

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/18/2024
NAME OF PROVIDER OR SUPPLIER  Culver West Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  4035 Grandview Blvd. Los Angeles, CA 90066	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>45528</p> <p>Based on observation, interview and record review, the facility failed to provide reasonable accommodation of needs for one of three sampled residents (Resident 1) by failing to ensure Resident 1 ' s call light (a device with a button or touchpad a resident uses to set off an alarm that flashes/rings to alert the facility staff the resident needs assistance) was within reach as indicated in the facility ' s Policy and Procedures (P&amp;P) titled Call Light Answering revised on 9/11/23.</p> <p>This deficient practice had the potential for Resident 1 not to receive emergency care or have a delay in care and services that could result in a fall or accident.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 5/29/2024 with diagnoses that included chronic obstructive pulmonary disease (COPD-a common lung disease causing restricted airflow and breathing problems), acute and chronic respiratory failure (acute respiratory failure-occurs when there is a sudden decrease in the ability to exchange oxygen and carbon dioxide between the lungs and blood stream; chronic respiratory failure occurs gradually and requires longer-term treatment), bronchiectasis (chronic lung condition where the walls of the airways widen and are thickened from inflammation and infection), weakness (state or condition of lacking strength), difficulty walking, and Alzheimer ' s disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks).</p> <p>A review of Resident 1 ' s History and Physical dated 5/30/24, indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 1 ' s Minimum Data Set (MDS-a comprehensive assessment and care screening tool) dated 6/2/2024, indicated Resident 1 had severe cognitive (ability to think, read, learn, remember, reason, express thoughts, and make decisions) impairment and was dependent on facility staff with eating, toileting, lower body dressing and putting on/taking off footwear. The MDS indicated the resident needed substantial/maximal assistance (helper does more than half the effort/helper lifts of holds trunk or limbs and provides more than half the effort) with oral hygiene, shower/bathing, upper body dressing, personal hygiene, and indoor mobility (the ability to move freely or purposefully, or to change and control one's body position).</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
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1 ' s care plan initiated on 5/3/23, indicated Resident 1 was at risk for falls related to balance problem when standing/ambulating (walking), gait (the way a person walks or moves on foot, including the coordination of their feet, legs, and arms) disturbance, impaired cognition/poor safety awareness, noncompliance in using call light, use of medication that could affect balance and weakness. The care plan indicated the nurse was tokeep the call light within reach and answer the call light promptly.</p> <p>A review of Resident 1 ' s care plan initiated on 5/29/24 indicated Resident 1 was at risk for falls related to confusion, deconditioning, gait/balance problem, incontinence, noncompliance to using call light, psychoactive drug (a chemical substance that changes brain function and can alter a person's perception, mood, consciousness, cognition, or behavior) use and being unaware of safety needs. The care plan indicated to keep call light within reach, encourage resident to use the call light for assistance as needed and staff was to respond promptly to all requests for assistance.</p> <p>During a concurrent observation and interview in Resident 1 ' s room on 07/18/24 at 8:54 AM with Resident 1 at the bedside, Resident 1 was observed lying in bed with oxygen at 2 liters per minute (flow of oxygen measured in liters per minute) via nasal cannula (a device that delivers extra oxygen through a tube and into the nose). A call light was observed on the floor behind Resident 1 ' s bed. Resident 1 stated she needed help with diaper change and stated she wasunable to find the call light. Resident 1 started to look for the call light, tried to get up to move herself to the edge of the bed and almost lost balance and fell off the bed.</p> <p>During a concurrent observation in Resident 1 ' s room and interview on 7/18/24 at 9:16 AM, Certified Nurse Assistant 1 (CNA 1) was observed picking up the call light and placing it next to Resident 1 ' s hand. CNA 1 stated she (CNA 1) went to the resident ' s room after being notified by another staff that Resident 1 needed help. CNA 1 confirmed by stating the call light was on the floor and the call light had to be within reach. CNA 1 stated if the call light was not within reach, it was dangerous for the residents because they would try to get up and could fall and injure themselves.</p> <p>During an interview on 7/18/24 at 12:09 PM, Licensed Vocational Nurse 1 (LVN 1) stated button call lights and touch pads had to be within the residents ' reach. LVN 1 stated staff had to answer call lights right away and all staff were responsible for answering call lights. LVN 1 stated it was important to answer call lights right away as it could be an emergency or residents needing to be changed or assisted to the bathroom. LVN 1 stated residents could potentially fall if they triedto get up by themselves.</p> <p>During an interview on 7/18/2024 at 2:16 PM, the Director of Nursing (DON) stated he did not know how Resident 1 ' s call light ended up behind Resident 1 ' s bed. The DON stated call lights had to be within reach, answered right away, and acknowledged by a staff whether the staff was assigned to Resident 1 or not. The DON stated call lights had to be within reach of the residents so residents could call for assistance or alert staff if they were not feeling well. The DON satedif call lights were not answered right away, residents could fall if they tried to get up by themselves. The DON stated if residents were not changed right away, skin breakdown or infection could result.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility ' s P&amp;P titled Call Light Answering revised on 9/11/23, indicated the purpose of the policy was to meet the resident ' s needs and requests within an appropriate time frame. The policy indicated the call lights was the only mechanism at the resident ' s bedside the residents could use to alert nursing personnel to their needs. The policy indicated facility staff was to educate residents upon admission on how to use the call light system where the call light was positioned at the bedside. The policy indicated all residents were to always have a call light within reach. The policy indicated call lights were to be answered as quickly as possible.</p>		