Respiratory Failure (a condition in which one's blood does not have enough oxygen or has too much carbon dioxide). A Review of the Minimum Data Set (MDS - a standardized assessment and screening tool) for Resident 1 dated 4/15/22, indicated Resident 1 was not able to complete cognitive ((meant ability to make decisions of daily living) interview. The MDS indicated Resident 1 was totally dependent on one to two staff for activities of daily living (ADL- bed mobility, surface transfer, dressing, toilet use, eating, personal and personal hygiene. During concurrent interview and record review with Minimum Data Set Nurse 2 (MDSN 2) on 6/9/2022 at 8:40 a.m., the care plan on diabetes initiated 7/7/2021 for Resident 1 was reviewed. The care plan was updated on 9/17/21, 1/26/2022, and 2/28/2022. The MDSN 2 stated and confirmed that care plans are reviewed and revised every three months. Also, the MDSN 2 stated the care plan was not revised/updated for the month of 5/2022. MDSN 2 stated that failure to update/revise the care plan for Resident 1 could result in, Obvious things such as low or high blood sugar. A review of the facility's policy and procedures titled Care Plan-Comprehensive, reviewed 1/2022, indicated Care plans are revised as changes in the resident's condition dictate. Care plans are reviewed at least quarterly.

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	06/10/2022

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to maintain complete and accurate medical records in accordance with professional standards and practices for two of two sampled residents (Residents 13 and 14) by failing to: a) Ensure activities of daily living (ADLs) were properly documentation for Resident 13. b) Ensure a late entry were accurately documented in the medical records for Resident 14. Residents 13 and 14 were dependent on staff for activities of daily living (ADL). These deficient practices had the potential to delay communication between facility staff that could negatively impact the delivery of services provided to Residents 13 and 14. Findings: a. A review of the Admission Record for Resident 13 indicated the facility admitted Resident 13 on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe), dysphagia (difficulty swallowing food or liquid) and diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]). A review of the Minimum Data Set (MDS - a standardized assessment and care screening tool) for Resident 13, dated [DATE], indicated Resident 13 had severe cognitive (mental action or process of acquiring knowledge and understanding) skills impairment for daily decision-making. The MDS indicated Resident 1 required extensive staff for activities of daily living (ADLs- bed mobility, transfer dressing, eating, toilet use and personal hygiene). A review of the Certified Nursing Assistant (CNA) Daily Charting Form for Resident 13, which included CNA assistance with eating, dressing, bathing, repositioning, rang of motion and personal hygiene for the month of [DATE], indicated documentation missing /left blank on following days/shifts: i. On 7:00 a.m. to 3:00 p.m., shift: [DATE] [DATE] [DATE] [DATE] [DATE] [DATE] (continued on next page)

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	06/10/2022

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ii. On 3:00 p.m. to 11:00 p.m., shift: [DATE] [DATE] [DATE] [DATE] [DATE] [DATE] [DATE] [DATE] iii. 11:00 p.m.to 7:00 a.m., shift: [DATE] [DATE] [DATE] [DATE] [DATE] [DATE] [DATE] [DATE] [DATE] During a concurrent interview and record review with Director of Nursing (DON) on [DATE] at 11:43 a.m., the DON stated and confirmed documentation on the CNA charting form for ,d+[DATE] for Resident 13 was mostly blank with no documentation per facility ' s policy if Resident 13 was assisted by CNA(s). The DON stated lack of/blank documentation indicated the task was never done/completed. The DON stated this deficient practice had the potential to decline in the health status for not receiving quality of care for Resident 13. A review of facility ' s policy and procedures (P&P) reviewed on ,d+[DATE], titled, Activities of Daily Living (ADLs), Supporting, indicated residents will be provided with care, treatment, and services to ensure that their activities of ADLs do not diminish . appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care. (continued on next page)

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	06/10/2022

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility ' s undated Job Description (JD), titled, Certified Nursing Assistant (CNA), indicated that under the direct supervision of the Registered Nurse/Licensed Vocational Nurse, the CNA assists in the direct resident care including vital signs, bathing, beds, and all other activities of daily living. 43261 b. A review of the Admission Record for Resident 14 indicated the facility originally admitted Resident 14 on [DATE], and was readmitted on [DATE] with diagnoses including, surgical amputation (removal of a limb) of right leg above the knee and left foot, DM, epilepsy (seizure-uncontrolled electrical disturbance in the brain), atrial fibrillation (AF-an irregular rapid heart rate that commonly causes poor blood flow) and congestive heart failure (CHF-a chronic condition in which the heart does not pump blood as well as it should). A review of the MDS for Resident 14 dated [DATE], indicated resident had an intact cognitive skills for daily decision making and required extensive to total dependence on staff with ADL (bed mobility, transfers, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene). A review of the Order Summary Report for Resident 14 dated [DATE], indicated to monitor Resident 14 for episodes of seizure every shift and ensure safety, document, and notify physician if noted. A review of the Medication Administration Record (MAR) for Resident 14 dated [DATE], indicated Licensed Vocational Nurse 10 (LVN 10), documented, Yes for an episode of seizure for 3:00 p.m. to 11:00 p.m., shift on [DATE]. A review of the Progress Notes for Resident 14 dated [DATE], indicated Resident 14 was found unresponsive on [DATE] at 5:00 p.m. Resident 14 expired (died) on [DATE] at 5:33 p.m. A review of the Progress Notes for Resident 14 effective [DATE] at 7:04 p.m., indicated no documentation for late entry. However, LVN 10 documented that on [DATE], LVN 10 accidentally clicked Yes instead of No on the MAR under the seizure monitoring for Resident 14. The progress notes also indicated Resident 14 had no episodes of seizure activity, therefore no change in condition indicated. During a concurrent record review and interview with Registered Nurse 1 (RN 1) on [DATE] at 1:15 p.m., RN 1 stated licensed nurses are allowed to document a late entry and should note that the documentation was a late entry on a resident ' s medical records. RN 1 also stated that late entry should not be entered more than 24 hours per professional standard of care. A review of facility ' s policy and procedures (P&P), titled, Charting and Documentation, revised on , d+[DATE], indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident ' s medical, physical, functional, or psychosocial condition, shall be documented in the resident ' s medical record. A review of facility ' s P&P, titled, Charting Errors and/or Omission, revised ,d+[DATE], indicated that facility will maintain an accurate medical records. The P&P further indicated that if it is necessary to change or add information in the resident ' s medical record, it shall be completed by means of an addendum and signed and dated by the person making such change or addition, and late entries in the medical record shall be dated at the time of entry and noted as a late entry. (continued on next page)

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	06/10/2022

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility ' s Job Description (JD), titled, Licensed Vocational Nurse (LVN), undated, indicated that LVN will demonstrate ability to appropriately document resident care and ensuring documentation is legible, neat and that records are appropriately signed.

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	06/10/2022

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 43261 Based on observation, interview, and record review, the facility failed to implement its ' policy and procedures titled Posting Direct Care Daily Staffing Numbers by failing to ensure that staffing information posted was accurate, complete, and updated information reflected the actual Direct Care Services Hours Per Patient Day (DHPPD - means the actual hours of work performed per patient day by a direct caregiver) staffing hours for each shift for two of three sampled dates (6/8/2022 and 6/9/2022). As a result, the residents, visitors, and staff could not determine the actual, accurate, and final staffing DHPPD hours on 6/8/2022 and 6/9/2022. Findings: During an observation on 6/8/2022 at 1:35 p.m., nurse staffing information posted dated 6/8/2022, did not indicate actual DHPPD hours. During an observation on 6/9/2022 at 4:09 p.m., nurse staffing information posted dated 6/9/2022, did not indicate actual DHPPD hours. During a concurrent observation and interview with the Administrator on 6/9/2022 at 4:09 p.m., the Administrator verified and stated the facility only updates and posts the projected DHPPD hours, and not the actual hours from the previous day or shift. During an interview with the Director of Staff Development (DSD) on 6/9/2022 at 4:14 p.m., the DSD stated the DSD assistant ' s is responsible to change and or update the nurse DHPPD posting daily. The DSD stated licensed nurses were not responsible to change the nurse posting daily and that the facility does not post the actual nursing hours. A review of facility ' s policy and procedures (P&P) titled, Posting Direct Care Daily Staffing Numbers, reviewed on 1/2022, indicated that within two hours of the beginning of the shift, the number of the Licensed Nurses and the number of the unlicensed nursing personnel directly responsible for the resident care will be posted in a prominent location. The P&P also indicated that shift staffing information will be recorded each shift on the form to include: a. Name of the facility b. Date for which information is posted. c. Resident census at the beginning of the shift for which the information is posted. d. Twenty-four hours shift schedule operated by the facility. e. Shift for which the information is posted. (continued on next page)

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	06/10/2022

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Type (RN, LVN, CNA) and category (licensed and non-licensed) of nursing staff working during the shift. g. Actual time worked during that shift for each category and type of nursing staff. h. Total number of licensed and non-licensed nursing staff working for the posted shift. A review of All Facilities Letter (AFL) 21-11 dated 3/17/2021, indicated that facilities are mandated to use the CDPH 612 to record daily census and The Administrator, DON, or designee must sign the census form verifying that the information is true and accurate and unacceptable documentation includes, but is not limited to: substantially similar or modified versions of CDPH 530 or CDPH 612. In addition, in determining time, the actual time will be based upon the calculation of the actual (not scheduled) time worked by direct caregivers while providing skilled nursing care to patients.

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	06/10/2022

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on observation, interview and record review, facility failed to provide necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care to one of one sampled resident (Resident 19) by failing to address behavioral health care needs and implementing a person-centered care plan when Resident 19 had episodes of uncontrollable screaming in the hallway. This deficient practice had the potential to negatively affect the delivery of behavioral health care and services to Resident 19. Findings: A review of Resident 19 ' s Admission Record indicated resident was originally admitted on [DATE], but was readmitted on [DATE] with diagnoses including, schizophrenia (mental disorder in which people interpret reality abnormally), Tourette ' s disorder (a nervous system disorder involving repetitive movements or unwanted sounds), anxiety disorder and mood disorder (a mental health problem that primarily affects a person ' s emotional state). A review of Resident 19 ' s Minimum Data Set (MDS-a standardized assessment and care screening tool), dated 5/11/22, indicated resident was severely impaired in cognitive skill (thought processes) for daily decision making and with limited assistance with staff on activities of daily living (ADLs-bed mobility, transfers, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene). MDS also indicated that Resident 19 was taking anti-psychotic (classification of medication to treat psych illness) medication. A review of Resident 19 ' s Order Summary Report, dated 8/6/2021, indicated to give Seroquel (anti-psychotic medication) 125 milligram (mg) twice a day and Depakote (anti-psychotic medication) 125 mg once a day for schizophrenia as manifested by sudden outburst of anger. It also indicated to monitor behavior of schizophrenia as manifested by frequent outburst and tally by hashmarks every shift. A review of Resident 19 ' s Behavioral Care Plan, dated 2/14/2022, indicated under approach plan that staff will approach resident calmly and unhurriedly, speak in a clam and unhurriedly manner, attempt to refocus attention to something positive when resident is agitated, monitor for safety of patient, and other patients and staff, monitor progress of behavior, and provide reality orientation. A review of Resident 19 ' s Medication Administration Record (MAR), dated 6/1/2022 to 6/9/2022, indicated that Resident 19 had episodes of schizophrenia as manifested by frequent outbursts on the following days: 6/4/2022 1 episode for the morning shift 6/4/2022 1 episode for the evening shift 6/6/2022 1 episode for the morning shift (continued on next page)

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	06/10/2022

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/7/2022 1 episode for the morning shift 6/7/2022 1 episode for the evening shift 6/8/2022 1 episode for the morning shift 6/8/2022 3 episodes for the evening shift 6/9/2022 5 episodes for the morning shift. During an observation 6/8/2022 at 7:22 p.m., Resident 19 was seen and heard uncontrollably screaming loudly from his room, but none of the staff sitting in the nursing station was observed attending his needs. During an interview with Licensed Vocational Nurse 5 (LVN 5) on 6/8/2022 at 7:31 p.m., LVN 5 stated that Resident 19 had tendencies of screaming and they monitor the resident every shift. LVN 5 also stated that the staff could not do anything for the resident since the resident will get more agitated. LVN 5 stated that the doctor will be made aware. During an observation and interview with Certified Nursing Assistant 11 (CNA 11), on 6/9/2022 at 6:35 a.m., Resident 19 was seen and heard calling and screaming, help, help! The call light was observed turned on in the same room. CNA 11 was observed sitting inside one of the residents ' rooms in front of the nurses station, using his cellphone. CNA 11 stated that Resident 19 screamed constantly and that he was not assigned to the resident. A review of Resident 19 ' s chart and concurrent interview on 6/9/2022 at 1:15 p.m., with Registered Nurse 1 (RN 1), RN 1 stated and verified that Resident 19 did not have any changes of condition (COC) documentation or an SBAR (situation, background, appearance and review/notify- structured tool for healthcare provider that provides communication between members. Also, being used as documentation for any changes of condition) was completed. RN 1 stated that for any COC or changes in resident ' s behavior, they have to start a COC/SBAR and notify the doctor due to possible changes with the treatment. A review of facility ' s Policy and Procedure (P&P), titled, Care Plan-Comprehensive, dated 1/2018, indicated the facility will have an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident ' s medical, nursing, mental and psychological needs was developed for each resident. A review of facility ' s P&P, titled, Behavioral Assessment, Intervention and Monitoring, revised 3/2019, indicated that that facility will provide and resident will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan or care. P&P also indicated that the nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual ' s mental status, behavior, and cognition, including: a. Onset, duration, intensity, and frequency of behavioral symptoms. b. Any recent precipitating or relevant factors or environmental triggers; and (continued on next page)

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	06/10/2022

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Appearance and alertness of the resident and related observations.

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	06/10/2022

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review, the facility failed to ensure one of 12 sampled residents (Resident 12) was not prescribed and administered Aricept (a medication used to treat memory loss) without a qualifying diagnosis to support its use. The deficient practice of prescribing and administering Aricept to Resident 12 without a supporting diagnosis could have caused him to experience adverse effects (unwanted and dangerous side effects of drug therapy) of Aricept leading to a diminished quality of life. Findings: During a telephone interview on 6/7/22 at 2:33 PM, the Facility Monitor (FM) stated he observed Resident 12 refusing to take Aricept from the Licensed Vocational Nurse (LVN 9) on 6/2/22 around 12:50 PM. The FM stated Resident 12 expressed he was not aware of what Aricept was for and received no education regarding the risks or benefits of taking the medication. The FM stated upon reviewing the clinical record, Aricept was prescribed for one episode of forgetfulness mentioned back in March 2022 during an Interdisciplinary Team (IDT - a team of facility staff with different areas of expertise who meet quarterly to discuss and plan a resident ' s care) meeting. The FM stated Resident 12 indicated he was not invited to join this IDT meeting to participate in his own care even though he is self-responsible (makes his own decisions regarding medical treatments and procedures). The FM stated Resident 12 was self-aware and able to make his needs known and Resident 12 had no history of dementia and no clinical record indicating a diagnoses or workup of any kind of dementia was done prior to prescribing Aricept. A review of Resident 12 ' s Admission Record (a facility record containing a resident ' s diagnostic and demographic information), dated 6/9/22, indicated he was originally admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including unspecified dementia without behavioral disturbance (a group of medical conditions characterized by impairment of at least two brain functions such as memory and judgement). A review of Resident 12 ' s physician's order dated 3/15/22 indicated Resident 12 ' s attending physician (MD) prescribed Aricept 5 milligrams (mg - a unit of measure for mass) by mouth once daily for dementia. Further review indicated the MD discontinued this order on 6/3/22. A review of Resident 12 ' s Minimum Data Set (MDS - a comprehensive resident assessment tool) quarterly assessment, dated 4/27/22, section I4800 (active diagnoses) listed Non-Alzheimer ' s Dementia as an active diagnosis for Resident 12. A review of the nurse progress notes entries from 6/2/22 and 6/3/22 indicated Resident 12 was refusing to take his Aricept, was being educated by licensed staff regarding the risks and benefits of refusing the medication, and MD was contacted regarding his repeated refusals. A review of Resident 12 ' s Resident Care Conference Review (notes regarding the quarterly IDT meeting), dated 3/4/22, indicated Resident recently started ' Aricept ' per episode of forgetfulness (per resident)/Dementia. Further review of this document did not indicate, in the space provided, whether Resident 12 elected to attend the meeting or not. (continued on next page)

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	06/10/2022

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 12 ' s clinical record did not show any documentation or clinical work up from MD or any other provider supporting a diagnosis of dementia such as any record of checking memory, language, visual perception, attention, problem-solving, movement, senses, balance, reflexes, or other neurological work up. During a concurrent observation and interview on 6/9/22 at 1:06 PM in Resident 12 ' s room, Resident 12 was observed sitting up in his wheelchair in his room responding to questions and was alert and oriented to person, place, time, and activity. Resident 12 stated he was never invited to participate in any care conference concerning his care since after he was first admitted . Resident 12 stated he was not invited to attend the IDT team meeting regarding his care held on 3/4/22 which included the discussion of adding Aricept to his medication regimen. Resident 12 stated he did not ask for Aricept due to forgetfulness and doesn ' t even know what Aricept is. Resident 12 stated he was never evaluated by MD in person or remotely concerning the diagnosis of dementia and to his knowledge no other medical workup was done regarding his episode of forgetfulness. Resident 12 stated that it was not uncommon at this facility for residents to be started on medications without having been properly educated or evaluated by medical staff regarding their use. Resident 12 stated neither MD nor any other facility staff educated him on the risks or benefits of taking Aricept before they started giving it to him. Resident 12 stated he may forget something occasionally but it ' s not uncommon for someone almost [AGE] years old to forget something from time to time. Resident 12 stated I don ' t have dementia and don ' t have any trouble remembering who other people are, who I am, or where I am. During an interview on 6/10/22 at 10:59 AM with the Registered Nurse Supervisor (RN 1), RN 1 stated prior to his care conference on 3/4/22, Resident 12 had an episode where he slid out of his wheelchair while out on pass to his methadone (a medication used to treat pain) clinic. RN 1 stated Resident 12 expressed that he was having moments of forgetfulness and requested medication for it. RN 1 stated MD was contacted regarding his request, and she added a diagnosis of dementia and prescribed Aricept over the phone. RN 1 stated she was unsure whether the resident was invited to participate in that care conference, but it is important to ensure they are informed about the risks and benefits of their treatment options to ensure they have the right to refuse them if they choose. During an interview on 6/10/22 at 11:14 AM with the Minimum Data Set Nurse 1 (MDSN 1), MDSN 1 stated she was responsible for coordinating the resident care conferences. MDSN 1 stated Resident 12 ' s IDT meeting on 3/4/22 was misdated. MDSN 1 stated this conference happened after the Aricept was already started on 3/15/22 as it discussed the ongoing Aricept therapy. MDSN 1 stated the resident opted out of attending this care conference, but he usually comes to them when they involve incidents. MDS stated the Aricept was started pursuant to a telephone order from MD. MDSN 1 stated MD did not evaluate this resident in person for dementia prior to ordering this medication. MDSN 1 stated she could find no written record that this resident was educated on the risks and benefits of Aricept before the medication was prescribed or administered. During a telephone interview on 6/10/22 at 11:29 AM with MD, MD stated she was the primary attending physician for Resident 12. MD stated occasionally this resident was forgetful or confused, but stated I don ' t think he has dementia. MD stated she did not prescribe Aricept for this resident and did not know why her name was on the order. MD stated, I thought maybe he received this from the [hospital] when he was discharged . MD stated she was made aware that the resident was refusing the Aricept in early June and then discontinued it because I don ' t think he needs it. (continued on next page)

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	06/10/2022

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s policy titled, Medication Therapy, reviewed January 2022, indicated each resident ' s mediation regimen shall include only those medication necessary to treat existing conditions and address significant risks. Medication use shall be consistent with an individual ' s conditions, prognosis, values, wishes, and responses to such treatments. All medication orders will be supported by appropriate care processes and practices.

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	06/10/2022

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview and record review, the facility failed to adequately monitor for specific target behaviors for the use of Zyprexa zydis (an antipsychotic - a type of drug used to treat symptoms of psychosis [a mental health problem that causes people to perceive or interpret things differently from those around them]) for one of 31 sampled residents (Resident 18). This deficient practice had the potential to result in overuse of an antipsychotic medication, without monitoring for the effectiveness and/or ineffectiveness of the medication and could lead to adverse drug reactions. Findings: A review of Resident 18's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 18's diagnoses included multiple sclerosis (a progressive disease involving cell damage of the brain, spinal cord which will leave numbness, impairment of speech, muscular coordination, blurred vision and extreme tiredness), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities). A review of the Minimum Data Set (MDS - a comprehensive assessment and care screening tool), dated 5/25/2022, indicated Resident 18's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision-making was intact. Resident 18 required total dependence from staff for activities of daily living (ADL- transfer, toilet use and locomotion on unit). During an observation on 6/10/2022 at 9:45 a.m., Resident 18 was heard in the hallway screaming and yelling at the staff. During an interview on 6/8/2022 at 2:53 p.m., Resident 6 stated Resident 18 screamed and loudly yelled every night after midnight that woke her up and she was then unable to go back to sleep. A review of Resident 6's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6's diagnoses included acute respiratory failure (occurs when fluid builds up in the air sacs in your lungs), Type II diabetes (a chronic condition that affects the way the body processes blood sugar [glucose]), and heart failure (a condition in which the heart does not pump blood as well as it should). A review of the MDS, dated [DATE], indicated Resident 6's cognitive skills for daily decision-making was intact. Resident 6 required total dependence from staff for transfer and locomotion off unit. During an interview on 6/8/2022 at 2:57 p.m., Resident 17 stated Resident 18 screamed and loudly yelled every night, waking her up on sleep. (continued on next page)

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	06/10/2022

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 17's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 17's diagnoses included respiratory failure, sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs) and heart failure. A review of the MDS, dated [DATE], indicated Resident 17's cognitive skills for daily decision-making was intact. Resident 17 required total dependence from staff for transfer and toilet use. During an interview with on 6/9/2022 at 6:14 a.m., Licensed Vocational Nurse 3 (LVN 3) stated Resident 18 had episodes of screaming and yelling in the room loudly during her night shift that the other residents complained about it. LVN 3 further stated it has been going on for about two weeks now. A review of Resident 18's Progress Notes dated 6/10/2022 at 8:41 a.m., indicated Disruptive Behavior, causing disturbance to other patients and roommates Background: Resident noted screaming uncontrollably with aggressive behavior towards staff when providing care residents winging her hands and kicking nurse assigned and screaming without no reason, per roommates she also does it at nighttime, causing them not able to sleep and becoming restless due to lack of sleep. A review of Psychiatric (medical specialty devoted to the diagnosis, prevention, and treatment of mental disorder) Follow-Up Note, dated 5/4/2022 indicated, episode of cursing and screaming at staff during ADLs plus sad intermittently. The same Follow-up note also indicated the Mental Status Examination found Resident 18 had a guarded behavior, suspicious interactions, blunted/constricted affect, and irritable mood with intermittent sadness. A review of Resident 18's Summary Order Report -as of 6/8/2022 indicated an active order: i. Zyprexa zydis tablet disintegrating 5 milligram (mg) - give 1 tablet by mouth every 12 hours related to Schizophrenia manifested by (m/b) rapid mood swing from calm to angry. ii. Zyprexa: monitor episode of psychosis m/b rapid mood swings from calm to angry every shift for on psychotropic record Yes if behavior observed. A review of Resident 18's Medication Administration Record for the Month of May and June 2022 indicated as follows: i. Zyprexa: monitor episode of psychosis m/b rapid mood swings from calm to angry every shift on psychotropic record Yes if behavior observed -for June 1 - 7, 2022, staff documented No for behaviors observed during evening and night shift ii. Zyprexa: monitor episode of psychosis m/b rapid mood swings from calm to angry every shift on psychotropic record Yes if behavior observed - for May 1 - 31, 2022, staff documented No for behaviors observed during night shift. (continued on next page)

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	06/10/2022

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Director of Nursing (DON) on 6/10/2022 at 10:24 a.m., the DON stated and confirmed Resident 18 had been having episodes of screaming and yelling at staff with an increase of behavioral issues from the last two weeks. The DON stated Resident 18 was on Zyprexa medication and physician had ordered to monitor Resident 18's psychosis behavior every shift. The DON stated and confirmed, staffs did not document properly that Resident 18 had been having episodes of psychosis which included yelling and verbally abusing staff. The DON stated, not monitoring behavior appropriately led to not properly assessing if Zyprexa medication had been effective and/or ineffective, which could put Resident 18 at risk of not getting proper treatment of antipsychotic medications. A review of facility's policy and procedure (P&P) titled, Behavioral Assessment, Intervention and Monitoring revised March 2019, indicated, the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being . Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavioral.

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	06/10/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to ensure licensed staff, including Licensed Vocational Nurse 1, 7 and 8 (LVN) measured blood sugar levels prior to administering insulin (a medication used to lower blood sugar) to seven of 11 sampled residents (Residents 1, 2, 3, 4, 5, 6 and 7) receiving sliding scale insulin (dose of insulin dependent on blood sugar readings taken immediately before administration) between 1/1/20222 and 3/31/2022. The deficient practice of administering insulin without first checking blood sugar levels could have caused Resident 1 -7's blood sugar levels to drop dangerously low likely leading to hospitalization or death. On 6/9/2022 at 11:11 AM, an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the facility's Administrator (ADM) and Director of Nursing (DON) regarding the facility's failure to ensure blood sugar levels were checked prior to administering insulin as required by the physician's order and failure to provide required care and services to Residents 1-7 by failing to check their blood sugar as required by their physician's orders and care plans. On 6/10/2022 at 3:23 PM, while onsite at the facility, the IJ was removed after the facility submitted an acceptable removal plan (interventions to correct the deficient practices), which was verified and confirmed through observation, interview and record review. The IJ situation was removed in the presence of the ADM and the DON. The accepted removal plan included the following actions: 1. Facility staff identified a total of 17 residents currently in the facility with a physician's order to check blood sugar prior to administering sliding scale insulin, Medication Administration Records (MAR) were reviewed for duplicate blood sugar entries between 6/1/2022 and 6/9/2022, and found no additional duplicate blood sugar levels. 2. On 6/9/2022, the Pharmacist Consultant (PC) conducted educational training with licensed staff regarding the following topics: A. Obtaining a fingerstick glucose (sugar) level B. Importance of accuracy and integrity of medical records C. Importance of measuring blood sugar level per physician's order prior to administering insulin based on a sliding scale dosing regimen. 3. On 6/10/2022, the Pharmacy Nurse Consultant began to conduct direct observations of licensed staff to ensure competency in technique and documentation for five licensed staff per day with a target date of completion for the entire nursing staff by 6/15/2022. (continued on next page)

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	06/10/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. On 6/9/2022, the Medical Director (MD) reviewed the blood sugar readings of all 17 residents with physician's orders to check blood sugar prior to administering sliding scale insulin. On 6/10/2022, the Physician personally assessed residents affected by the duplication of blood sugar readings for any adverse effect. 5. On 6/9/2022, facility staff notified the respective primary care physicians of all residents found to be affected by duplicate blood sugar readings. 6. On 6/9/2022, the DON and/or the Quality Assurance Nurse will audit eight residents three times weekly to ensure licensed staff were checking blood sugar levels prior to administering sliding scale insulin. 7. The DON to be responsible for the implementation of the plan and will review and monitor the effectiveness of the plan and present findings in quarterly quality assurance meetings. Findings: During a telephone interview on 6/7/2022 at 2:33 PM, the Facility Monitor (FM) stated Residents 1, 2, and 3 have multiple identical blood sugar readings documented for insulin administration dated between January and March 2022. The FM stated multiple nurses documented the same blood sugar readings multiple times throughout the day, on multiple days and for multiple residents. The FM stated many of the duplicate readings were used to determine the dose of sliding scale insulin and insulin was administered as a result. A review of Resident 1's Admission Record, dated 6/9/2022, indicated he was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including: Type II diabetes mellitus (impairment in the way the body regulates and uses sugar [glucose] as a fuel). A review of the Physician's Order Summary Report, dated 6/9/2022, indicated the following active orders for Resident 1's insulin: -On 3/3/22, Resident 1's physician prescribed insulin lispro (a fast-acting form of insulin) to inject three units (a unit of dosage for insulin) subcutaneously (under the skin) three times a day for Type II diabetes with instructions to hold if the blood sugar value is less than 120 milligrams ([ml] - a unit of measurement for mass) per deciliter ([dl] - a unit of measurement for volume). -On 3/3/2022, Resident 1's physician prescribed insulin lispro to inject as per sliding scale: if blood sugar (BS) = 71-150, no coverage, 151-200 = 3 units, 201-250 = 5 units, 251-300 = 7 units, 301-350 = 9 units, 351-400 = 11 units, more than 400 = 13 units subcutaneously before meals and at bedtime for Type II diabetes. -On 4/21/2022, Resident 1's physician prescribed insulin glargine (a slow-acting insulin) to inject 30 units subcutaneously in the morning for Type II diabetes. A review of Resident 1's Resident Care Plan for diabetes, last updated April 2022, indicated he was at risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) due to diabetes with an approach plan to Accucheck (take blood sugar measurement) as ordered QID (four times daily) AC (before meals) and QHS (at bedtime). (continued on next page)

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	06/10/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident 1's MAR from January to March 2022 indicated the following examples of duplications of blood sugar readings in the record on 1/17/22 at 9 AM - 214 mg/dl - 3 units of lispro administered by Licensed Vocational Nurse (LVN 8), -1 PM - 214 mg/dl - 3 units of lispro administered by LVN 8 -5: PM - 214 mg/dl - 3 units of lispro administered by LVN 7 11 PM - 214 mg/dl - 20 units of glargine administered by LVN 7. On 1/28/2022 at 9 AM - 254 mg/dl - 3 units lispro administered by LVN 8 -11:30 AM - 254 mg/dl - 7 units lispro administered per sliding scale by LVN 8 -1 PM - 254 mg/dl - 3 units lispro administered by LVN 8 -4:30 PM - 254 mg/dl - 7 units lispro administered per sliding scale by LVN 8 -5 PM - 254 mg/dl - 3 units lispro administered by LVN 7 -6 PM - 254 mg/dl - 14 units glargine administered by LVN 7 -11 PM - 254 mg/dl - 7 units lispro administered per sliding scale by LVN 7. On 2/1/2022 at 6 AM - 371 mg/dl - 14 units glargine administered, -6:30 AM - 371 mg/dl - 11 units lispro administered per sliding scale -9 AM - 371 mg/dl - 3 units lispro administered by LVN 7 -11:30 AM - 371 mg/dl - 11 units lispro administered per sliding scale by LVN 7 -1 PM - 371 mg/dl - 3 units lispro administered by LVN 7 -4:30 PM - 371 mg/dl - 11 units lispro administered per sliding scale by LVN 7 -5 PM - 371 mg/dl - 3 units lispro administered by LVN 7 -6 PM - 371 mg/dl - 14 units glargine administered by LVN 7 -11 PM - 371 mg/dl - 11 units lispro administered per sliding scale by LVN 7. On 2/4/2022 at 6 AM - 397 mg/dl - 14 units glargine administered -6:30 AM - 397 mg/dl - 11 units lispro administered per sliding scale -9 AM - 397 mg/dl - 3 units lispro administered by LVN 7 (continued on next page)

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	06/10/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-11:30 AM - 397 mg/dl - 11 units lispro administered per sliding scale by LVN 7 -1 PM - 397 mg/dl - 3 units lispro administered by LVN 7 -4:30 PM - 397 mg/dl - 11 units lispro administered per sliding scale by LVN 7 -5 PM - 397 mg/dl - 3 units lispro administered by LVN 7 -6 PM - 397 mg/dl - 14 units glargine administered by LVN 7 -11 PM - 397 mg/dl - 11 units lispro administered per sliding scale by LVN 7. Further review of Resident 1's MAR dated between January and March 2022 indicated similar findings (duplications) on the following dates: 2/5, 2/6, 2/8, 2/18/2022, and 3/4/2022 for a total of 134 duplicate blood sugar readings. A review of Resident 2's Admission Record, dated 6/9/2022, indicated she was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Type II diabetes mellitus. A review of the Physician's Order Summary Report, dated 6/9/2022, indicated the following active orders for Resident 2's insulin on 3/31/2022, -Resident 2's physician prescribed Humulin R (a type of insulin) to administer per sliding scale: for blood sugar reading 70-130 = 0 units, 131-180 = 2 units, 181-240 = 4 units, 241-300 = 6 units, 301-350 = 8 units, 351-399 = 10 units, greater than 400 = 12 units and contact physician, subcutaneously before meals and at bedtime for Type II diabetes. On 3/10/2022, Resident 2's physician prescribed insulin glargine to inject 30 units subcutaneously at bedtime related to Type II diabetes. A review of Resident 2's Resident Care Plan for diabetes, updated April 2022, indicated Resident 2 was at risk for hypoglycemia and hyperglycemia related to a diagnosis of diabetes mellitus with an approach plan to Accucheck (take blood sugar measurement) as ordered. A review of Resident 2's MAR dated from January to March 2022 indicated the following example of duplications of blood sugar readings in the record on 2/22/2022 at 6:30 AM - 279 mg/dl - 6 units of Humulin R were administered per sliding scale, -11:30 AM - 279 mg/dl - 6 units of Humulin R were administered per sliding scale by LVN 7 -4:30 PM - 279 mg/dl - 6 units of Humulin R were administered per sliding scale by LVN 7 -11 PM - 279 mg/dl - 6 units of Humulin R were administered per sliding scale by LVN 7. Further review of Resident 2's MAR dated between January and March 2022 indicated similar findings (duplications) on the following dates: 1/7, 1/10, 1/11, 1/17, 1/18, 1/25/2022, and 3/24/2022 for a total of 51 duplicate blood sugar readings. (continued on next page)

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	06/10/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident 3's Admission Record, dated 6/9/2022 indicated he was originally admitted to the facility on [DATE] with diagnoses including Type II diabetes mellitus. A review of Resident 3's Physician's Order dated 2/2/2022 indicated he was to receive Humulin R according to the following sliding scale: If blood sugar is 201-250 = 3 units, 251 - 300 = 4 units, 301-350 = 6 units, 351-400 = 9 units, above 400 = 12 units and report to the physician subcutaneously before meals and at bedtime for Type II diabetes. A review of Resident 3's Resident Care Plan for diabetes, last updated May 2022, indicated Resident 3 was at risk for hypoglycemia and hyperglycemia related to a diagnosis of diabetes with an approach plan to Accucheck (take blood sugar measurement) as ordered. A review of Resident 3's MAR dated from February to March 2022 indicated the following example of duplications of blood sugar readings in the record on 3/24/2022 at 11:30 AM - 210 mg/dl - 3 units of Humulin R administered by sliding scale, -4:30 PM - 210 mg/dl - 3 units of Humulin R administered by sliding scale by LVN 7 -11 PM - 210 mg/dl - 3 units of Humulin R administered by sliding scale by LVN 7. Further review of Resident 3's MAR dated between February and March 2022 indicated similar findings (duplications) on the following dates: 2/4, 2/5, 2/6, 2/7, 2/8, 2/9, 2/15, 2/18, 2/25/2022 and 3/7/2022 for a total of 62 duplicate blood sugar readings. A review of Resident 4, 5, 6, and 7's MARs dated between January and March 2022 indicated similar findings (duplications) between 1/20/22 and 3/31/22 for a total of 303 total duplicate blood sugar readings for Residents 1 to 7 documented by multiple licensed staff, including LVN 1, 7 and 8. During an interview on 6/8/2022 at 5:47 PM with the DON and the ADM, the DON stated LVN 7 and 8 have resigned and were no longer working at this facility. The DON stated LVN 7 resigned on 3/29/2022 after having previously been suspended as disciplinary action for possible duplication or false entries for vital signs and blood sugar readings. The DON stated a FM had brought her attention to LVN 7 possibly duplicating vital signs and blood sugar readings around the end of March 2022. The DON stated, when she asked LVN 7 about entering duplicate blood sugar and vital sign values in the MAR without measuring them, LVN 7 denied doing so. The ADM stated she was unsure why LVN 8 resigned. The ADM stated when a FM advised them of the trend of duplicated blood sugar readings, the facility attempted to retrain their staff regarding proper documentation procedures at that time. The DON and ADM stated they also began conducting audits of the medical records of two residents per medication cart per week to search for duplicate entries. (continued on next page)

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	06/10/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The ADM and DON stated they did not know why so many of their residents would have so many identical blood sugar readings and could not offer any plausible alternative explanation to an intentional fabrication of the medical record. The DON stated it was possible that the resident could have as many as nine identical blood sugar readings consecutively in a 24-hour period. The DON stated the staff cannot see the previous readings when they were documenting blood sugar and do not have time to look it up. The DON stated if the blood sugar readings were inaccurate, especially if it was higher than the true value, there was a chance that the dose of insulin given to the resident could have been too high based on the sliding scale order. The DON stated that if a resident received too much insulin it could cause them to crash by dropping the residents' blood sugar too low possibly resulting in hospitalization or death. A review of the Employee Notice of Discipline form, dated 3/25/2022, for LVN 7 indicated the DON suspended LVN 7 from work due to, On 3/24/2022 there was a review of documentation indicated that there was a possibility of inaccurate blood sugar readings and V/S (vital signs) documented in E-MAR (electronic MAR). During an interview on 6/9/2022 at 1:59 PM, the Pharmacist Consultant (PC) stated if residents were given large doses of insulin when their blood sugar was too low, it may cause medical complications of hypoglycemia depending on how low the glucose level ultimately goes including: sweating, dizziness, irritability, and generally not feeling well for mild hypoglycemia to possible loss of consciousness resulting in hospitalization or death for major hypoglycemia. The PC stated hopefully the low blood sugar would be discovered and corrected by facility staff before it got to a life-threatening level or before hospitalization would be needed but that depends on the staff's ability to monitor residents properly or the residents' ability to communicate their change in status. The PC stated if a resident did not have the ability to communicate a change in their status, there was a higher risk that they may experience more severe effects of hypoglycemia as the episode may go longer without being detected. The PC stated that in his professional opinion, documenting the same blood sugar multiple times in a row for the same resident in the same day indicated that the medical record regarding those blood sugar readings was inaccurate and most likely fabricated. The PC stated, even without giving insulin, blood sugar levels will naturally rise and fall throughout the day based on food consumed and activity level so it would be highly unlikely to have two consecutive identical blood sugar readings let alone multiple times across multiple residents on multiple dates. The PC stated the onset of action (how quickly the drug starts working) for lispro insulin was 15-30 minutes, so if 11 units of lispro were given at 4:30 PM and the blood sugar was measured again at 5 PM, as per the record for Resident 1, we would expect to see a lower blood sugar reading due to the insulin activity. The PC stated that if multiple doses of scheduled and sliding scale insulin are given at high doses throughout the day together, there could be a risk the resident develops a life-threatening hypoglycemic episode which would require medical intervention. PC stated that it is important for the medical record to be accurate to ensure that providers and pharmacists have the correct information on which to base their treatment decisions and recommendations regarding medication therapy. PC stated if the medical records are inaccurate, pharmacists and physicians may recommend or prescribe inaccurate doses of insulin which could possibly result in further medical complications. (continued on next page)

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	06/10/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 6/10/2022 at 11:29 AM, the Medical Director (MD) stated in her professional opinion, administering large doses of fast-acting insulin to a resident pursuant to false or fabricated high blood sugar readings could result in that resident experiencing a hypoglycemic event that could end in a diabetic coma or other serious medical complications causing hospitalization or death. The MD stated there was a higher chance that more vulnerable residents who were unable to communicate their needs or a change in their status would suffer, or be more likely to suffer, a more serious hypoglycemic event. During a telephone interview on 6/10/2022 at 1:02 PM, LVN 7 stated he used a duplicate entry function within the MAR that copied the last entry on the order when documenting blood sugars and doses of sliding scale insulin for the residents under his care between January and March 2022. LVN 7 stated he and other licensed staff were having difficulty understanding the proper way to document the blood sugar readings in the MAR and accidentally used the duplicate entry function rather than entering his own blood sugar and vital sign readings. LVN 7 denied intentionally entering any false information into the MAR. LVN 7 stated he took his own blood sugar readings, documented them in the MAR, and only administered insulin to residents when appropriate based on the parameters. LVN 7 stated he did not know why his own readings were not available anywhere in the residents' records. LVN 7 stated he also accidentally duplicated records of sliding scale insulin administrations in the MAR. During an observation and concurrent interview on 6/10/2022 at 1:19 PM, LVN 1 was observed demonstrating how to record new blood sugar readings for a resident on the MAR data input screen. LVN 1 was observed selecting the medication cart number and a resident name to input a new reading. LVN 1 was observed entering a new blood sugar reading requiring the value to be manually typed in each time. No duplicate button or similar functionality was observed on the MAR data input screen. LVN 1 stated there used to be a repeat last entry functionality on the data entry screen in the MAR but it was disabled several months ago once the facility was informed about multiple duplicate entries on vital signs and blood sugar readings on multiple residents. LVN 1 stated it was too convenient for some nurses to input false information into the record by using this duplicate functionality. LVN 1 stated, If they wanted to lie, they should have just changed the number a little bit on a new entry. LVN 1 stated that once the repeat last entry functionality was used, for a nurse to change it, they would have to manually perform an edit to strike the previous value and record a new one by entering the value manually. LVN 1 stated it would be apparent on the MAR that the new reading would be indicated as the correct one after the correction was made. LVN 1 stated the MAR was the only place blood sugar readings or medication administration records can be documented. LVN 1 stated sometimes the nurses will use the progress notes to explain anomalous (not standard or expected) readings or add clarification to an action, but will not routinely record blood sugars, vital signs, or medication administration records anyplace other than the MAR. LVN 1 stated, If it's not in the MAR, it most likely means they didn't do it. A review of the facility's policy titled, Administering Medications, reviewed January 2022 indicated medications were administered in a safe and timely manner, and as prescribed. The following information was checked/verified for each resident prior to administering medications, vital signs, if necessary. As required or indicated for a medication, the individual administering the medication records in the resident's medical record, the dosage. (continued on next page)

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	06/10/2022

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the facility's policy titled, Insulin Administration, reviewed January 2022, indicated to provide guidelines for the safe administration of insulin to residents, and check blood glucose by fingerstick. A review of the facility's policy titled, Obtaining a Fingerstick Glucose Level, reviewed January 2022, indicated the person performing this procedure should record the following information in the resident's medical record, the blood sugar results. Follow facility policies and procedure for appropriate nursing interventions regarding the blood sugar results (if resident is on sliding scale coverage, and/or physician intervention is needed to adjust insulin or oral medication dosages).

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	06/10/2022

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 40994 Based on interview and record review, the facility administration failed to seek timely guidance from the medical director regarding duplicated blood sugar readings in 7 of 11 sampled residents (Resident 1, 2, 3, 4, 5,6 and 7) between January and March 2022. The deficient practice of failing to seek timely guidance from the medical director on reports of duplicated blood sugars could have caused Residents 1-7 to continue to receive substandard quality of care resulting in possibly medical complications and diminished quality of life. Findings: During a telephone interview on 6/7/22 at 2:33 PM with the Facility Monitor (FM), The FM stated Residents 1, 2, and 3 had multiple identical blood sugar readings documented for insulin administration between January and March 2022. The FM stated multiple nurses documented the same blood sugar readings multiple times throughout the day, on multiple days and for multiple residents. The FM stated many of the duplicate readings were used to determine the dose of sliding scale insulin and insulin was administered as a result. The FM stated he informed the Director of Nursing (DON) of these findings while conducting an onsite visit on 3/24/22 and 3/25/22 and sent a follow up email to the DON and the Administrator (ADM) detailing the findings on 4/5/22. A review of Resident 1-7's Medication Administration Records (MAR - a record of all medications administered, and monitoring done for a resident) between January and March 2022 indicated a total of 303 total duplicate blood sugar readings documented by multiple licensed staff. During a telephone interview on 6/10/22 at 11:29 AM with the Medical Director (MD), the MD stated she is this facility's medical director and her duties in that role involve bridging the gaps in resident care by liaising with other physicians and attending the facility's regular quality assurance meetings. The MD stated she regularly attends monthly quality assurance meetings in person, but many times the meetings are canceled due to emergencies or scheduling conflicts. The MD stated many times she must leave the meetings early to attend to other patient's medical needs or must excuse herself from the meetings to take phone calls while they are ongoing. The MD stated she was never made aware of the issue of duplicated blood sugar readings in residents receiving insulin until the DON informed her on 6/9/22. The MD stated she did not recall any meeting since March or afterward where this issue was discussed in a quality assurance meeting when she was present. A review of the facility document Summary of Quarterly Quality Assurance Meeting dated April 27, 2022, indicated Similarities and possibilities of duplication of vital signs was a quality assurance agenda item discussed at this meeting. A review of the facility document QAA Meeting - Quarterly in-service record/QAPI, dated 4/27/22, indicated the MD signed the attendance sheet for this meeting as the Director of Medical Services. (continued on next page)

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	06/10/2022

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/22 at 4:28 PM with the ADM and the DON, the ADM stated the MD was informed that the blood sugar readings were anomalous and duplicated at the QAPI meeting on 4/27/22. The ADM stated she did not know why the MD stated she was not informed regarding duplicated blood sugar readings until 6/9/22 other than maybe she doesn't remember. The ADM stated the MD knew or should have known about the duplicated blood sugar readings by 4/27/22. The ADM stated she did not receive any guidance from the MD regarding the best way to resolve the issue with duplicated blood sugar readings and vital signs to ensure overall quality of resident care and can provide no documentation that the MD was informed of the issue prior to 4/27/22. During the same interview on 6/10/22 at 4:28 PM, the DON stated the FM gave her information regarding duplicated blood sugar readings on the third or fourth week of March 2022. The DON stated she cannot recall whether she informed the MD of the findings at that time. The DON stated that multiple duplicated blood sugar readings from multiple licensed staff affecting multiple residents across several months would have been serious enough that the MD should have been made aware right away. The DON stated that she did not seek or receive any sort of clinical guidance from the medical director regarding ensuring residents received care and services according to professional standards. A review of the facility's policy Administrative Management, reviewed January 2022, indicated The facility's governing board is the supreme authority and has full legal authority and responsibility for the management operation of our facility. The Administrator is appointed by and accountable to the governing board. The governing board is responsible for . oversight of facility care and services in accordance with professional standards of practice and principles.

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	06/10/2022

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 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 40994 Based on interview and record review, the facility failed to ensure the medical director assisted the facility to ensure 7 of 11 sampled residents (Residents 1, 2, 3, 4, 5, 6 and 7) received adequate services required to meet their needs by failing to respond to reports of duplicated blood sugar readings identified in the medical record between January and March 2022. The deficient practice of failing to ensure the medical director responded to and provided guidance on reports of duplicated blood sugars could have caused Residents 1-7 to continue to receive substandard quality of care resulting in possible medical complications and diminished quality of life. Findings: During a telephone interview on 6/7/22 at 2:33 PM, the Facility Monitor (FM) stated Residents 1, 2, and 3 have multiple identical blood sugar readings documented for insulin administration dated between January and March 2022. The FM stated multiple nurses documented the same blood sugar readings multiple times throughout the day, on multiple days and for multiple residents and many of the duplicate readings were used to determine the dose of sliding scale insulin and insulin was administered as a result. The FM stated he informed the Director of Nursing (DON) of these findings while conducting an onsite visit on 3/24/22 and 3/25/22 and sent a follow up email to the DON and the Administrator (ADM) detailing the findings on 4/5/22. A review of Resident 1-7 ' s Medication Administration Records (MAR - a record of all medications administered, and monitoring done for a resident) dated between January and March 2022 indicated a total of 303 total duplicate blood sugar readings documented by multiple licensed staff. During a telephone interview on 6/10/22 at 11:29 AM, the Medical Director (MD) stated she ws this facility ' s medical director and her duties in that role involved bridging the gaps in resident care by liaising with other physicians and attending the facility ' s regular quality assurance meetings. The MD stated she regularly attends monthly quality assurance meetings in person, but many times the meetings are canceled due to emergencies or scheduling conflicts. The MD stated many times she must leave the meetings early to attend to other patient ' s medical needs or must excuse herself from the meetings to take phone calls while they are ongoing and stated she was not made aware of the issue of duplicated blood sugar readings in residents receiving insulin until the DON informed her on 6/9/22. The MD stated she did not recall any meeting since March or afterward where this issue was discussed in a quality assurance meeting when she was present. A review of the facility document Summary of Quarterly Quality Assurance Meeting, dated April 27, 2022, indicated Similarities and possibilities of duplication of vital signs was a quality assurance agenda item discussed at this meeting. A review of the facility document QAA Meeting - Quarterly in-service record/QAPI, dated 4/27/22, indicated the MD signed the attendance sheet for this meeting as the Director of Medical Services. (continued on next page)

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	06/10/2022

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 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/22 at 4:28 PM with the ADM and the DON, the ADM stated the MD was informed that the blood sugar readings were anomalous (not standard or expected) and duplicated at the QAPI meeting on 4/27/22. The ADM stated she did not know why the MD stated she was not informed regarding duplicated blood sugar readings until 6/9/22 other than maybe she doesn ' t remember. The ADM stated MD knew or should have known about the duplicated blood sugar readings by 4/27/22 and no guidance was received from the MD regarding the best way to resolve the issue with duplicated blood sugar readings and vital signs, to ensure overall quality of resident care. There was not documentation provided that the MD was informed of the issue prior to 4/27/22. The DON stated the FM gave her information regarding duplicated blood sugar readings on the third or fourth week of March 2022 and she could not recall whether she informed the MD of the findings at that time. The DON stated that multiple duplicated blood sugar readings from multiple licensed staff affecting multiple residents across several months would have been serious enough that MD should have been made aware right away. The DON stated that she did not seek or receive any sort of clinical guidance from the medical director regarding ensuring residents received care and services according to professional standards. A review of the facility ' s policy titled, Medical Director, reviewed January 2022, indicated the Medical Director was a licensed physician in this state and was responsible for: overseeing and helping develop and implement care-related policies and practices, serving as a source of education, training, and information. The policy indicated the Medical Director functions also include, but are not limited to acting as a consultant to the director of nursing services in matters relating to resident care services, helping assure that residents receive adequate services appropriate to meet their needs, participating in staff meetings concerning,quality assurance and performance improvement and resident care policies.

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	06/10/2022

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to ensure licensed staff did not enter 303 duplicated blood sugar readings into the medical record for seven of 11 sampled residents (Residents 1, 2, 3, 4, 5, 6 and 7) between January and March 2022. The deficient practice of entering duplicated or false blood sugar readings into Resident 1-7 ' s medical record could have caused insulin (a medication used to treat high blood sugar) to be prescribed or administered at too high of a dose leading to dangerously low blood sugar likely resulting in hospitalization or death. Findings: During a telephone interview on 6/7/22 at 2:33 PM, the Facility Monitor (FM) stated Residents 1, 2, and 3 have multiple identical blood sugar readings documented for insulin administration between January and March 2022. The FM stated multiple nurses documented the same blood sugar readings multiple times throughout the day, on multiple days and for multiple residents. The FM stated many of the duplicate readings were used to determine the dose of sliding scale insulin and insulin was administered as a result. A review of Resident 1 ' s Admission Record dated 6/9/22, indicated he was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including: Type II diabetes mellitus (a medical condition characterized by the body ' s inability to regulate blood sugar levels). A review of Resident 1 ' s Order Summary Report dated 6/9/22, indicated the following active orders for insulin: -On 3/3/22, Resident 1 ' s physician prescribed insulin lispro (a fast-acting form of insulin) to inject three units (a unit of dosage for insulin) subcutaneously (under the skin) three times a day for Type II diabetes with instructions to hold if the blood sugar value is less than 120 milligrams ([ml] - a unit of measurement for mass) per deciliter ([dl] - a unit of measurement for volume). -On 3/3/22, Resident 1 ' s physician prescribed insulin lispro to inject as per sliding scale: if blood sugar (BS) = 71-150, no coverage, 151-200 = 3 units, 201-250 = 5 units, 251-300 = 7 units, 301-350 = 9 units, 351-400 = 11 units, more than 400 = 13 units subcutaneously before meals and at bedtime for Type II diabetes. -On 4/21/22, Resident 1 ' s physician prescribed insulin glargine (a slow-acting insulin) to inject 30 units subcutaneously in the morning for Type II diabetes. A review of Resident 1 ' s Resident Care Plan for diabetes, updated April 2022, indicated he was at risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) due to diabetes with an approach plan to Accucheck (take blood sugar measurement) as ordered QID (four times daily) AC (before meals) and QHS (at bedtime). (continued on next page)

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	06/10/2022

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 1 ' s MAR from January to March 2022 indicated the following examples of duplications of blood sugar readings in the record on 1/17/22 at 9 AM - 214 mg/dl - 3 units of lispro administered by Licensed Vocational Nurse (LVN 8), -1 PM - 214 mg/dl - 3 units of lispro administered by LVN 8 -5 PM - 214 mg/dl - 3 units of lispro administered by LVN 7 -11 PM - 214 mg/dl - 20 units of glargine administered by LVN 7. On 1/28/22 at 9 AM - 254 mg/dl - 3 units lispro administered by LVN 8 -11:30 AM - 254 mg/dl - 7 units lispro administered per sliding scale by LVN 8 -1 PM - 254 mg/dl - 3 units lispro administered by LVN 8 -4:30 PM - 254 mg/dl - 7 units lispro administered per sliding scale by LVN 8 -5 PM - 254 mg/dl - 3 units lispro administered by LVN 7 -6 PM - 254 mg/dl - 14 units glargine administered by LVN 7 -11 PM - 254 mg/dl - 7 units lispro administered per sliding scale by LVN 7. On 2/1/22 at 6 AM - 371 mg/dl - 14 units glargine administered, -6:30 AM - 371 mg/dl - 11 units lispro administered per sliding scale -9 AM - 371 mg/dl - 3 units lispro administered by LVN 7 -11:30 AM - 371 mg/dl - 11 units lispro administered per sliding scale by LVN 7 -1 PM - 371 mg/dl - 3 units lispro administered by LVN 7 -4:30 PM - 371 mg/dl - 11 units lispro administered per sliding scale by LVN 7 -5 PM - 371 mg/dl - 3 units lispro administered by LVN 7 -6 PM - 371 mg/dl - 14 units glargine administered by LVN 7 -11 PM - 371 mg/dl - 11 units lispro administered per sliding scale by LVN 7. On 2/4/22 at 6 AM - 397 mg/dl - 14 units glargine administered, -6:30 AM - 397 mg/dl - 11 units lispro administered per sliding scale -9 AM - 397 mg/dl - 3 units lispro administered by LVN 7 (continued on next page)

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	06/10/2022

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-11:30 AM - 397 mg/dl - 11 units lispro administered per sliding scale by LVN 7 -1 PM - 397 mg/dl - 3 units lispro administered by LVN 7 -4:30 PM - 397 mg/dl - 11 units lispro administered per sliding scale by LVN 7 -5 PM - 397 mg/dl - 3 units lispro administered by LVN 7 -6 PM - 397 mg/dl - 14 units glargine administered by LVN 7 -11 PM - 397 mg/dl - 11 units lispro administered per sliding scale by LVN 7. Further review of Resident 1 ' s MAR dated between January and March 2022 indicated similar findings on the following dates: 2/5, 2/6, 2/8, 2/18/2022 and 3/4/22 for a total of 134 duplicate blood sugar readings. A review of Resident 2 ' s Admission Record, dated 6/9/22, indicated she was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Type II diabetes mellitus. A review of the Physician'sOrder Summary Report, dated 6/9/22, indicated the following active orders for insulin for Resident 2: -On 3/31/22, Resident 2 ' s physician prescribed Humulin R (a type of insulin) to administer per sliding scale: for blood sugar reading 70-130 = 0 units, 131-180 = 2 units, 181-240 = 4 units, 241-300 = 6 units, 301-350 = 8 units, 351-399 = 10 units, greater than 400 = 12 units and contact physician, subcutaneously before meals and at bedtime for Type II diabetes. - On 3/10/22, Resident 2 ' s physician prescribed insulin glargine to inject 30 units subcutaneously at bedtime related to Type II diabetes. A review of Resident 2 ' s Resident Care Plan for diabetes, last updated April 2022, indicated Resident 2 was at risk for hypoglycemia and hyperglycemia related to a diagnosis of diabetes mellitus with an approach plan to Accucheck (take blood sugar measurement) as ordered. A review of Resident 2 ' s MAR dated from January to March 2022 indicated the following example of duplications of blood sugar readings in the record: On 2/22/22 at 6:30 AM - 279 mg/dl - 6 units of Humulin R were administered per sliding scale, -11:30 AM - 279 mg/dl - 6 units of Humulin R were administered per sliding scale by LVN 7 -4:30 PM - 279 mg/dl - 6 units of Humulin R were administered per sliding scale by LVN 7 -11 PM - 279 mg/dl - 6 units of Humulin R were administered per sliding scale by LVN 7. Further review of Resident 2 ' s MAR between January and March 2022 indicated similar findings on the following dates: 1/7/22, 1/10/22, 1/11/22, 1/17/22, 1/18/22, 1/25/22, and 3/24/22 for a total of 51 duplicate blood sugar readings. (continued on next page)

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	06/10/2022

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 3 ' s Admission Record, dated 6/9/22 indicated he was originally admitted to the facility on [DATE] with diagnoses including Type II diabetes mellitus. A review of Resident 3 ' s Physician's Order dated 2/2/22 indicated he was to receive Humulin R according to the following sliding scale: If blood sugar is 201-250 = 3 units, 251 - 300 = 4 units, 301-350 = 6 units, 351-400 = 9 units, above 400 = 12 units and report to the physician subcutaneously before meals and at bedtime for Type II diabetes. A review of Resident 3 ' s Resident Care Plan for diabetes, last updated May 2022, indicated Resident 3 was at risk for hypoglycemia and hyperglycemia related to a diagnosis of diabetes with an approach plan to Accucheck (take blood sugar measurement) as ordered. A review of Resident 2 ' s MAR from February to March 2022 indicated the following example of duplications of blood sugar readings in the record on 3/24/22: -11:30 AM - 210 mg/dl - 3 units of Humulin R administered by sliding scale -4:30 PM - 210 mg/dl - 3 units of Humulin R administered by sliding scale by LVN 7 -11 PM - 210 mg/dl - 3 units of Humulin R administered by sliding scale by LVN 7. Further review of Resident 3 ' s MAR between February and March 2022 indicated similar findings on the following dates: 2/4/22, 2/5/22, 2/6/22, 2/7/22, 2/8/22, 2/9/22, 2/15/22, 2/18/22, 2/25/22, and 3/7/22 for a total of 62 duplicate blood sugar readings. A review of Resident 4, 5, 6, and 7 ' s MARs dated between January and March 2022 indicated similar findings between 1/20/22 and 3/31/22 for a total of 303 total duplicate blood sugar readings for Residents 1, 2, 3, 4, 5, 6, and 7 documented by multiple licensed staff. During an interview on 6/8/22 at 5:47 PM with the DON and the ADM, the DON stated LVN 7 and 8 have resigned and are no longer working at this facility. The DON stated LVN 7 resigned on 3/29/22 after having previously been suspended as disciplinary action for possible duplication or false entries for vital signs and blood sugar readings. The DON stated the FM had brought her attention to LVN 7 possibly duplicating vital signs and blood sugar readings around the end of March 2022 and when she asked LVN 7 about entering duplicate blood sugar and vital sign values in the MAR without measuring them, LVN 7 denied doing so. The ADM stated she was unsure why LVN 8 resigned and when the FM advised them of the trend of duplicated blood sugar readings, the facility attempted to retrain their staff regarding proper documentation procedures at that time. (continued on next page)

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	06/10/2022

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON and ADM stated they also began conducting audits of the medical records of two residents per medication cart per week to search for duplicate entries. The ADM and DON stated they don ' t know why so many of their residents would have so many identical blood sugar readings and could not offer any plausible alternative explanation to an intentional fabrication of the medical record. The DON stated it was possible that the resident could have as many as nine identical blood sugar readings consecutively in a 24-hour period. The DON stated the staff cannot see the previous readings when they are documenting blood sugar and do not have time to look it up. The DON stated if the blood sugar readings were inaccurate, especially if it was higher than the true value, there is a chance that the dose of insulin given to the resident could have been too high based on the sliding scale order. The DON stated that if a resident received too much insulin it could cause them to crash by dropping the residents ' blood sugar too low possibly resulting in hospitalization or death. A review of Employee Notice of Discipline, dated 3/25/22, for LVN 7 indicated the DON suspended LVN 7 from work due to On 3/24/22 there was a review of documentation indicated that there was a possibility of inaccurate blood sugar readings and V/S (vital signs) documented in E-MAR (electronic MAR). During a telephone interview on 6/10/22 at 1:02 PM with LVN 7, LVN 7 stated he used a duplicate entry function within the MAR that copied the last entry on the order when documenting blood sugars and doses of sliding scale insulin for the residents under his care between January and March 2022. LVN 7 stated he and other licensed staff were having difficulty understanding the proper way to document the blood sugar readings in the MAR and accidentally used the duplicate entry function rather than entering his own blood sugar and vital sign readings. LVN 7 denied intentionally entering any false information into the MAR. LVN 7 stated he took his own blood sugar readings, documented them in the MAR, and only administered insulin to residents when appropriate based on the parameters. LVN 7 stated he did not know why his own readings are not available anywhere in the residents ' records. LVN 7 stated he also accidentally duplicated records of sliding scale insulin administrations in the MAR. During a concurrent observation and interview on 6/10/22 at 1:19 PM with LVN 1, LVN 1 was observed demonstrating how to record new blood sugar readings for a resident on the MAR data input screen. LVN 1 was observed selecting the medication cart number and a resident name to input a new reading. LVN 1 was observed entering a new blood sugar reading requiring the value to be manually typed in each time. No duplicate button or similar functionality was observed on the MAR data input screen. LVN 1 stated there used to be a repeat last entry functionality on the data entry screen in the MAR but it was disabled several months ago once the facility was informed about multiple duplicate entries on vital signs and blood sugar readings on multiple residents. LVN 1 stated it was too convenient for some nurses to input false information into the record by using this duplicate functionality. LVN 1 stated if they wanted to lie, they should have just changed the number a little bit on a new entry. LVN 1 stated that once the repeat last entry functionality was used, for a nurse to change it, they would have to manually perform an edit to strike the previous value and record a new one by entering the value manually. LVN 1 stated it would be apparent on the MAR that the new reading would be indicated as the correct one after the correction was made. LVN 1 stated the MAR is the only place blood sugar readings or medication administration records can be documented. LVN 1 stated sometimes the nurses will use the progress notes to explain anomalous readings or add clarification to an action, but will not routinely record blood sugars, vital signs, or medication administration records anyplace other than the MAR. LVN 1 stated if it ' s not in the MAR, it most likely means they didn ' t do it. (continued on next page)

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	06/10/2022

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility ' s policy Charting and Documentation, reviewed January 2022, indicated The medical record should facilitate communication between the interdisciplinary team regarding the resident ' s condition and response to care . The following information is to be documented in the resident medical record . medications administered, treatments or services performed . Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate . Documentation of procedures and treatments will include care-specific details including: .the assessment data and/or any unusual findings obtained during the procedure/treatment. A review of the facility ' s policy titled, Charting Errors and/or Omissions. reviewed January 2022, indicated accurate medical records shall me maintained by this facility . If it was necessary to change or add information in the resident ' s medical record, it shall be completed by means of an addendum and signed and dated by the person making such change or addition.

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	06/10/2022

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 43261 Based on interview and record review, the facility failed to develop and implement a Quality Assurance and Performance Improvement (QAPI) plan during an identified quality deficiency per facility policy. As a result, Immediate Jeopardy (IJ) was called on 6/9/2022 in the areas of quality of care, neglect and pharmaceutical services. Findings: During an interview with the Director of Nursing (DON) on 6/10/2022 at 9:32 a.m., the DON stated that she was aware of the issues with the Licensed Vocational Nurse 7 (LVN 7) on March 2022, but unable to locate a QAPI plan documentation. The DON stated that she educated LVN 7 and in-services was done specific for the issue. During an interview on 6/10/2022 at 9:40 a.m., the Administrator stated she was made aware by the DON regarding an issue of the staff with a possibility of the inaccurate blood sugar readings. The Administrator stated that since she was out of town, the DON was responsible for any issues when she was not around. She also stated that this issue would have trigger them to do a QAPI to plan, a root cause analysis and implement a recommended plan on the issues, but verified that the DON was not able to locate proper written documentation of the plan and stated that if it was not documented, means that it was not completed. A review of facility ' s employee notice of discipline, dated 3/25/2022, indicated that LVN 7 had a violation on 3/24/2022 and was suspended until investigation was cleared. A review of facility ' s QAPI plan indicated no documentation from 11/2021 to present. A review of facility ' s policy and procedure (P&P), titled, Quality Assurance and Performance Improvement (QAPI) Program, reviewed 1/2022, indicated that the facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for the residents. P&P also indicated that the program will provide means to establish and implement performance improvement projects to correct and will establish systems through which to monitor and evaluate corrective actions. A review of facility ' s P&P, titled, Administering Medications, revised on 11/22/2021, indicated that Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training.

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	06/10/2022

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on observation, interview and record review, the facility failed to maintain an infection control prevention and control program to prevent COVID-19 (a deadly respiratory disease transmitted from person to person) by failing to ensure all staff were properly fit tested with N95 mask (respirators that filters at least 95 percent (%) of airborne particles) for five of five facility staff (Certified Nurse Assistant 1-CNA 1, Certified Nurse Assistant 10-CNA 10, Certified Nurse Assistant 11-CNA 11, Restorative Nurse Assistant 1-RNA 1 and Registered Nurse 2-RN 2). This deficient practice can place residents and staff at risk for exposure and contracting COVID-19. Findings: During an observation and concurrent interview on 6/8/2022 at 1:35 p.m., CNA 1 was observed wearing a [NAME] L-188/TC-84A-6973 (type of N95 mask). CNA 1 verified the type and stated that she was not fit tested for that specific type of N95 mask. She also stated that she was currently working at the yellow zone (area in the facility for residents under investigation for possible COVID-19 infection) room. A review of facility ' s nursing staffing assignment and sign-in sheet dated 6/8/2022 and 6/9/2022, indicated CNA 1 was assigned to a resident in a yellow zone room. A review of facility ' s N95 tracking list dated 6/8/2022, indicated missing date of N95 fit test to CNA 1. During an interview with RNA 1 on 6/8/2022 at 2:12 p.m., RNA 1 stated that the last time he was N95 fit tested was two years ago. A review of facility ' s N95 tracking list dated 6/8/2022, indicated RNA 1 was fit tested on [DATE]. During a concurrent observation and interview with CNA 10 on 6/8/2022 at 7:55 p.m., CNA 10 stated and verified that he was wearing a [NAME] L-188/TC-84A-6973. CNA 10 stated that he was not fit tested for that same N95 mask. He also stated that since the facility had only one N95 mask, he did not have any choice but to use it for his own protection. A review of facility ' s N95 tracking list dated 6/8/2022, indicated missing date of N95 fit test to CNA 10. During a concurrent observation and interview with CNA 11 on 6/9/2022 at 6:35 a.m., CNA 11 was observed wearing BYD (type of N95 mask). CNA 11 verified and stated that he used his own N95 mask and added that he was not fit tested for any N95 mask. A review of facility ' s N95 tracking list dated 6/8/2022, indicated missing date of N95 fit test to CNA 11. (continued on next page)

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	06/10/2022

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with RN 2 on 6/13/2022 at 4:46 p.m., RN 2 stated that she was using the [NAME] L-188/TC-84A-6973 but was never fit tested for any N95 mask. A review of facility ' s N95 tracking list dated 6/8/2022, indicated missing date of N95 fit test to RN 2. During an interview with the Infection Preventionist Nurse (IPN) on 6/10/2022 at 10:15 a.m., the IPN stated all staff must wear an N95 mask at work. The IPN also stated and verified missing N95 fit testing done to CNA 1, CNA 10, CNA 11, RNA 1 and RN 2. The IPN further stated that facility must do an N95 fit testing on a yearly basis and as needed to protect the staff from COVID-19 infection. During an interview with the Director of Nursing (DON) on 6/10/2022 at 2:23 p.m., the DON stated that it was important to do an N95 fit testing to all the staff, upon hire, every year and as needed due to the high risk of contracting COVID-19 if mask does not fit well. A review of facility ' s policy and procedure (P&P), titled, COVID-19 Mitigation Plan Manual, undated, indicated that it was the policy of the facility to protect the residents, staff and others who may be in their facility. It further indicated that N95 mask were required for all staff working in all resident care areas and/or areas where residents may access for any purpose. A review of facility ' s P&P, titled, COVID-19 Prevention and Control, reviewed 1/2022, indicated, that facility were implementing all reasonable measures to protect the health and safety of residents and staff and will based on the most current recommendations from health policy officials, state agencies and the federal government. A review of the most current recommendations from the County of Los Angeles Public Health (LAPH), titled, Guidelines for Preventing & Managing COVID-19 in Skilled Nursing Facilities, dated 5/26/2022, indicated that N95 mask were required for use by all staff that work in resident care areas, or areas accessed by residents for any reason, at all times when working in these areas. It further indicated that initial and annual N95 respiratory fit testing was required for all staff per California Division of Occupational Safety and Health (Cal-OSHA). LAC | DPH | Guidelines for Preventing & Managing COVID-19 in Skilled Nursing Facilities (lacounty.gov) A review of All Facilities Letter (AFL 20-15.1) dated 4/9/2020, under Centers for Disease Control and Prevention (CDC) indicates that when a respirator was used to protect HCP from an infectious agent, a written respiratory protection program that meets the requirements of Occupational Safety and Health Administration ' s (OSHA) Respiratory Protection standard must be used. OSHA specifies that before an employee use any respirator, the employee must be fit tested with the same make, model, style, and size of respirator that will be used and that an employer shall ensure that an employee is fit tested prior to initial use of the respirator, whenever a different respirator facepiece (size, style, model or make) is used, and at least annually thereafter.

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	06/10/2022

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528 Based on observation, interview and record review, the facility failed to provide a functioning call light for one of one sampled resident (Resident 18). This deficient practice had the potential to result in a delay in meeting Resident 18 ' s needs for assistance and can lead to fall and/or accident. Findings: A review of Resident 18 ' s Admission Record indicated that the Resident was originally admitted on [DATE] with diagnoses including generalized muscle weakness (muscle weakness throughout the body), abnormalities of gait and mobility (unable to walk in the usual way) and lack of coordination (loss of coordination). A review of Resident 18 ' s Minimum Data Set Assessment (MDS, a standardized assessment and care screening tool) dated 5/25/22, indicated Resident 18 had a score of intact cognitive skills (thought processes) for decision making and extensive to total dependance a functional status of total dependance for transfer, toilet use and needed extensive assistance for bed mobility, dressing and personal hygiene. During an interview Resident 18 stated, My call light is not working. I reported this and they did not fix it. I have to call out every time I need help. During a concurrent observation and interview with the Certified Nurse Assistance 7 (CNA7) on 6/10/2022 at 2:47 p.m., CNA 7 stated, Yes, the call light is not working. CNA 7 further states Resident 18 usually calls out her name whenever she is in need of her assistance. During a concurrent interview and observation on 6/10/2022 at 2:57 p.m., the Director of Maintenance (DM) stated the call light, is not the way it should be, it is not up to factory standard. It ' s not working. A review of facility ' s policy and procedure (P&P), titled, Maintenance Service, revised on 1/2022, indicated that the maintenance Department was responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel include but are not limited to maintaining the paging system in good working order.

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	06/10/2022

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure the facility was properly maintained by: a. Failing to ensure that the resident's room paint was properly maintained and free from peeling and cracks for three of 31 sampled residents (Resident 23, 24, 25) and Shower room [ROOM NUMBER]. b. Failing to ensure the signages in Shower room [ROOM NUMBER], Laundry Room and Maintenance Room are complete. These deficient practices had the potential for the resident physical discomfort that may affect the resident's quality of life. Findings: a.During the facility tour with Maintenance Staff 1 (MS 1) on 6/8/2022 at 1:41 p.m., observed Room A, Room B (bed B) and Shower room [ROOM NUMBER] ' s paint on the wall and ceiling had cracks and peeling. Room A had big parts of the wall peeling and some parts of the ceiling as well. This room was currently being used as a Staff ' s break room. MS 1 stated, it was their responsibility to maintain the whole facility including painting of the room. MS 1 stated he was not aware of the paints in the wall for these rooms were peeling or had cracks. A review of facility ' s daily Census on 6/1/2022 to 6/6/2022 indicated Resident 23 and 25 was placed in room [ROOM NUMBER]. The Daily census on 6/1/2022 - 6/9/2022 indicated Resident 24 was placed in Room B. A review of the Admission Record indicated Resident 23 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN - elevated blood pressure), and history of falling. A review of the Minimum Data Set (MDS - a comprehensive assessment and care screening tool), dated 5/3/2022, indicated Resident 23's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making was moderately severe and required limited assistance from staff for activities of daily living (ADLs- transfer dressing, and personal hygiene). A review of the Admission Record indicated Resident 24 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain) and muscle weakness. A review of the MDS dated [DATE], indicated Resident 24's cognitive skills for daily decision-making was moderately severe and required extensive assistance from staff for ADLs- transfer, dressing, and personal hygiene. (continued on next page)

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	06/10/2022

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Admission Record indicated Resident 25 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe) and hypertension. A review of the MDS dated [DATE], indicated Resident 25's cognitive skills for daily decision-making was severely impaired and required extensive assistance from staff for ADLs- dressing, toilet use and personal hygiene. b.During a facility tour on 6/8/2022 at 1:30 p.m., observed Shower room [ROOM NUMBER] missing signage on the door, Laundry Room was missing letters and the Maintenance Room was missing letters as well. During an interview with Director of Maintenance (DM) on 6/9/2022 at 9:54 a.m., stated and confirmed the paint on the wall and ceiling in Room A, B and Shower room [ROOM NUMBER] was peeling and had cracks. The DM stated they check each room during monthly deep cleaning but did not document if the paint was being checked regularly. The DM stated peeling paint and have cracks need to be fixed. The DM stated he will get it this fixed as soon as possible. During an interview with Director of Nursing (DON) on 6/10/2022 at 11:55 a.m., the DON stated and confirmed the paint in the wall for Room A, Room B and Shower room [ROOM NUMBER] was peeling and had cracks. The DON stated the signages for Shower room [ROOM NUMBER] was missing, and the signages for Laundry Room and Maintenance Door were not complete. The DON stated this puts residents at risk of hazards due to lead from the peeling paints (the danger from lead paint increases when it's peeling or otherwise deteriorating, which can lead to the inhalation of lead dust or the swallowing of lead-based paint chips) and not a very homelike environment. A review of facility ' s policy and procedure (P&P) titled, Maintenance Service, reviewed January 2022, indicated the maintenance department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel include, but were not limited to: maintaining the building in a good repair and free from hazards.