

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2024
NAME OF PROVIDER OR SUPPLIER St. John of God Retirement		STREET ADDRESS, CITY, STATE, ZIP CODE 2468 South St Andrews Place Los Angeles, CA 90018	

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)
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36331</p> <p>Based on observation, interview and record review, the facility failed to ensure head of bed was elevated to 30 to 45 degrees as ordered by the physician, for 1 of 4 sampled residents, Resident 2, while gastrostomy tube feeding [GT] nutrition administered via an surgical opening in the abdomen into the stomach) was ongoing.</p> <p>This failure had the potential to result in aspiration (occurs when food or liquid is breathed into the airways or lungs, instead of being swallowed), difficulty breathing, infections and hospitalization .</p> <p>Findings:</p> <p>During a concurrent observation and interview on 7/22/2024 at 10:15 a.m. with Treatment Nurse 1 (TN 1), Resident 2 was observed on bed with GT feeding of Jevity (feeding formula) 1.5 cal (calorically dense) at 65 cc (cubic centimeter) per hour. Resident 2's head of bed (HOB) was at a low angle of 20-degree. TN 1 stated the HOB should be elevated to 30 degrees to prevent aspiration.</p> <p>During a review of Resident 2's Admission Record dated 7/22/2024, the admission record indicated Resident 2 was readmitted to the facility on [DATE] with diagnosis of dysphagia, oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat), respiratory failure (a serious condition that makes it difficult to breathe on your own), and toxic encephalopathy (characterized by an altered mental status, memory loss, and visual problems).</p> <p>During a review of Resident 2's Minimum Data Set ([MDS] an assessment and care planning tool), dated 4/30/2024, the MDS indicated Resident 2 had clear speech, had the ability to express ideas and was able to understand. The MDS indicated Resident 2 was dependent (helper does all the effort) on staff for eating, toileting hygiene and shower/bathe self (the ability to bathe self).</p> <p>During a review of Resident 2's Order Summary Report , dated 6/14/2024, the order indicated to elevate the HOB to 30 to 40 degrees at all times during feeding and at least 30 to 40 minutes after the feeding has stopped every shift.</p> <p>During a review of Resident 2's care plan titled GT feedings related to dysphagia, the care plan indicated Resident 2 was at risk for aspiration. The intervention included to elevate HOB 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feeding stopped.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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: 055253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2024
NAME OF PROVIDER OR SUPPLIER St. John of God Retirement		STREET ADDRESS, CITY, STATE, ZIP CODE 2468 South St Andrews Place Los Angeles, CA 90018	
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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Enteral Feedings (a form of nutrition that is delivered into the digestive system as a liquid) -Safety Precautions, dated 11/2018, the P&P indicated to elevate the head of the bed (HOB) to at least 30 degrees during tube feeding and at least 1 hour after feeding to prevent aspiration.</p>		