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	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Culver West Health Center	4035 Grandview Blvd. Los Angeles, CA 90066

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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 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. 45528 Based on interview and record review, the facility failed to ensure staff consulted with a physician, the Interdisciplinary team (IDT - a group of professionals from different specialties working together to provide care) or the faciity Bioethics committee (a group of individuals, often including doctors, nurses, ethicists, and community members, who help navigate complex moral and ethical questions in healthcare and research) regarding vaccinations for one of five sampled residents (Resident 33) who did not have a resident presentative and did not have the mental ability to make decisions. This deficient practice violated Resident 33's right to be supported and represented supported in making decisions regarding vaccinations. Cross reference F883 Findings: During a record review of Resident 33's Admission Record indicated the facility initially admitted Resident 33 on 3/10/2021 and readmitted Resident 33 on 7/30/2023 with diagnoses including adult failure to thrive (a state of decline in older adults characterized by a decline in physical, mental, and social functioning), anemia (not having enough healthy red blood cells to carry oxygen to the body's tissues) and cholelithiasis (the presence of gallstones in the gallbladder). During a record review, Resident 33's History and physical (H&P -a detailed assessment a doctor does to understand a patient's health) dated 11/10/2024, the H&P indicated Resident 33 does not have the capacity (ability to do something) to understand and make decisions. During a record review, Resident 33's Minimum Data Set (MDS - a resident assessment tool) dated 3/17/2025, indicated Resident 33 had moderate cognitive impaiment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 33 was dependent on staff for toileting, dressing, transfers and person hygiene. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review, Resident 29's physician order dated 4/17/2025, at 11:08 P.M., the physician's order indicated to collect urine for urinalysis (UA- a laboratory test that examines a urine sample to detect and analyze various substances and conditions) with culture and sensitivity (C&S - a procedure that involves growing bacteria or other microorganisms from a urine sample to identify the specific organism causing an infection and determine its sensitivity to antibiotics [medications used to prevent and treat infection]). During a concurrent interview and record review, on 4/30/2025, at 3:24 P.M., with the Director of Nursing (DON), Resident 33's vaccination consent forms for pneumonia (a shot that protects against several types of pneumococcal bacteria that can cause serious illnesses, including pneumonia, blood infections, and even meningitis), influenza (helps protect you from getting sick with the flu), covid 19 (help our bodies develop immunity to the virus that causes COVID-19 without us having to get the illness) and Resident 33's chart were reviewed. The vaccination consents indicated that Resident 33 refused the pneumonia, influenza and covid 19 vaccinations. The DON stated that Residents 33 had a BIMS score of 10, meaning that Resident 33 was moderately cognitively impaired, and that the H&P indicated that Resident 33 does not have the capacity to understand or make decisions. The DON stated Resident 33 was not able to comprehend rationally to make medical decisions and should not have signed the informed consent for his vaccinations. The DON stated the facility should have consulted with Resident 33's Physician, the Interdisciplinary team (IDT - a group of professionals from different specialties working together to provide care) or Bioethics committee (a group of individuals, often including doctors, nurses, ethicists, and community members, who help navigate complex moral and ethical questions in healthcare and research) regarding Resident 33 vaccinations as Resident 33 did not have a resident presentative. The DON stated adverse effects of not giving Resident 33 pneumonia, influenza and covid 19 vaccinations is that Resident 33 may be at high risk for infections especially due to Resident 33's advanced age, comorbidities that lead to a weakened immune system/infections that may lead to decline in function, sepsis (a life-threatening emergency that arises when the body's immune system's response to an infection goes into overdrive, causing damage to vital organs), and possible hospitalization . During a record review, the facility Policy and Procedures (P&P) titled, Treatment Consent: Non-Routine Service/Care, revised 1/13/2025, indicated, The facility shall obtain a treatment consent for a prescribed treatment and/or medication that is not included in the admission consent for care . During a record review, the facility P&P titled, Bioethics Committee revised 1/13/2025, indicated, It is the policy of this facility to respect and support residents' rights of health care decision making by facilitating bioethics discussions through the formation of an interdisciplinary group called the Bioethics Committee . To assure that residents' preference for care are upheld and provide a forum for discussion should this be indicated by an individual case.

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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** 45455 Based on observation, interview and record review, the facility's interdisciplinary team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of their clients) failed to ensure one out of four sampled residents (Resident 42) had a physician's order for self-administrations, was assessed determined capable to self-administer medications left at the bedside. This deficient practice had the potential for unintended for and unauthorized access to the medications which could result in adverse reactions (any unwanted, unpleasant, noxious, or potentially harmful effect of a drug or medication), unnecessary hospitalization and possible poor outcomes. Findings: During a record review, Resident 42's admission record indicated Resident 42 was admitted to the facility on [DATE], with diagnoses that include atrial fibrillation (an irregular and often very rapid heart rhythm), hypertension (a medical condition characterized by persistently elevated blood pressure), neuropathy (A nerve problem that causes pain, numbness, tingling, swelling, or muscle weakness in different parts of the body) Osteoarthritis (a degenerative joint disease where the cartilage that cushions the ends of bones in the joints wears away and leads to pain, stiffness, and decreased range of motion) and difficulty walking. During a record review, Resident 42's Minimum Data Set (MDS - a resident assessment tool) dated 03/17/2025, indicated Resident 42's cognition (The mental ability to make decision of daily living) was intact. The MDS indicated Resident 42's required setup for eating and oral hygiene. During a facility tour and observation of Resident 42'ss room on 4/29/2025 at 9:29 AM, Resident 42 was not inside the room. Resident 42's bedside drawer was observed to have: 1. A bottle of extra strength acetaminophen (medication for mild pain and fever) 500 milligrams (mg - unit of measurement) caplets a pain reliever/fever reducer. 2. A bottle of Ducolax (stool softener) 100mg. During an interview on 4/29/2025, at 9:32 AM, with Registered Nurse (RN) 1, RN1 stated Resident 42 did not have a physician's order to self-administer the extra strength acetaminophen 500mg caplets a pain reliever/fever and/or bottle of Dulcolax 100mg stool softener laxative, RN1 additionally stated the acetaminophen and dulcolax medications should not be left at the bedside where they are easily accessible. RN1 stated a confused wandering resident can ingest (take by mouth) the medications resulting in an adverse reaction. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/2/2025 at 3:12 PM, Director of Nursing (DON) stated residents are only allowed for have Medications at the bedside if the residents have been assessed to be cognitivly intact, have physically demonstrated that they can safely and are able to self administer medications, and must have a physician approval to self administer medications. DON stated residents medications left at the bedside should be in a locked container. DON further stated medications should not be left at residents bedside, because of the risk of medication duplicity that can lead to an overdose. DON sated a confused resident and or a wandering resident may access and consume the medications which could lead to an adverse reactions, unnecessary hospitalization and possible poor outcomes, During a record review, the facility policy and procedures titled Self-Administration of Medication dated 01/13/2025, indicated .Residents have the right to self-administer medications if the interdisciplinary team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the Resident), has determined that it is clinically appropriate and safe for the resident to do so. As part of their overall evaluation, the staff and practitioner will assess each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the Resident self-administered medications are stored in a safe and secure place, which is not accessible by other Residents .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455 Based an observation, interview and record review, the facility failed to ensure one out of 25 sampled Residents (Resident 16) was cared for in a manner that promotes, maintains and/or enhances his (Resident 16s) quality of life and individuality by failing to ensure Resident 16 by received routine personal hygiene (nail hygiene) services that meet the needs of residents. This deficient practice and the potential to result in Resident 16's loss of dignity, selfrespect, and identity that allows the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Findings: During a record review, Resident 16's admission record indicated Resident 16 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that include hyperlipidemia (abnormally high of fats in the blood), anemia, history of falling, fracture (break in a bone) of humerus (left arm) and pneumonia. During a record review, Resident 16's history and physical (H&P) dated 10/4/2024 indicated Resident 16 does not have the capacity to understand and make decisions. During a record review, Resident 16's Minimum Data Set (MDS, a resident assessment tool) dated 4/8/2025, indicated Resident 16 had severe cognitive impairment, Resident 16 required set-up or clean up assistance with eating, required partial moderate assistance with oral hygiene and was dependent on personal hygiene. During a tour on 4/29/2025 at 9:30 AM, Resident 16 was observed to have black like color residue underneath the fingernails. During a breakfast observation in the dining room and concurrent interview with Resident 16 on 5/2/2025 at 8:15 AM, Resident 16 was observed picking and eating breakfast toast with his hands. Resident 16's fingernails were observed with black like color residue. Resident 16 stated no staff had offered to clean and/or cut his fingernails. During an interview on 5/2/2025 at 8:25 AM, Certified Nurse Assistant (CNA) 1 stated Resident 16's nails are dirty and unkempt. CNA 1 stated Resident 16 eating with dirty fingernails can cause Resident 16 to orally (by mouth) ingest bacteria (disease carrying microorganisms) which can result in sickness and unnecessary hospitalization . During an interview on 5/2/2025 at 2:42 PM, Director of Nursing (DON) stated cleaning Resident's nails is part of the daily routine and is a dignity issue for the resident. DON stated dirty uncut nails can harbor microorganisms, that can spread infections, resulting in abnormal physical function, unnecessary hospitalization s. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review, the facility Policy and Procedures (P&P) titled Quality of Life-Dignity, dated 1/13/2025, indicate, Residents shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents shall be groomed as they wish to be groomed (hair, nails etc).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48026 Based on observation, interview, and record review, for two of five residents (Resident 29 and Resident 71), the facility failed to: 1. Label the indwelling catheter (a flexible tube that is used to drain urine in the bladder) bag (a device forcollecting urine) labeled with date and time the facility changed the indwelling catheter bag for Resident 71. 2. Immediately notify a physician of the abnormal lab values for urinalysis (a laboratory test that examines a person's urine to detect any abnormalities or health conditions) and record in the resident's medical record regarding the change in condition evaluation (COC -a noticeable alteration in someone's health or circumstances that could have a significant impact on their well-being or the situation they're in) on 4/21/2025 for Resident 29. 3. Timely administer Ertapenem (an antibiotic - medication used to treat severe infections) 1 gram (GM -unit of measure in weight) intramuscularly (IM - inject medication into a muscle) antibiotics (medicines that fight bacterial infections) leading to a nine-day delay of medication administration for Resident 29 according to physician's order for urinary tract infection (UTI - an infection in the bladder/urinary tract) dated 4/24/2025. These deficient practices had the potential to result in hospitalization and death for Resident 29 and placed Resident 71 at increased risk of getting a urinary tract infection infection (UTI- is an infection that affects a part of the urinary tract). Cross Reference F760 and F880 Findings: a. During a record review, Resident 71's admission record (face sheet - a document containing demographic and diagnostic information) indicated, Resident 71 was admitted to the facility on [DATE] and was readmitted on [DATE] with the following diagnoses: neuromuscular dysfunction of the bladder (a condition where the nerves and muscles controlling bladder function don't work properly due to damage to the brain, spinal cord, or nerves), history of urinary tract infections (UTIs - a person has previously experienced one or more UTIs), and presence of urogenital implants (the existence of artificial devices or materials within the urogenital system, which includes the urinary and reproductive organs). During a record review, Resident 71's History and Physical (H&P - a physician's complete patient examination) dated 1/17/2025, indicated, Resident 71 can make needs known but cannot make medical decisions. During a record review, Resident 71's Minimum Data Set (MDS - a resident assessment tool) dated 1/20/2025 and 3/06/2025, indicated, Resident 71 was cognitively intact (a person's thinking and reasoning abilities are functioning properly and are not significantly impaired). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review, Resident 71's Physician Order Summary Report dated 2/19/2025, indicated, Resident 71 had an order for indwelling catheter site care to be done every shift and to change the catheter as needed. The Physician Order Summary Report also indicated, to insert an indwelling catheter due to a diagnosis of neurogenic bladder. During a record review of Resident 71's care plan (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) on potential for infection, dated 3/11/2025, indicated, Resident 71 had an indwelling catheter. The CP goal indicated Resident 1 will have no signs and symptoms of infection as evidenced by no pain, swelling, tenderness, or change in level of consciousness, vital signs within normal limits daily for 90 days. The CP interventions included observe for signs and symptoms of infection and to practice good infection control (measures taken to prevent or stops the spread of infections in healthcare settings). During a record review, Resident 71's physician progress notes dated 4/23/2025, indicated, Resident 71 had an indwelling catheter placed on 2/19/2025. During a concurrent observation and interview on 4/29/2025 at 8:33 AM with licensed vocational nurse (LVN) 1, LVN 1 stated the indwelling catheter bag did not have a label which would have indicated when the indwelling catheter bag was last changed. LVN 1 was asked how often the indwelling catheter bag was ordered to be changed and the potential harm to Resident 71 for not labeling the bag, LVN 1 stated monthly or prn (as needed) so we know when the [bag] was last changed, if there may be obstruction, infection, potential for misdiagnose like UTI, or other infection. LVN 1 also stated all of the nurses are responsible for changing the indwelling catheter bag. During a record review, Resident 71's Treatment Administration Record (TAR) for 4/2025, did not indicate when Resident 71's indwelling catheter bag was last changed. During a record review, the facility policy and procedure (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Urinary Catheter Care revised on 1/13/2025, indicated, indwelling catheters or drainage bags are not to be changed on routine, fixed intervals. 45528 b. During a record review, Resident 29's Admission Record indicated the facility initially admitted Resident 29 on 9/26/2023 and readmitted Resident 29 on 2/22/2025 with diagnoses including dependence on renal dialysis (a treatment to clean the blood to stay alive because the kidneys are no longer functioning properly), urinary tract infection (UTI - an infection in the bladder/urinary tract) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a record review, Resident 29's Minimum Data Set (MDS - a standard assessment and care screening tool) dated 3/10/2025, indicated Resident 29 was cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 29 was dependent on staff for toileting, dressing, transfers and person hygiene. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review, Resident 29's COC dated 4/17/2025, at 8:55 P.M., indicated Resident 29 complained of dysuria (painful or uncomfortable urination, often described as a burning and void hesitancy. During a record review, Resident 29's physician order dated 4/17/2025, at 11:08 P.M., the physician's order indicated to collect Resident 29's urine for UA with C&S. During a record review, Resident 29's laboratory UA report dated 4/21/2025 at 4:02 P.M., indicated that the urine sample for Resident 29 was collected on 4/19/2025, at 8:20 A.M. The laboratory UA results indicated that Resident 29's urine sample was cloudy (indicates presence of an infection, blood, pus, protein [normal urine color is pale/light/clear yellow]), white blood cells (WBC - are part of CBC that help fight infections) count was high at greater than 50 (fifty) per high power field (HPF- diagnostic evaluation such as the quantification), (reference range [RR] is zero to two [0-2]), and protein was 3 plus (+) milligrams per deciliter (mg/dL-unit of measurement (RR negative or none)). The UA results indicated the presence of bacteria (RR is none) and moderate mucus (RR is none to few). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/29/2025 at 12:24 P.M., with Registered Nurse Supervisor (RNS) 1, Resident 29's medical chart and the facility antibiotic stewardship binders were reviewed. RNS 1 stated Resident 29 had a COC on 4/17/2025 at 8:55 P.M., for dysuria and voiding hesitancy (having difficulty starting or maintaining a steady flow of urine) and a physician order for urinalysis, culture and sensitivity (C&S -a lab test used to diagnose infections, especially bacterial ones) on 4/17/2025 at 11:08 P.M. RNS 1 stated Resident 29's urine sample was collected on 4/19/2025 at an unknown time as there was no documented evidence indicating the time the urine sample was collected. However, RNS 1 stated there was a lab result of Resident 29's urinalysis indicated that the urine sample was collected on 4/19/2025 and resulted on 4/21/2025 which was positive for bacteria. RNS 1 stated the urine sample for the UA/C&S should have been put in as a STAT (immediately or without delay) order so that the results can be obtained and resident 29's symptoms of dysuria and voiding hesitancy can be treated right away as leaving the symptoms untreated can lead to worsening infection (when the body is invaded by germs [like bacteria or viruses] that cause problems and make you sick) and sepsis (a life-threatening emergency that arises when the body's immune system's response to an infection goes into overdrive, causing damage to vital organs). RNS 1 stated the lab results on 4/21/2025 that were positive for bacteria is a change in the resident's condition and the facility should have initiated a COC and notified the physician, RNS 1 stated there was no documented evidence of a COC or physician notification of the urinalysis that was positive for bacteria. RNS 1 stated facility received Resident 29's C&S lab results on 4/24/2025, and an antibiotic (medicines that fight bacterial infections) Ertapenem (an antibiotic that is used to treat severe infections) 1 gram (GM -unit of measure in weight) intramuscularly (IM - inject medication into a muscle) shot where medication is delivered directly into a muscle, bypassing the skin and fat layers) one time a day for UTI for 7 (seven) days and the first dose of the antibiotic was administered on 4/28/2025, RNS 1 the MAR on 4/26/2025 indicated 9 meaning see progress notes. RNS 1 stated the nursing progress note dated 4/26/2025, at 10:08 P.M., indicated the pharmacist stated Resident 29 was allergic to Penicillin (an antibiotic, a type of medication used to treat bacterial infections) and wanted to confirm if the physician wanted to continue with the order. RNS 1 stated the physician was notified and instructed the facility staff to continue with the order. RNS 1 stated the MAR on 4/27/2025 indicated 9, see progress notes, RNS 1 stated a review of the medication administration note stated medication was not given because it was an intravenous (IV - into or within a vein) however, there was no documented evidence that the physician was notified of the delay in the administration of the antibiotic. RNS 1 stated the facility process for antibiotics is that the antibiotic order should be carried out as soon as the order is given to ensure that treatment is started on time and prevent adverse effects such as sepsis. RNS 1 stated if the nursing staff is not clear with the order, they need to call the physician to clarify the order to prevent a delay in the medication administration time. During an interview with Resident 29 on 4/30/2025, at 1:19 P.M., Resident 29 stated Resident 29 had pain when urinating and difficulty urinating. Resident 29 stated the pain when urinating and difficulty urinating started about two weeks ago and had notified the staff (unidentified). Resident 29 stated that the antibiotics were started three days ago. Resident 29 stated that there was a delay in the process and felt like the antibiotic should have been started/adminsitered to Resident 29 sooner than the facility did. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/2025, at 1:55 P.M., with the medical doctor (MD -a trained healthcare professional who diagnoses and treats illnesses and injuries), the MD stated that UA/C&S order needs to be collected the same day, or the next day of the order being given. MD stated the abnormal labs should be called to the MD 2-3 hours after being received and that an intraIM injection is given as opposed to a by mouth (PO -taking something, like medicine or food, through the mouth and down the esophagus to the stomach) because the resident has a nasty bug that needs to be treated right away because left untreated the resident may become septic. During an interview on 4/30/2025, at 2:10 P.M., with the Director of Nursing (DON), the DON stated that UA/C&S should be a STAT order, the sample needs to be collected within 6 to 8 hours so that intervention may begin early. The DON stated abnormal lab results need to be communicated to the MD right away, as soon as it is available to prevent delays in care and further discomfort which can lead to a systemic infection. The DON stated a COC needed to be initiated upon discovery of the unusual s/s or abnormal lab finding. The DON stated there was about a week that went by between when Resident 29 initially has s/s of the UTI and the time that the antibiotic was given, the DON stated, they was a delay in the care and it is essential that we address the s/s as soon as possible. During a record review, the facility Policy and Procedures (P&P) titled, Medication and Treatment Orders, revised 1/2025, indicated, Orders for medications and treatments will be consistent with principles of safe and effective order writing. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order . During a record review, the facility P&P titled, Change in a Residents Condition or Status revised 1/13/2025, indicated, Our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the residents [NAME]/mental condition and/or status . A significant change of condition is a major decline or improvement in the resident's status that: will not normally resolve itself without interventions by a staff or by implementing standard disease related clinical interventions (is not self-limiting . During a record review of the facility's P&P titled, Abnormal Laboratory value Reporting and Documentation Guideline revised 1/13/2025, indicated, The purpose of this guideline is to ensure that each facility's resident's abnormal laboratory values are identified and reported timely so proper interventions can be implemented . Notify physician of the results as soon as the result is received.

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	055350	A. Building B. Wing	05/02/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528 Based on interview and record review, the facility failed to timely administer Ertapenem (an antibiotic - medication used to treat severe infections) 1 gram (GM -unit of measure in weight) intramuscularly (IM - inject medication into a muscle) antibiotics (medicines that fight bacterial infections) leading to a nine-day delay of medication administration for Resident according to physician's order for urinary tract infection (UTI - an infection in the bladder/urinary tract) dated 4/24/2025. This deficient practice had the potential to result in hospitalization and/or death for Resident 29. Cross Reference F690 Findings: During a record review, Resident 29's Admission Record indicated the facility initially admitted Resident 29 on 9/26/2023 and readmitted Resident 29 on 2/22/2025 with diagnoses including dependence on renal dialysis (a treatment to clean the blood to stay alive because the kidneys are no longer functioning properly), urinary tract infection (UTI - an infection in the bladder/urinary tract) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a record review, Resident 29's Minimum Data Set (MDS - a resident assessment tool) dated 3/10/2025, indicated Resident 29 was cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 29 was dependent on staff for toileting, dressing, transfers and person hygiene. During a record review, Resident 29's COC dated 4/17/2025, at 8:55 P.M., indicated Resident 29 complained of dysuria (painful or uncomfortable urination, often described as a burning and void hesitancy. During a record review, Resident 29's physician order dated 4/17/2025, at 11:08 P.M., the physician's order indicated to collect Resident 29's urine for UA with C&S. During a record review, Resident 29's laboratory UA report dated 4/21/2025 at 4:02 P.M., indicated that the urine sample for Resident 29 was collected on 4/19/2025, at 8:20 A.M. The laboratory UA results indicated that Resident 29's urine sample was cloudy (indicates presence of an infection, blood, pus, protein [normal urine color is pale/light/clear yellow]), white blood cells (WBC - are part of CBC that help fight infections) count was high at greater than 50 (fifty) per high power field (HPF- diagnostic evaluation such as the quantification), (reference range [RR] is zero to two [0-2]), and protein was 3 plus (+) milligrams per deciliter (mg/dL-unit of measurement (RR negative or none)). The UA results indicated the presence of bacteria (RR is none) and moderate mucus (RR is none to few). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/29/2025 at 12:24 P.M., with Registered Nurse Supervisor (RNS) 1, Resident 29's medical chart and the facility antibiotic stewardship binders were reviewed. RNS 1 stated Resident 29 had a COC on 4/17/2025 at 8:55 P.M., for dysuria and voiding hesitancy (having difficulty starting or maintaining a steady flow of urine) and a physician order for urinalysis, culture and sensitivity (C&S -a lab test used to diagnose infections, especially bacterial ones) on 4/17/2025 at 11:08 P.M. RNS 1 stated Resident 29's urine sample was collected on 4/19/2025 at an unknown time as there was no documented evidence indicating the time the urine sample was collected. However, RNS 1 stated there was a lab result of Resident 29's urinalysis indicated that the urine sample was collected on 4/19/2025 and resulted on 4/21/2025 which was positive for bacteria. RNS 1 stated the urine sample for the UA/C&S should have been put in as a STAT (immediately or without delay) order so that the results can be obtained and resident 29's symptoms of dysuria and voiding hesitancy can be treated right away as leaving the symptoms untreated can lead to worsening infection (when the body is invaded by germs [like bacteria or viruses] that cause problems and make you sick) and sepsis (a life-threatening emergency that arises when the body's immune system's response to an infection goes into overdrive, causing damage to vital organs). RNS 1 stated the lab results on 4/21/2025 that were positive for bacteria is a change in the resident's condition and the facility should have initiated a COC and notified the physician, RNS 1 stated there was no documented evidence of a COC or physician notification of the urinalysis that was positive for bacteria. RNS 1 stated facility received Resident 29's C&S lab results on 4/24/2025, and Ertapenem (an antibiotic that is used to treat severe infections) 1 gram (GM -unit of measure in weight) intramuscularly (IM - inject medication into a muscle) shot where medication is delivered directly into a muscle, bypassing the skin and fat layers) one time a day for UTI for 7 (seven) days and the first dose of the antibiotic was administered on 4/28/2025, RNS 1 the MAR on 4/26/2025 indicated 9 meaning see progress notes. RNS 1 stated the nursing progress note dated 4/26/2025, at 10:08 P.M., indicated the pharmacist stated Resident 29 was allergic to Penicillin (an antibiotic, a type of medication used to treat bacterial infections) and wanted to confirm if the physician wanted to continue with the order. RNS 1 stated the physician was notified and instructed the facility staff to continue with the order. RNS 1 stated the MAR on 4/27/2025 indicated 9, see progress notes, RNS 1 stated a review of the medication administration note stated medication was not given because it was an intravenous (IV - into or within a vein) however, there was no documented evidence that the physician was notified of the delay in the administration of the antibiotic. RNS 1 stated the facility process for antibiotics is that the antibiotic order should be carried out as soon as the order is given to ensure that treatment is started on time and prevent adverse effects such as sepsis. RNS 1 stated if the nursing staff is not clear with the order, they need to call the physician to clarify the order to prevent a delay in the medication administration time. During an interview with Resident 29 on 4/30/2025, at 1:19 P.M., Resident 29 stated Resident 29 had pain when urinating and difficulty urinating. Resident 29 stated the pain when urinating and difficulty urinating started about two weeks ago and had notified the staff (unidentified). Resident 29 stated that the antibiotics were started three days ago. Resident 29 stated that there was a delay in the process and felt like the antibiotic should have been started/adminsitered to Resident 29 sooner than the facility did. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/2025, at 1:55 P.M., with the medical doctor (MD -a trained healthcare professional who diagnoses and treats illnesses and injuries), the MD stated that UA/C&S order needs to be collected the same day, or the next day of the order being given. MD stated the abnormal labs should be called to the MD 2-3 hours after being received and that an intraIM injection is given as opposed to a by mouth (PO -taking something, like medicine or food, through the mouth and down the esophagus to the stomach) because the resident has a nasty bug that needs to be treated right away because left untreated the resident may become septic. During an interview on 4/30/2025, at 2:10 P.M., with the Director of Nursing (DON), the DON stated that UA/C&S should be a STAT order, the sample needs to be collected within 6 to 8 hours so that intervention may begin early. The DON stated abnormal lab results need to be communicated to the MD right away, as soon as it is available to prevent delays in care and further discomfort which can lead to a systemic infection. The DON stated a COC needed to be initiated upon discovery of the unusual s/s or abnormal lab finding. The DON stated there was about a week that went by between when Resident 29 initially has s/s of the UTI and the time that the antibiotic was given, the DON stated, they was a delay in the care and it is essential that we address the s/s as soon as possible. During a record review, the facility Policy and Procedures (P&P) titled, Medication and Treatment Orders, revised 1/2025, indicated, Orders for medications and treatments will be consistent with principles of safe and effective order writing. Verbal orders must be recorded immediately in the resident's chart by the person receiving the order . During a record review, the facility P&P titled, Change in a Residents Condition or Status revised 1/13/2025, indicated, Our facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the residents [NAME]/mental condition and/or status . A significant change of condition is a major decline or improvement in the resident's status that: will not normally resolve itself without interventions by a staff or by implementing standard disease related clinical interventions (is not self-limiting . During a record review of the facility's P&P titled, Abnormal Laboratory value Reporting and Documentation Guideline revised 1/13/2025, indicated, The purpose of this guideline is to ensure that each facility's resident's abnormal laboratory values are identified and reported timely so proper interventions can be implemented .Notify physician of the results as soon as the result is received.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455 Based on interview and record review, for two of five sampled residents (Resident 26 and Resident 33), the facility failed to assess the individual needs and food preferences to ensure the menus and/or the resident's food plan met the nutritional needs and preferences for Resident 26. This deficient practice had the potential for insufficient food intake and weight loss for Resident 26. Findings: During a record review, Resident 26's Admission Record indicated Resident 26 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included congestive heart failure (CHF- a weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other body organs), chronic obstructive pulmonary disease (COPD-), atrial fibrillation (Afib-irregular heart beat), peripheral neuropathy (any nerve damage outside of the brain and spinal cord) and repeated falls. During a record review, Resident 26's Minimum Data Set (MDS - a resident assessment tool) dated 01/31/2025, indicated Resident 26's cognition (The mental ability to make decision of daily living) was intact and that Resident 26's required setup for eating and oral hygiene. During a record review, Resident 26 History and Physical examination document dated 7/16/2024, indicated Resident 26 could make decisions. During a record review, Resident 26's Order Summary Report dated 5/2/2025, indicated Resident 26's diet consisted of Fortified (a diet that has had nutrients added to it, either by fortifying foods or using supplements) Regular texture, no added salt (NAS) diet, thin liquids consistency for breakfast, lunch and dinner. During a facility tour and concurrent interview on 4/29/2024 at 8:30 AM, Resident 26 stated she has told the facility staff on numerous times that she (Resident 26) does not like the smell of eggs and sweet foods in the morning but the facility staff still serves her eggs and sweet rolls in the morning, Resident 26 stated she was served a sweet roll today morning and ate it just to keep her from being hungry. During an interview on 5/2/2025 at 8:31 AM Dietary Supervisor (DS) stated, upon admission, she visits every newly admitted resident within 24 hrs. of admission and/or on Mondays if the Resident was admitted on a weekend. DS stated the purpose of her visit to the Residents is to ask about their food preferences, likes and dislikes. DS stated she documents the Residents preferences of the Residents health records; the Residents food preferences likes and dislikes are reflected on the Resident meal tray ticket. During a record review, Resident 26's meal tray ticket dated 5/3/2025 did not indicate Resident 26's food preference dislike of eggs and/or no sweet food in the morning. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review, Resident 26's indicated last nutritional screening was completed on 7/11/2024. During a record review, the facility Dietary Supervisor (DS) Job descriptio, undated, indicated DS responsibilities as Visit patients routinely; maintains carded diet list and diet count to date, Supervises closely that diets are served as prescribed. Visits new patients regarding food likes and dislikes; initiates nutritional assessment and records dietary input into care plan, reviews patient nutritional status quarterly making appropriate progress notes and patient care plan review, informs dietitian of entries for review . During a record review, the facility policy and procedures titled Nutritional Assessment and Patient Care Documentation Charting Guidelines, dated 1/13/2025, indicated . Nutritional updates or Nutritional Progress; Notes to be done on a quarterly basis or more often as the resident condition warrants. Quarterly reviews; Visit Resident to review food preferences.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48026 Based on observation, interview and record review, the facility failed to ensure one of two sampled residents (Resident 66) was served with the correct food portion per facility menu spreadsheet when serving meals to residents on 4/30/2025. This deficient practice had the potential for Resident 66 to suffer unintentional weight loss. Findings: During a record review of Resident 66's admission record (face sheet - a document containing demographic and diagnostic information) indicated, Resident 66 was admitted to the facility on [DATE] and was readmitted on [DATE] with the following diagnoses: hemiplegia (paralysis that affects one side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing), essential primary hypertension (abnormally high blood pressure not caused by a medical condition), and muscle weakness (when muscles are weak causing difficulty performing normal activities that require strength). During a record review, Resident 66's 1's History and Physical (H&P - a physician's complete patient examination) dated 2/13/2025 indicated, Resident 66 has the capacity to understand and make decisions. During a record review, Resident 66's Minimum Data Set (MDS - a resident assessment tool) dated 3/15/2025, indicated, Resident 66 had moderately impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). During a record review, the facility Inservice Meeting Minutes dated 3/17/2025 at 1 PM, indicated, Dietary Aide (DA) participated in the in-service education. During a record review, the facility Spring Cycle Menu Spreadsheet for the week of 4/28/2025, indicated that each resident should receive one half cup of fresh green salad for lunch on 4/30/2025. During a record review, the facility menu for the week of 4/28/2025, the facility served fresh green salad for lunch on 4/30/2025. During an observation in the kitchen on 4/30/2025 at 10:20 AM with the Dietary Supervisor (DS), DA was using one third cup scooper to measure fresh green salad during trayline. DS stated no, it should be the one-half cup scooper wne asked if DA was using the approriate scooper size when plating the salad. DS stated the residents will have weight loss if the wrong scooper size is used to serve food. During a record review, the facility Policy and Procedures (policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Menu Planning undated, indicated, standardized recipes adjusted to appropriate yield shall be maintained and used in preparation.

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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** 45455 Based on observation, interview, and record review, for two of two sampled residents (Resident 19 and Resident 71) the facility staff failed to: 1. Observe infection control measures by failing ensure Certified Nurse Assistant (CNA) 2 put on and use (don) personal protective equipment (PPE- not limited to gowns, and gloves) while providing Activities of daily leaving (ADL- self-care tasks necessary for daily functioning and maintaining independence) to Resident 19 who was on enhanced barrier precaution (EBP- infection control measures that expand the use of PPE, during high-contact resident care activities to reduce the spread of multidrug-resistant organisms (MDROs - These are microorganisms, typically bacteria, that have become resistant to multiple classes of antibiotics). 2. Ensure that an indwelling catheter (a flexible tube that is used to drain urine in the bladder) bag (a device forcollecting urine) was labeled with date and time to indicate the indwelling catheter bag was changed. These deficient practices had the potential to expose other facility Residents and staff to contamination through exposure to disease causing pathogens (germs) from bodily fluids and waste placed resulting in, poor patient outcomes, medical complications, and unnecessary hospitalization , and placed Resident 71 at increased risk of getting a urinary tract infection infection (UTI- is an infection that affects a part of the urinary tract). Cross Reference F690 Findings a. During a facility tour on 4/28/25 at 11:35 AM, there was a sign posted outside Resident 19's room that indicated Residet 19 was EBP and to staff to don PPE prior to entering the room. CNA2 was inside the Resident 19's room and was providing ADL care to Resident19 without donning appropriate PPE (gown). During an interview 4/28/2025 at 11:39AM, CNA2 stated CNA2 was unaware PPE had to be donned (put on PPE) continuously while providing ADL care to a resident on EBP and doffed (remove PPE) only when care was completed. During an interview on 5/2/2025 at 1:10PM, infection prevention nurse (IPN) stated staff should don PPE when they have physical contact with a resident on EBP. IPN stated the facility had sufficient PPEs sufficient and the PPEs are located in areas close to the residents rooms for easy access. IPN stated staff who do not follow enhanced precaution procedures can spread infection to other residents through contamination of their (staff) clothing and hands from residents bodily fluids and waste. During an interview on 5/2/2025 at 3:09 PM, the Director of Nursing (DON) stated staff should don PPE when providing care to Residents on enhanced precautions to prevent transfer of disease-causing microorganisms from staff to facility residents and to break the cycle of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review, the facility policy and procedures (P&P) titled Personal Protective Equipment-Using Gowns dated 1/13/2025, indicated, The Purpose-to guide the use of gowns. Objectives: 1. To prevent the spread of infections 2. To prevent soiling of clothing with infectious material 3. To prevent splashing or spilling blood or body fluids onto clothing or exposed skin and 4. To prevent exposure to Viruses from blood or bodily fluids. 48026 b. During a record review, Resident 71's admission record (face sheet - a document containing demographic and diagnostic information) indicated, Resident 71 was admitted to the facility on [DATE] and was readmitted on [DATE] with the following diagnoses: neuromuscular dysfunction of the bladder (a condition where the nerves and muscles controlling bladder function don't work properly due to damage to the brain, spinal cord, or nerves), history of urinary tract infections (UTIs - a person has previously experienced one or more UTIs), and presence of urogenital implants (the existence of artificial devices or materials within the urogenital system, which includes the urinary and reproductive organs). During a record review, Resident 71's 1's history and physical (H&P - a physician's complete patient examination) dated 1/17/2025 indicated, Resident 71 can make needs known but cannot make medical decisions. During a record review, Resident 71's Minimum Data Set (MDS - a resident assessment tool) dated 1/20/2025 and 3/06/2025, indicated, Resident 71 was cognitively intact (a person's thinking and reasoning abilities are functioning properly and are not significantly impaired). During a record review, Resident 71's Physician Order Summary Report dated 2/19/2025, indicated, Resident 71 had an order for indwelling catheter site care to be done every shift and to change the catheter as needed. The Report also indicated, to insert an indwelling catheter due to a diagnosis of neurogenic bladder. During a record review, Resident 71's care plan (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) on potential for infection, dated 3/11/2025, indicated, Resident 71 had an indwelling catheter. The CP goal indicated Resident 1 will have no signs and symptoms of infection as evidenced by no pain, swelling, tenderness, or change in level of consciousness, vital signs within normal limits daily for 90 days. The CP interventions included observe for signs and symptoms of infection and to practice good infection control (measures taken to prevent or stops the spread of infections in healthcare settings). During a record review, Resident 71's Physician Progress Notes dated 4/23/2025, indicated, Resident 71 had an indwelling catheter placed on 2/19/2025. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/29/2025 at 8:33 AM with LVN 1, LVN 1 stated the indwelling catheter bag did not have a label which would have indicated when the indwelling catheter bag was last changed. LVN 1 was asked how often the indwelling catheter bag was ordered to be changed and the potential harm to Resident 71 for not labeling the bag, LVN 1 stated monthly or prn (as needed) so we know when the [bag] was last changed, if there may be obstruction, infection, potential for misdiagnose like UTI, or other infection. LVN 1 also stated all of the nurses are responsible for changing the indwelling catheter bag. During a record review, Resident 71's Treatment Administration Record for 4/2025, did not indicate when Resident 71's indwelling catheter bag has last been changed. During a record review, the facility Policy and Procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Urinary Catheter Care revised on 1/13/2025, indicated, indwelling catheters or drainage bags are not to be changed on routine, fixed intervals.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 45528 Based on interview and record review, the facility failed to ensure staff consulted with a physician, the Interdisciplinary team (IDT - a group of professionals from different specialties working together to provide care) or the faciity Bioethics committee (a group of individuals, often including doctors, nurses, ethicists, and community members, who help navigate complex moral and ethical questions in healthcare and research) regarding vaccinations for one of five sampled residents (Resident 33) who did not have a resident presentative and did not have the mental ability to make decisions. This deficient practice violated Resident 33's right to be supported and represented supported in making decisions regarding vaccinations and placed Resident 33 at increased risk for in infection and/or hospitalization . Cross reference F552 Findings: During a record review, Resident 33's Admission Record indicated the facility initially admitted Resident 33 on 3/10/2021 and readmitted Resident 33 on 7/30/2023 with diagnoses including adult failure to thrive (a state of decline in older adults characterized by a decline in physical, mental, and social functioning), anemia (not having enough healthy red blood cells to carry oxygen to the body's tissues) and cholelithiasis (the presence of gallstones in the gallbladder). During a record review, Resident 33's History and physical (H&P -a detailed assessment a doctor does to understand a patient's health) dated 11/10/2024, the H&P indicated Resident 33 does not have the capacity (ability to do something) to understand and make decisions. During a record review, Resident 33's Minimum Data Set (MDS - a resident assessment tool) dated 3/17/2025, indicated Resident 33 had moderate cognitive impaiment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 33 was dependent on staff for toileting, dressing, transfers and person hygiene. During a record review, Resident 29's physician order dated 4/17/2025, at 11:08 P.M., the physician's order indicated to collect urine for urinalysis (UA- a laboratory test that examines a urine sample to detect and analyze various substances and conditions) with culture and sensitivity (C&S - a procedure that involves growing bacteria or other microorganisms from a urine sample to identify the specific organism causing an infection and determine its sensitivity to antibiotics [medications used to prevent and treat infection]). (continued on next page)

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	055350	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Culver West Health Center	4035 Grandview Blvd. Los Angeles, CA 90066

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 4/30/2025, at 3:24 P.M., with the Director of Nursing (DON), Resident 33's vaccination consent forms for pneumonia (a shot that protects against several types of pneumococcal bacteria that can cause serious illnesses, including pneumonia, blood infections, and even meningitis), influenza (helps protect you from getting sick with the flu), covid 19 (help our bodies develop immunity to the virus that causes COVID-19 without us having to get the illness) and Resident 33's chart were reviewed. The vaccination consents indicated that Resident 33 refused the pneumonia, influenza and covid 19 vaccinations. The DON stated that Residents 33 had a BIMS score of 10, meaning that Resident 33 was moderately cognitively impaired, and that the H&P indicated that Resident 33 does not have the capacity to understand or make decisions. The DON stated Resident 33 was not able to comprehend rationally to make medical decisions and should not have signed the informed consent for his vaccinations. The DON stated the facility should have consulted with Resident 33's Physician, the Interdisciplinary team (IDT - a group of professionals from different specialties working together to provide care) or Bioethics committee (a group of individuals, often including doctors, nurses, ethicists, and community members, who help navigate complex moral and ethical questions in healthcare and research) regarding Resident 33 vaccinations as Resident 33 did not have a resident presentative. The DON stated adverse effects of not giving Resident 33 pneumonia, influenza and covid 19 vaccinations is that Resident 33 may be at high risk for infections especially due to Resident 33's advanced age, comorbidities that lead to a weakened immune system/infections that may lead to decline in function, sepsis (a life-threatening emergency that arises when the body's immune system's response to an infection goes into overdrive, causing damage to vital organs), and possible hospitalization . During a record review, the facility Policy and Procedures (P&P) titled, Treatment Consent: Non-Routine Service/Care, revised 1/13/2025, indicated, The facility shall obtain a treatment consent for a prescribed treatment and/or medication that is not included in the admission consent for care . During a record review, the facility P&P titled, Bioethics Committee revised 1/13/2025, indicated, It is the policy of this facility to respect and support residents' rights of health care decision making by facilitating bioethics discussions through the formation of an interdisciplinary group called the Bioethics Committee . To assure that residents' preference for care are upheld and provide a forum for discussion should this be indicated by an individual case.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45037 Based on observation, interview and record review, the facility failed to provide at least 80 square feet (sq. ft. -unit of measure) per resident in multiple resident bedrooms for 38 resident rooms. This deficient practice had the potential to result in inadequate useable living space for the residents and working space for the health caregivers. Findings: During a record review, the facility Request for Room Size Waiver letter, dated 5/5/2025, submitted by the Administrator, indicated, there are 38 rooms not meeting the 80 square feet requirement per resident according to federal regulation. This waiver is in accordance with the special needs of the residents. These rooms are utilized for higher acuity residents requiring more care. Also, this waiver is in accordance with special needs of the residents and does not adversely affect the health and safety of the residents or impede the ability of any resident from attaining his or her highest practicable well being. During a record review of the Client Accommodations Analysis submitted by the facility on 5/5/2025, indicated the following rooms with their corresponding measurements: Rooms # total Sq. Ft/Resident # Beds Floor Area Sq. Ft/Resident. room [ROOM NUMBER] is 154 square feet with 1 bed (2 bed room) (77 sq ft per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) Room121 is154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Culver West Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4035 Grandview Blvd. Los Angeles, CA 90066	

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is154.00 square feet 2 beds (77 square feet per resident) room [ROOM NUMBER] is 220.00 square feet 3 beds (73 square feet per resident) room [ROOM NUMBER] is 220.00 square feet 3 beds (73 square feet per resident) room [ROOM NUMBER] is 220.00 square feet 3 beds (73 square feet per resident) room [ROOM NUMBER] is 220.00 square feet 3 beds (73 square feet per resident) room [ROOM NUMBER] is 220.00 square feet 3 beds (73 square feet per resident) room [ROOM NUMBER] is 220.00 square feet 3 beds (73 square feet per resident) (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	room [ROOM NUMBER] is 220.00 square feet 3 beds (73 square feet per resident) room [ROOM NUMBER] is 220.00 square feet 3 beds (73 square feet per resident) The minimum square footage for a 2-bed room should be 160 square feet, and for a 3 bedroom it should measure 240 square feet per federal regulation. During the multiple observations of the residents' rooms from 4/28/2025 to 5/2/2025, the residents had ample space to move freely inside the rooms. There were sufficient spaces to provide freedom of movement for the residents and for nursing staff to provide care to the residents. There was also sufficient space for beds, side tables and resident care equipment. During the recertification Survey on 5/2/2025, staff interviews indicated there were no concerns regarding the size of the rooms.

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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** 45455 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation for one out four sampled Resident (Resident 19) by failing to ensure the resident's call light was in working condition and within reach. This deficient practice had the potential to negatively impact on the psychosocial well-being of the residents or result in delayed provision of necessary and emergent services. Findings: During a record review, Resident 19's admission record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses that included indwelling urethral catheter (flexible tube, that is inserted into the urethra (the tube carrying urine from the bladder) and into the bladder to drain urine or administer fluids) hematuria (blood in the urine), difficulty walking, type II diabetes mellitus (condition in which the body has trouble controlling blood sugar and using it for energy), obstructive and reflux uropathy (blockage in the urinary tract that prevents urine from flowing normally), benign prostatic hyperplasia (an enlarged prostate gland) with lower urinary tract symptoms (frequent urination, including at night, difficulty starting to urinate, slow or weak flow of urine, feeling that the bladder is not fully emptied after urination and leaking urine when the bladder is full or there is a sudden urge to urinate) , cerebral infarction (death of brain tissue due to inadequate blood supply, leading to oxygen deprivation)and Parkinson's disease (progressive neurodegenerative disorder characterized by movement problems, including tremors, stiffness, and slow movements) During a record review, Resident 19's Minimum Data Set (MDS, a resident assessment tool) dated 2/14/2025, indicated Resident 16 had severe cognitive impairment (The mental ability to make decisions of daily living). The MDS indicated Resident 19 required partial moderate assistance with eating, oral hygiene and upper body dressing, and substantial maximal assistance with shower/bathing self, lower body dressing, putting on/taking off footwear and, was dependent for toileting hygiene. During a record review, Resident 19's history and physical dated 4/2/2025, indicated Resident 19 did not have the capacity to understand and make decisions. During a facility tour on 4/28/2024 11:39AM, Certified Nurse Assistant (CNA) 2 was observed providing activities of daily living (ADL) care (cleaning the resident) to Resident 19 at the bedside. CNA2 completed ADL care and left Resident 19 bedside. During an observation on 4/28/2025 at 11:56 AM, Resident 19 was observed moaning and groaning while lying in bed, Resident 19 stated that he was in pain. Resident 19 pressed the call light for assistance, however, the call light was observed not in working order (did not turn on). A call bell was observed on top of Resident 19's bedside drawer and not within reach of Resident 19. During an interview on 4/28/2024 at 12:08 PM, Treatment Nurse (TXN) 1 stated the call bell should be within Residents reach so that the residents can call for assistance or have an emergency. TXN1 stated not having call bell within reach can cause a delay in residents care that results in poor health outcomes for a Resident if have an emergency. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/28/2025 at 12:13 PM, Maintenance Supervisor (MS) 1, stated he (MS1) does not know how long the call light has not been working, MS1 stated nurses will usually indicate in the maintenance log any issues that require repair, or flag down maintenance and report issues when they see them (MS) walking in the hallways. During a record review, the facility Maintenance log indicated a log notification for call light not working in Resident 19's room on 4/15/2025 and 4/28/2025. During an interview on 5/2/2025 at 3:02 PM, Director of Nursing (DON) stated, facility Maintenance log lists any equipment/item that is not working to be addressed by Maintenance Supervisor. DON stated call bells are provided to Residents in rooms where call lights are not working, the call bells are placed at Residents bedside within reach so they can call for our attention. DON stated a Call bell should be within reach; Resident's should be able to access it. DON stated in an emergency, a resident should be able to reach the call light/call bell call for help. During a record review of facility Policy and Procedures (P&P) titled Answering the Call Light dated 1/13/2025 indicated, the purpose of this procedure is to ensure timely responses to the resident's requests. Ensure that the call light is accessible to the resident when in bed.