STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055350	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Culver West Health Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the certified nursing assistant (CNA) 3 failed to put on personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) before entering a room identified with signage as enhanced barrier precautions() to transfer Resident 3 from bed to chair for one of three sampled residents, Resident 3.This deficient practice placed other residents at risk of transmission of possible bacteria.A review of Resident 3's admission Record indicated the facility admitted this [AGE] year-old male on 12/17/2025 most recently with diagnoses including Chronic Obstructive Pulmonary Disorder (COPD-a chronic lung disease causing difficulty in breathing) dysphagia (difficulty swallowing), Congestive Heart Failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), Hypertension (HTN-high blood pressure), glaucoma, atrial fibrillation (irregular heartbeat), emphysema, asthma (condition causing narrowing and swelling of the airways in the lungs), gastroesophageal reflux (GERD-heartburn), gout (arthritis), chronic kidney disease (damaged kidney function for more than 3 months), dependent on oxygen and benign prostatic hypertrophy (BPH-enlarged prostate gland).A review of Resident 3's physician order dated 2/3/2026 indicated Indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) for BPH, chronic kidney disease, stage 3A.A review of Resident 3's physician order dated 2/11/2026 indicated enhanced barrier precaution r/t urinary catheter.A review of Resident 3's minimum data set (MDS-a resident assessment tool) dated 2/16/2026 indicated Resident 1's cognition (mental ability to make decisions for daily living) was moderately impaired. Resident 3 was dependent (helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting, personal hygiene, and transfers (moving between surfaces) from bed to chair.A review of Resident 3's care plan titled, I am on Enhanced Standard Precautions r/t urinary catheter; I am at risk for acquiring or being source of MDRO (multidrug-resistant organisms). The care plan included the intervention my nurse will render enhanced barrier precaution procedures in accordance to facility infection control plan.During a concurrent observation and interview on 4/1/2026 at 10:51 am with the licensed Vocational Nurse (LVN) 1, outside of Resident 3's room; we witnessed CNA 3 inside of Resident 3's room touching surfaces, touching the resident while in bed removing the blankets while not wearing gloves, gown or mask. LVN 1 stated, I believe one of the Resident's has a gastrostomy tube (g tube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) so anyone handling Resident 3 should put on gown, mask and gloves before entering the room. LVN 1 then asked CNA 3 to exit the room and put on PPE.During an interview on 4/1/2026 at 11:52am with CNA 3. CNA 3 stated, When the sign says enhanced barrier precaution I am supposed to put on a gown and gloves before entering the room if I am going to do anything with the resident. CNA 3 was going into the room to transfer Resident 3 from bed to chair and prepare Resident 3 for lunch. Lastly, CNA 3 stated, I should have put on the gown and gloves before I went into the room to transfer Resident 3 to the wheelchair.A review of the facility's policy and procedure titled, Enhanced Barrier Precautions, reviewed 1/2026 indicated,1. Enhanced (continued on next page)

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents.2. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply.a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room).b. Personal protective equipment (PPE) is changed before caring for another resident.c. Face protection may be used if there is also a risk of splash or spray.3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include:a. dressing;b. bathing/showering;c. transferring;d. providing hygiene;e. changing linens;f. changing briefs or assisting with toileting;g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); andh. wound care (any skin opening requiring a dressing).4. EBPs are indicated (when contact precautions do not otherwise apply) for residents infected or colonized with a CDC targeted or epidemiologically important [NAME], including:a. Pan-resistant organisms;b. Carbapenemase-producing carbapenem-resistant Enterobacterales;c. Carbapenemase-producing carbapenem-resistant Pseudomonas spp;d. Carbapenemase-producing carbapenem-resistant Acinetobacter baumannii;e. Candida auris;f. Methicillin-resistant Staphylococcus aureus (MRSA);g. ESBL-producing Enterobacterales;h. Vancomycin-resistant Enterococci (VRE);i. Multidrug-resistant Pseudomonas aeruginosa; andj. Drug-resistant Streptococcus pneumonia.5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of [NAME] colonization.a. Wounds generally include chronic wounds (i.e., pressure ulcers, diabetic foot ulcers, venous stasis ulcers, and unhealed surgical wounds), not shorter-lasting wounds like skin breaks or skin tears.b. Indwelling medical devices include central lines, urinary catheters, feeding tubes and tracheostomies. Peripheral IV catheters are not considered an indwelling medical device for purposes of EBPs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observations, interview and record review the facility failed to ensure the call light was accessible for one of three sampled residents, (Resident 1).This deficient practice caused Resident 1 to sit in wet diaper from 12:30 am to 6:30 am and further cause burning sensation to buttocks.A review of Resident 1's admission Record indicated the facility originally admitted this [AGE] year old male on 6/14/2025 and most recently on 9/21/2025 with diagnoses including Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (total weakness of the arm, leg, and trunk on the same side of the body) of the right side, end stage renal disease(ESRD-End Stage Renal Disease-irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), essential hypertension (HTN-high blood pressure), hyperlipidemia (fat in the blood), cerebral infarction(CI-stroke, loss of blood flow to a part of the brain, generalized weakness, dysphagia (difficulty swallowing), aphasia (a disorder that makes it difficult to speak) and anemia (a condition where the body does not have enough healthy red blood cells.A review of Resident 1's History and Physical (H&P- a physician assessment and treatment plan) dated 8/21/2025 indicated Resident 1's cognition (mental ability to make decisions for daily living) was intact.A review of Resident 1's Minimum Data Set (MDS-resident assessment tool) dated 3/16/2026, indicated Resident 1 was dependent (helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting, personal hygiene, and transfers (moving between surfaces) from bed to chair.A review of Resident 1's care plan titled, I have functional and ADL self-care performance deficit, revised 3/20/2026 included the following interventions: turn and reposition every 2 hours, call light within reach and attend to needs promptly, encourage resident to call nurse for help.A review of Resident 2's admission Record indicated the facility admitted this [AGE] year-old male on 1/19/2026 with diagnoses including Rhabdomyolysis (breakdown of muscle causing kidney damage), hypokalemia (low potassium), HTN, venous insufficiency (poor circulation in legs), cataract (cloudy lens) of right eye and chronic kidney disease (long term kidney failure).A review of Resident 2's H&P dated 1/20/2026 indicated Resident 2's cognition was intact.A review of the Daily Assignment Sheet dated 4/1/2026 11:00pm to 7:00am indicated CNA 2 was assigned to Resident 1.On 3/24/2026 The California Department of Public Health (CDPH) received a complaint alleging Resident 1's call light was not accessible causing Resident 1 to contact family when help is needed. During an interview on 4/2/2026 at 10:34 am The Certified Nursing Assistant (CNA) 1 assigned to Resident 1 stated Resident 1 went to dialysis at 9:00 am. CNA 1 stated, I changed Resident 1 after breakfast; Resident 1 was not soaking wet because the night shift had just changed Resident 1. Resident 1 should be back between 12:00pm and 1:00pm.During an interview on 4/2/2026 at 10:39 am with Resident 2; the roommate of Resident 1. Resident 2 stated, Last night it was pretty quiet between 2:00am and 6:00am I don't recall anyone coming into the room. I have seen them come in and change Resident 1 at night, Resident 1 uses the button, and they come but last night was pretty quiet.During an interview on 4/2/2026 at 11:17am with Resident 1. Resident 1 was found on the patio near the front nursing station using communication board to communicate. Resident 1 types out on board that no one came to check on Resident 1 last night between 12:30am and 6:30 a.m. Resident 1 stated, I needed to be changed at 12:30am but my call light was on the floor. I did not sleep much because my bottom was burning, I was not repositioned, I have told all shifts about my bottom burning, I have learned to just tolerate it because no one cares started to cry. CNA 2 changed me at 6:30am this morning and that is the only time I have been changed today since last night. During an interview on 4/2/2026 at 1:49 pm with CNA 2. CNA 2 stated that Resident 1 slept all night long and Resident 1 was changed once at 6:30 am. Resident 1 had an appointment this morning, so I changed and got Resident 1 dressed this morning. When I started my shift at 11:00pm I saw that (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 was asleep and I saw what I thought was the call light coming out of the wall. Resident 1 usually calls during the night between 1:00am and 2:00am but last night Resident 1 did not call for a change. When I went into the room this morning what I thought was the call light was the phone charger cord. When I came in this morning, I did see the call light dangling on the right side of the bed out of Resident 1's reach; Maybe that's why Resident 1 did not call last night. Lastly, CNA 2 stated, That's probably why Resident 1 was more wet than usual when I changed him this morning.During a concurrent observation and interview on 4/2/2026 at 2:39pm with CNA 1 inside of Resident 1's room. Resident 1's call light was on the floor on the right side of the bed. CNA 1 opened Resident 1's diaper and intact skin was observed on Resident 1's bottom. CNA 1 raised the head of bed, placed bedside table in front of resident with communication board, went to trash can to take off gown and attempted to exit the room. CNA 1 stated, Do you have everything you need and Resident 1 looked and smiled Surveyor stopped CNA 1 from exiting the room and stated, Where is the call light? CNA 1 then walked over and picked up call light from the floor and pinned it onto the bed linen.During an interview on 4/2/2026 at 4:16pm with the Director of Nursing (DON), The DON stated the call light should always be in reach. A review of the facility's policy and procedure titled, Call Light Answering revised 1/12/2026 indicated:NURSING ACTION1. Upon admission, the nurse call system will be demonstrated to the resident. To acquaint resident with a system he/she can use to communicate. 2. Instruct the resident to use the call button any time he/she needs to talk with a nurse or be assisted. To make resident feel secure that his/her needs will be met.3. Check to see that the system is functioning. If any malfunction, report immediately to maintenance.4. If resident is able to ambulate, instruct him/her on bathroom emergency call button.5. Keep constant watch on all call lights.6. Answer all lights promptly, regardless of whose resident it is.7. Turn off call light as soon as you enter room before complying with resident's request.9. Always check with the charge nurse before doing anything of an unusual nature for the resident.10. Report to charge nurse if the task is beyond your authority to perform.11. Reposition call light within resident's To assure resident can call for help.DOCUMENTATIONThe licensed nurse will document in the resident's care plan any needed intervention for the resident to use the call light system (e.g. - quad light, positioning on right or left side, etc.).A review of the facility policy and procedure titled, Routine Resident Checks reviewed 1/12/2026 indicated1. To ensure the safety and well-being of our residents, nursing staff shall make a routine resident check on each unit at least once per each 8-hour shift.2. Routine resident checks involve entering the resident's room and/or identifying the resident elsewhere on the unit to determine if the resident's needs are being met, identify any change in the resident's condition, identify whether the resident has any concerns, and see if the resident is sleeping, needs toileting assistance, etc.3. The person conducting the routine check shall report promptly to the Nurse Supervisor/Charge Nurse any changes in the resident's condition and medical needs.4. The Nursing Supervisor/Charge Nurse shall keep documentation related to these routine checks, including the time, identity of the person making checks, and any outcomes of each check. (Note: CNAs may also record this information and provide it to the Nurse Supervisor/Charge Nurse.)