STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055704	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Angels Nursing Health Center	415 S Union Avenue Los Angeles, CA 90017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851 Based on interviews and record reviews, the facility failed to submit the required complete information contained in the Minimum Data Set (MDS- a standardized data collection tool used to assess cognitive and functional status, and care needs) for four of 13 sampled residents (Resident 2, Resident 29, Resident 32, and Resident 34) within 14 days of initiation to the Centers for Medicare & Medicaid Services (CMS: a federal agency within the United States Department of Health and Human Services) System. This deficient practice had the potential to deny Resident 2, Resident 29, Resident 32, and Resident 34 proper healthcare monitoring to ensure all the necessary care and services were provided. Findings: A review of Resident 2's Admission Record indicated the facility originally admitted the resident on 11/16/2027 and readmitted the resident on 11/27/2023 with diagnoses that included chronic obstructive pulmonary disease (COPD, a lung disease that causes airflow blockage and breathing-related problems), urinary tract infection (infection that happens when bacteria enters the urethra and infects the urinary tract), type 2 diabetes (a condition in which the body maintain high levels of blood sugar), anxiety disorder (persistent and excessive worry that interferes with daily activities), bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and hyperlipidemia (high levels of cholesterol in the blood). A review of Resident 2's MDS dated [DATE], indicated the resident had moderately impaired cognition (ability to make decisions, think, and understand). The MDS indicated Resident 2 required setup or clean up assistance from facility staff for eating, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 2 required supervision or touching assistance for oral hygiene, toileting hygiene, showering/bathing self, upper body dressing and lower body dressing. A review of Resident 29's Admission Record indicated the facility originally admitted the resident 5/22/2020 and readmitted the resident on 5/25/2021 with diagnoses that included hepatic failure (a condition in which liver cells are damaged), atrial fibrillation (when the heart beats irregularly), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), and benign prostatic hyperplasia (an enlarged prostate). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 29's MDS dated [DATE], indicated the resident had severely impaired cognition. The MDS indicated Resident 29 required supervision or touching assistance for eating and was dependent on help for oral hygiene, toileting hygiene, showering/bathing self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. A review of Resident 32's Admission Record indicated the facility originally admitted the resident on 3/11/2021 and readmitted the resident on 3/14/2022 with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness to one side of the body) , chronic obstructive pulmonary disease, gastrostomy (a tube that is inserted through the belly to bring nutrition into the stomach), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability), and benign prostatic hyperplasia. A review of Resident 32's MDS dated [DATE], indicated the resident had severely impaired cognition. The MDS indicated Resident 32 was dependent on facility staff for help for eating, oral hygiene, toileting hygiene, showering/bathing self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. A review of Resident 34's Admission Record indicated the facility originally admitted the resident on 6/24/2022 and readmitted the resident on 1/24/2023 with diagnoses that included congestive heart failure (a weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs), type 2 diabetes, chronic pulmonary edema, adult failure to thrive, chronic kidney disease, bipolar disorder (a mental disorder that causes dramatic shifts in a person's mood or energy, and may affect the ability to think clearly), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily life). A review of Resident 34's MDS dated [DATE], indicated the resident had severely impaired cognition. The MDS indicated Resident 34 was dependent on facility staff for help with oral hygiene, toileting hygiene, showering/bathing self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. During a concurrent interview and record review, on 4/29/2024 at 10 AM, the facility's Batch Report (electronic report of MDS submissions to the CD) document was reviewed with the Minimum Data Set Nurse (MDSN). The MDSN stated Resident 2's last quarterly MDS assessment was dated 3/11/2024. The MDSN stated she submitted Resident 2's MDS assessment on 4/28/2024. The MDSN stated there had been a delay in the submission of the assessment because she had been busy with admissions lately. The MDSN stated Resident 2's MDS assessment was opened on 3/11/2024 but it was not submitted until 4/28/24. The MDSN stated Resident 29's MDS assessment was opened on 3/20/2024 but was submitted to CMS on 4/28/2024. The MDSN stated there was a delay in the submission of Resident 29's MDS assessment. The MDSN stated Resident 32's MDS assessment was opened on 3/21/2024 but was submitted to CMS on 4/24/2024. The MDSN stated there was a delay in the submission of Resident 32's MDS assessment. The MDSN stated Resident 34's MDS assessment was opened on 3/21/2024 but stated it was submitted to CMS on 4/24/2024. The MDSN stated there was a delay in the submission of Resident 34's MDS assessment. The MDS stated the facility had only 14 days from the time of opening and initiating the assessment to submitting the assessment to CMS. The MDSN stated the potential outcome of not submitting MDS assessment on time is a delay of care for the residents. (continued on next page)

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/30/2024 at 1:30 PM, the Administrator stated the MDS assessments should not be opened for more than two weeks and was required to be submitted with 14 days to CMS. The Administrator stated there was a potential for delay in care for the residents if the MDS assessments were not submitted timely. A review of the facility's policy and procedure titled, Minimum Data Set (MDS) Assessment Schedule reviewed 1/18/2024, indicated The facility shall adhere to Resident Assessment Instrument (RAI) Manual assessment schedules as required by federal and state agencies Minimum Data Set (MDS) provides a core set of screening, clinical and functional status elements that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare and Medicaid. MDS Assessment timing schedule will be completed per attachment A. Admission Assessment, Transmission Date: Care Plan Completion date + 14 calendar days, Annual Assessment, Transmission Date, Transmission Date: Care Plan Completion date + 14 calendar days, Significant Change in Status Assessment, Transmission Date: Care Plan Completion date + 14 calendar days Quarterly Assessment, Transmission Date: Care Plan Completion date + 14 calendar days.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851 Based on interview and record review, the facility failed to develop a resident centered comprehensive care plan (a document outlining a detailed approach to care customized to an individual resident's need) for three of 13 sampled residents (Resident 9, Resident 13, and Resident 28) as evidenced by: 1. Failing to develop a care plan for Resident 9's gastrostomy tube (G-tube: a surgical procedure to insert a tube through the abdomen and into the stomach used for feeding, usually via a feeding tube) and tube feeding (TF, a liquid form of food that's carried through your body through a G-tube). 2. Failing to develop a care plan with goals and interventions for pain for Resident 13's post-surgery left hip pain. 3. Failing to develop a care plan for Resident 28's antipsychotic [a type of medication primarily used to manage psychosis (when people lose some contact with reality) principally in schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly)] and antidepressant medication [medication used to treat depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily life)]. These deficient practices had the potential to for the residents to receive inadequate care which could affect the resident's quality of care and cause resident harm. Findings: 1. A review of Resident 9's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included severe protein-calorie malnutrition (when the body doesn't get enough nutrients caused by a poor diet, digestive conditions, or another disease), gastrostomy (also known as G-tube, a tube inserted through the belly that brings nutrition directly to the stomach), type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) and adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability). A review of Resident 9's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 3/30/2024, indicated the resident had moderately impaired cognition (the ability to think, understand, and make decisions). The MDS indicated Resident 9 required partial/moderate assistance from facility staff with showering/bathing, upper body dressing, and personal hygiene. The MDS indicated Resident 9 required substantial/maximal assistance with oral hygiene, toileting hygiene, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 9 was dependent on help for eating. The MDS indicated Resident 9 had a feeding tube and was on a therapeutic diet (a meal plan that controls the intake of certain foods or nutrients and is part of the treatment of a medical condition). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 9's physician order dated 1/5/2024 indicated the resident was to receive Glucerna 1.5 (a type of tube feeding formula used for individuals with type 2 diabetes) at 70 milliliters (ml) per hour (hr) via g-tube pump two times a day. A review of Resident 9's undated care plan indicated the resident had a g-tube. The care plan did not address Resident 9's tube feeding of Glucerna 1.5. During a concurrent interview and record review on 4/27/2024 at 1:57 PM, Resident 9's undated care plan was reviewed with the Minimum Data Set Nurse (MDSN). The MDSN stated Resident 9 had a g-tube and was receiving tube feeding of Glucerna 1.5. The MDSN stated Resident 9's care plan did not indicate the type of tube feeding the resident was receiving. The MDSN stated that care plans needed to be resident specific and stated Resident 9's was not specific. The MDSN stated Resident 9's care plan should have indicated what kind of tube feeding the resident was receiving. The MDSN stated there was a potential for the resident to not receive adequate care if the care plan was not resident specific. During a concurrent interview and record review on 4/28/2024 at 1:49 PM with Registered Nurse (RN) 1, Resident 9's undated care plan was reviewed. RN 1 stated Resident 9's care plan should have been resident specific and should have addressed the type of tube feeding the resident was receiving. RN 1 stated not having a specific care plan may affect the resident's quality of care. 2. A review of Resident 13`s Admission Record indicated the facility originally admitted the resident on 9/16/2014, and readmitted on [DATE], with diagnoses including pain in left hip, chronic pain syndrome (occurs when pain remains long after an illness or injury has healed), and lack of coordination (not able to move different parts of the body together well or easily). A review of Resident 13's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 2/7/2024, indicated that the resident had intact cognition (decisions consistent/reasonable). The MDS indicated Resident 13 was dependent on facility staff (helper does all the job) for showering. The MDS indicated that Resident 13 required partial/moderate assistance (helper does less than half the effort) with personal hygiene, toileting hygiene, dressing upper and lower body, and oral hygiene. The MDS indicated Resident 13 almost constantly experienced pain, occasionally pain made it hard for him to sleep at nights, and the pain frequently limited Resident 13 `s day-to-day activities.  A review of Resident 13's History and Physical dated 2/2/2024, indicated the resident does not have the capacity to understand and make decisions.  A review of Resident 13`s Physician orders dated 3/15/2024, indicated to administer Tylenol (pain medication) oral tablet 325 milligrams (mg - a unit of measure for mass), two tablets by mouth two times a day for pain management related to chronic pain syndrome. During a concurrent observation and interview on 4/28/2024 at 6:00PM, inside Resident 13`s room, Resident 13 was observed sitting on his bed. Resident 13`s left leg appeared to be swollen. Resident 13 stated he used to be able to walk. The resident stated he was involved in an accident and his left leg was injured and experienced pain since the accident. Resident 13 stated that he tripped and fell in the facility and underwent surgery to his left hip. Resident 13 stated the pain to the left leg had improved but was still taking pain medication every day. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 13`s Care Plans on 4/29/2024 at 12:19 PM, indicated there was no individualized person-centered care plan for Resident 27`s pain which includes measurable objectives, monitoring, and a timetable to meet resident`s needs.  During a concurrent interview and record review on 4/30/2024 at 11:20 AM, with the Director of Staff Development (DSD), Resident 13`s care plans were reviewed. The DSD stated that licensed staff did not initiate a person-centered care plan for Resident 13`s pain. The DSD stated Resident 13 had chronic pain and staff were required to develop a care plan with interventions and measurable goals for the resident's pain. The DSD stated the potential outcome of not initiating a care plan for pain was lack of care and inability to deliver necessary interventions to manage resident`s pain. 3. A review of Resident 28's Admission Record indicated the facility originally admitted the resident on 12/8/2020 and readmitted the resident on 1/3/2024 with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), paranoid schizophrenia, and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily life). A review of Resident 28's MDS dated [DATE], indicated the resident had moderately impaired cognition. The MDS indicated Resident 28 required supervision or touching assistance with eating and required substantial/maximal assistance for oral hygiene, toileting hygiene, showering/bathing self, upper body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 28 was dependent on help for lower body dressing. The MDS indicated Resident 28 was taking antipsychotic and antidepressant medication. A review of Resident 28's physician order dated 4/5/2024, indicated the resident was to receive Remeron (antidepressant medication) 15 milligram (mg) 1 tablet by mouth at bedtime for depression manifested by loos of appetite. A review of Resident 28's physician order dated 4/5/2024, indicated the resident was to receive Risperdal (antipsychotic medication) 0.25 mg, 1 tablet by mouth two times a day for paranoid schizophrenia, due to resident stating people were out to get her. A review of Resident 28's care plan indicated the resident did not have a care plan for Remeron or Risperdal. During a concurrent interview and record review on 4/27/2024 at 5:33 PM, Resident 28's care plan was reviewed with RN 1. RN 1 stated Resident 28 was on Remeron and Risperdal and verified there was no care plan for either medication in the resident's chart. RN 1 stated Resident 28 needed a care plan for both Remeron and for Risperdal. RN 1 stated care plans are formulated to prevent unwanted effects and are formulated to ensure residents have appropriate interventions. RN 1 sated Resident 28 could have abnormal side effects that were not monitored due to there being no care plan for antipsychotic or antidepressant medication. RN 1 stated there was a potential to affect Resident 28's overall well-being. During an interview on 4/30/2024 at 1:30 PM, the Administrator stated care plans were important documentation and an important part of care. The Administrator stated there was a potential for non-personalized care if care plans were not developed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Comprehensive Plan of Care, reviewed 1/18/2024, indicated It is the policy of this facility to provide each resident with a comprehensive plan of care developed that includes, goals, measurable objectives and timetables to meet their medical, nursing, mental, psychosocial needs identified during comprehensive assessment. The comprehensive care plan must describe services that are provided to the resident to attain or maintain the resident's highest physical, mental, and psychosocial well-being. The comprehensive plan of care will include: address the resident's individual needs, strengths, and preferences; reflect current standards of professional practice; include treatment goals with measurable objectives' reflect interventions to meet both short and long-term resident goals. Develop goals and approaches for each problem and/or condition that are realistic, specific, measurable, and include interventions/approaches that related to each stated long or short term goal.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on interview and record review, the facility failed to identify and ensure one of three sampled residents (Resident 43), who had difficulty swallowing and was at risk for aspiration (accidentally inhaling your food or liquid into your airway), received necessary care and services in accordance with professional standards of practice by failing to: -Follow the Physician's Order dated [DATE], for Resident 43 to receive a pureed diet (food has been ground, pressed, and/or strained to a soft, smooth consistency, like a pudding). - Assess for tolerance of diet, per the Alteration in Oral / Dental Status care plan dated [DATE]. - Develop comprehensive person-centered Dysphagia (difficulty swallowing) care plan, per the facility's Comprehensive Plan of Care policy. -Monitor Resident 43 for any changes in condition and inform the physician, per the Activities of Daily Living care plan dated [DATE]. -Perform assessments consistently and accurately, during each shift or Resident 43's change in condition and report to physician timely. As a result, on [DATE] at 12:38 AM, after eating a regular food brought in by the family, Resident 43 became congested, had difficulty breathing, and cyanotic (blue- indicating reduced blood oxygen levels). Resident 43 became unresponsive, required cardiopulmonary resuscitation (CPR - medical intervention used to restore circulatory and/or respiratory function that has stopped) and at 1 AM, Resident 43 was pronounced dead (nine days after his admission). On [DATE] at 8:11 PM, an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the Administrator (ADM), regarding the facility's failure to identify and ensure Resident 43, who had difficulty swallowing and was at risk for aspiration, received necessary care and services in accordance with professional standards of practice. On [DATE] at 1:12 PM, while onsite at the facility, the IJ was removed in the presence of the ADM, after the ADM submitted an acceptable Removal Plan (interventions and implementation to correct the deficient practices) which was verified and confirmed through observation, interview, and record review. The acceptable removal plan was as follows: On [DATE], the Minimum Data Set (MDS) nurse reviewed the diet orders of all current residents (42) to determine if their diet texture and fluid consistency needed to be clarified with the physician. 39 residents needed clarification of their diet orders. The MDS completed the clarification of diet orders on the same day. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Starting [DATE], the Nurse Consultant provided an in-service to 6 Interdisciplinary Team (IDT - a group of healthcare professionals from different disciplines [nurses, social worker, therapist, physician, etc.] that provide care for the residents) members to inform the resident's family, during the initia1 IDT meeting and subsequent IDT meetings as needed, about the resident's prescribed diet order and the facility's policy on Food for Resident from Outside Sources. The resident's family will be asked to sign a form acknowledging that they have received this information. The DON was the remaining IDT member who will be provided with an in-service by the Nurse Consultant upon their return to work. Starting [DATE], the IDT reviewed 36 current residents who were on a therapeutic diet and informed their family members via telephone conversation about the resident's prescribed diet order and the facility's policy on Food for Resident from Outside Sources. The information was provided using the family members' native language. The IDT members documented in the resident's chart that the family has been informed. The consultant provided an in-service to RNs, Licensed Vocational Nurses, Certified Nursing Assistants and Restorative Nurse Aides (60% of staff) regarding the facility's policy on Food for Resident from Outside Sources and the different diet textures available in the facility. The in-service emphasized the following: o Diet orders will be printed daily by the licensed nurse and will be made available as a reference at the nurses' station. o Food brought in by family from outside sources must be consistent with the resident's prescribed diet; o Food brought in by family from outside sources should be shown to the licensed nurse for evaluation if it matches the resident's prescribed diet. o The licensed nurse must be notified if the resident is observed to be eating food that does not match the diet order or when the family is observed to have brought in food for the resident that is different from the diet order. o The licensed nurse will check on residents who have food brought in by family every two hours and as needed; and, o The licensed nurse will record both the evaluation of the food brought from outside and the q2 hour visual checks in a log that will be submitted to the DON or designee for further review. Licensed nurses and CNAs were asked questions at the end of the in-service to evaluate their knowledge of the information provided in the in-service. In-services will be completed for all the active nursing staff by the Nurse Consultant on or before [DATE]. Staff who were currently on vacation or on leave will be provided the in-service upon their return to work. (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Starting [DATE], the Nurse Consultant checked competencies of two RNs, eight LVNs, and 16 CNAs in identifying different diet textures by presenting them with different sample meal trays and asking them to correctly identify different diet textures and fluid consistencies. Competency evaluations will be performed by the Nurse Consultant and completed for all active nursing staff by [DATE]. Staff who were currently on vacation or on leave will have their competencies evaluated upon their return to work. On [DATE], the Nurse Consultant provided a one-to-one in-service with CNA 1 regarding the facility's policy on Food for Resident from Outside Sources, emphasizing the importance of reporting to the licensed nurse when the resident was observed to be eating food that was different from the diet order. At the end of the in-service, the CNA was asked questions to evaluate his knowledge about the information provided to him and was able to answer questions correctly. On [DATE], the Nurse Consultant provided an in-service to 15 CNAs and two RNAs (50%) regarding the importance of immediately reporting to the licensed nurse any observed changes in the resident's condition and acting upon any actions that do not match the facility's policy on Food for Resident from Outside Sources. The Nurse Consultant would complete the in-service for all the active CNAs and RNAs by [DATE]. Staff who were currently on vacation or on leave will be provided the in-service upon their return to work. Starting [DATE], the Nurse Consultant provided an in-service to 2 RNs and 8 LVNs (60%) regarding the facility's policy on Change of Condition. The in-service addressed the importance of identifying significant changes in condition, performing a timely assessment, providing appropriate interventions, and immediately notifying the physician of a resident's change in condition. The in-service also addressed notifying the alternate physician or the medical director of the changes in condition within a two -hour timeframe if unable to contact the primary physician, except during medical emergencies. A post-test was given to evaluate the staff's knowledge about the information they received. Passing score was three out of three Licensed nurses who did not pass will be asked to attend the in-service and take the posttest again. The Nurse Consultant will complete the in-service and post-test for all of active licensed nurses by [DATE]. Staff who were currently on vacation or on leave will be provided the in-service and post-test upon their return to work. Starting [DATE], the Medical Records staff will conduct changes in condition audits daily Monday through Friday, five times a week to identify changes in condition, determine completeness of documentation, and determine if physician notification had occurred. On Mondays, the audit will cover changes in condition that occurred during the weekend. The DON or RN designee will review the audits daily five times a week to review the timeliness and appropriateness of the assessment and interventions in response to the change in condition. RN 2 was dismissed from facility and no longer an employee of the facility since [DATE]. Starting [DATE], the Director of Nursing (DON) or Director of Staff Development (DSD) would evaluate licensed nurses' competencies related to identifying, managing, and notifying the physician, alternate physician, or medical director of any changes in condition upon hire and annually. (continued on next page)

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Angels Nursing Health Center	415 S Union Avenue Los Angeles, CA 90017

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], the Nurse Consultant provided a one-to-one in-service with the Administrator regarding the statute on Reporting Unusual Occurrences, emphasizing the definition of an unusual occurrence and the requirement to report unusual occurrences to the state survey agency within 24 hours of the incident. Starting [DATE], the Nurse Consultant provided in-service to 48 facility staff (60%) regarding the statute on Reporting Unusual Occurrences, emphasizing the definition of an unusual occurrence, the importance of reporting unusual occurrences to the Administrator, the requirement to report unusual occurrences to the state survey agency within 24 hours of the incident, and to report to the state survey agency unusual occurrences that constitute abuse within 2 hours of the incident. The Administrator will review changes of condition during the stand-up meeting daily five times a week to identify abuse, suspicious deaths, major injuries, and other types of unusual occurrences and ensure that they are reported timely. The outcome of the review will be recorded in the stand-up meeting minutes. Findings: A review of Resident 43's Admission Record indicated the facility admitted the resident on [DATE], with diagnoses including but not limited to history of stroke, adult failure to thrive, repeated falls and presence of cardiac pacemaker. A review of Resident 43's Admission Assessment, dated [DATE], indicated the resident was admitted with a regular heartbeat and a strong pulse. The Admission Assessment indicated Resident 43 did not have a cough, breath sounds were clear, and was not receiving respiratory therapy. A review of Resident 43's Nursing Progress Notes, dated [DATE], indicated Resident 43 was awake, alert and oriented to name. Resident 43 was able to make his needs known, responsive to all stimuli, had no complaints of pain or discomfort and his breathing was even and unlabored. According to a review of the Physician's Order Summary Report, dated [DATE], Resident 43 was to receive a pureed diet, speech therapy (ST), physical therapy (PT) and occupational therapy (OT) evaluations. A review of Resident 43's Alteration in Oral / Dental Status care plan initiated [DATE], indicated the resident did not have teeth and the goal was for Resident 43 to not have unrecognized signs and symptoms of oral or dental problems daily. The care plan interventions indicated to provide the diet as ordered and monitor percentage of intake, ensure good oral hygiene and for staff to assess for tolerance of prescribed diet. A review of the Activities of Daily Living (ADLs -essential and routine activities include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet) care plan, dated [DATE], indicated Resident 43 required limited assistance with eating and the interventions included to monitor the resident for any changes in condition and inform physician. A review of the Nursing Progress notes, dated [DATE], indicated Resident 43 was able to make his needs known, responsive to all stimuli, there were no significant changes, was calm and compliant, denied pain or discomfort, and the resident's breathing was even and unlabored. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 43's Admission Interdisciplinary Team (IDT) conference record dated [DATE], indicated Resident 43's diagnoses, physical therapy and the resident's pain were discussed. The IDT conference record indicated Resident 43's diet and diet texture was not mentioned. According to a review of the Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated [DATE], Resident 43 had moderate cognitive impairment (problems with a person's ability to think, learn, remember, use judgement) and required setup or clean up assistance with eating. The MDS indicated the resident had a mechanically altered diet (required change in texture of food or liquids [pureed food, thickened liquids]) and did not have a problem with vomiting. The MDS indicated Resident 43 had complaints of difficulty or pain with swallowing and had no natural teeth or tooth fragments. A review of the Speech-Language Pathologist (SLP) Evaluation and Plan of Treatment, dated [DATE], indicated Resident 43's oral motor (movements of the muscles in the mouth, jaw, tongue, lips and cheeks) structure and function was impaired. The SLP evaluation indicated a recommendation for Resident 43 to receive pureed food. A review of the Physician's Order, dated [DATE], indicated Resident 43 was to receive Speech Therapy (ST) three times a week for dysphagia (difficulty swallowing) and the treatment included diet assessment, compensation strategies (learning new ways to perform tasks in an alternative manner) and resident / caregiver education. A review of the Skilled ST care plan dated [DATE], indicated the goals for Resident 43 included to demonstrate improved oral motor strength for functional swallowing, the progression of his diet and for Resident 43 to tolerate his diet without signs and symptoms of aspiration. The care plan interventions included safe swallowing strategies, ongoing assessment of swallow efficiency and skilled ST evaluation and treatment. A review of the Nutritional Assessment, dated [DATE], indicated Resident 43's current diet order was a mechanically altered diet, pureed with regular consistency liquids due to dysphagia. A review of the Nutritional Assessment, dated [DATE], indicated Resident 43's current diet order was a mechanically altered diet (foods that can be safely and successfully swallowed) pureed with regular consistency liquids (no chewing required) due to dysphagia. According to a review of the Situation, Background, Assessment, Recommendation (SBAR - a technique that can be used to facilitate prompt and appropriate communication between the different disciplines caring for the resident) dated [DATE] at 11:21 PM, it was reported by the prior shift (,d+[DATE] PM staff) that Resident 43 vomited a large amount of undigested food (around 5PM). At 12:38 AM, on [DATE], Resident 43 had congestion which worsened, manifested by an acute change in the resident's level of consciousness (LOC), shallow and labored breathing with cyanotic nail beds and cold, clammy skin. The SBAR indicated code blue (a person is in need of immediate medical attention) was announced, 911 (a telephone number used to reach emergency medical, fire, and police services) was called and pulmonary resuscitation CPRP with high flow oxygen support through ambu bag (a device used to provide respiratory support to patients in emergency situations) was initiated, while active chest compression were performed by a trained support staff. At 12:55 AM, paramedics arrived and assumed care. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 43's Certificate of Death indicated the resident expired on [DATE] at 1 AM, with the cause of death as acute cardiopulmonary arrest (the heart and lungs suddenly and unexpectedly stop working), with acute myocardial infarction (heart attack). The Certificate of Death indicated Resident 43 passed away at the facility. During an interview on [DATE] at 10:21 AM, Registered Nurse 1 (RN 1) stated on [DATE], RN 1 worked the 11 PM to 7 AM shift, and the prior shift nurse, Registered Nurse (RN) 2, told RN 1 that during the 3PM to 11 PM shift, Resident 43 had eaten foods with a regular texture including a tortilla, and subsequently vomited a large amount of undigested food. RN 1 stated Resident 43 later became congested with difficulty breathing. After review of Resident 43's electronic chart, RN 1 stated RN 2 had not documented any progress notes, had not completed an SBAR and had not notified the primary physician regarding any of these changes of condition for the resident (eating regular textured food, vomiting). RN 1 stated he left a message for the primary physician due to Resident 43's congestion and difficulty breathing, the resident became more congested and then was unresponsive around 12:38 AM, on [DATE]. RN 1 stated he started CPR, called emergency services and the paramedics took over the CPR upon their arrival. Resident 43 was pronounced dead several minutes later. RN 1 further stated Resident 43's congestion may have resulted from the resident ingesting regular textured foods. During an interview on [DATE] at 12:06 PM, the Registered Dietician (RD) 1 stated Resident 43 was on a pureed diet and if Resident 43 received a regular texture while prescribed a puree diet, this would make the resident at risk for aspiration or choking. During an interview on [DATE] at 12:53 PM, the Dietary Supervisor (DS) stated a pureed diet was to be creamy soft, as it was placed in a food processor to have a smooth texture with no pieces inside of it. The primary physician did not respond to requests for interview. RN 2 did not respond to voicemail requests for interview. During a phone interview on [DATE] at 4:35 PM, Certified Nursing Assistant 1 (CNA) 1 stated he saw from outside the room that the family brought in food for Resident 43. CNA 1 stated he saw Resident 43 eating the food and did not attempt to stop the resident. CNA 1 stated he did not enter the room because he was busy. CNA 1 further stated Resident 43 then vomited about 30 minutes later and that was when he notified RN 2 that Resident 43 had eaten the wrong texture food. During an interview on [DATE] at 11:03 AM, the Director of Staff Development (DSD) stated the facility policy indicated that food brought in by family should be shown to the charge nurse or RD prior to giving it to the resident. The DSD stated when CNA 1 knew Resident 43 was eating the wrong diet, he should have gone in and reminded the resident and his family that the resident was eating the wrong food. Resident 43 had difficulty swallowing, choking could be very imminent, and the food could go to the lungs. The DSD stated RN 2 should have assessed the resident once Resident 43 vomited and should have notified the physician. The DSD stated if the resident's doctor was not responding, staff can contact the physician's alternate physician or the medical director. The DSD also stated there was a delay in care after the resident was found to have eaten the wrong type of food, after the resident vomited, and also when the resident was found to be congested. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:29 PM, the Medical Director (MD) stated she was not aware of Resident 43's death in the facility and the primary physician should be notified of all changes in condition. The MD further stated she was always available if staff were unable to contact the primary physician. During a phone interview on [DATE] at 12:26 PM, Family Member (FM) 1 stated he called the facility and received permission to bring in food for Resident 43. FM 1 stated he brought in chicken quesadillas for Resident 43, and no one educated him on any special diet or texture that Resident 43 was to receive. A review of the facility's Certified Nursing Assistant (CNA) Job Description, undated indicated essential responsibilities and job functions were to ensure that any change in resident condition or unusual circumstances was reported immediately to the charge nurse. A review of the facility's Registered Nurse (RN) Job Description, undated, indicated the RN was under the general supervision of the Director of Nursing. The Registered Nurse performs a variety of resident care functions and closely observes residents for changes in medical status. Consistently and accurately performs reassessments during each shift and when the resident condition changes and reports all abnormal test results to physician in a timely manner; triages activities based on borderline and/or abnormal and/or unusual findings. A review of the facility's policy and procedure (P&P) titled, Change of Condition, reviewed [DATE], indicated to promptly notify the resident, his or her Attending Physician, and representative (sponsor), of changes in the resident's medical/mental condition and/or status. Under 'Procedure,' the P&P indicated acute medical changes or any sudden or serious change in condition manifested by a marked change in physical, mental and psychosocial status: -a Licensed Nurse will notify the physician, -If unable to contact attending physician or alternate physician, notify the Medical Director, -Notify and inform legal surrogate for any change of condition. -Using the Interact Tool SBAR - notify physician for all signs and symptoms manifested by the patient. The form will be used to initiate change of condition documentation for any decline or improvement. The P&P also indicated nurses notes would record information relative to changes in the resident's medical/mental condition or status. A review of the facility's P&P titled, Comprehensive Plan of Care, reviewed [DATE], indicated to provide each resident with comprehensive plan of care that includes goals, measurable objectives, and timetables to meet their medical, nursing, psychosocial needs identified during comprehensive assessment. The comprehensive care plan would address resident's needs, strengths, and preferences, would include treatment goals with measurable objectives, interventions to prevent avoidable decline in function or functional level and would be periodically reviewed and revised by the IDT team as changes in the resident's care and treatment occur. The comprehensive care plan was required to be maintained in the resident's current chart.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview and record review, the facility failed to ensure three of four sampled residents (Residents 13, 29, and 36) received care and services necessary to prevent accidents and falls by failing to: -Assess Resident 13 accurately for a high fall risk on 11/3/2023. - Identify measures and interventions for risk for falls prior to Resident 13's fall on 1/20/2024. -Complete the Fall Risk Assessments quarterly for Residents 29 and 36, per facility policy. As a result, Resident 13 had a witnessed fall on 1/20/2024, was transferred to the General Acute Care Hospital (GACH) 1 and sustained an acute (new) left femoral neck fracture (hip fracture) and placed Resident 29 and 36 at increased risk for recurrent falls. Findings: A review of Resident 13's Admission Record (face sheet) indicated the facility admitted the resident on 9/16/2014, with diagnoses including fracture of left femur (thigh bone), personal history of traumatic healed fracture (occurs when significant or extreme force is applied to a bone), pain in left hip, chronic pain syndrome (occurs when pain remains long after an illness or injury has healed), schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), and lack of coordination (not able to move different parts of the body together well or easily) and muscle weakness. A review of Resident 13's History and Physical (H&P) dated 2/26/2020, indicated the resident could make needs known but could not make medical decisions. The H&P indicated Resident 13 required Physical Therapy (PT- certain exercises, massages, and treatments that relieve pain and help you move better), and Occupational Therapy (OT-therapy that focuses on helping people do all the things that they want and need to do in their daily lives) due to potential for falls. A review of Resident 13's Physical Therapy (PT) Evaluation and Plan of Treatment dated 3/5/2023, indicated the resident exhibited knee instability which was associated with the underlying causes of muscle weakness and reduced functional activity tolerance. The PT evaluation indicated Resident 13 had reduced quad (a group of muscles in our front thigh that support activities such as standing, walking, climbing, and running) strength and felt unsteady when walking. A review of Resident 13's Pain assessment dated [DATE], indicated the resident had pain to his bilateral (both) knees and he thought the chronic pain syndrome and osteoarthritis (a joint disease, in which the tissues in the joint break down over time) were the causes of his pain. The pain assessment further indicated Resident 13 was feeling sharp pain to his knees. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 13's Minimum Data Set (MDS- standardized assessment and care planning tool) dated 11/3/2023, indicated the resident had moderately impaired cognition (problems with a person's ability to think, learn, remember, use judgement), required facility staff set up or clean up assistance with putting on taking off footwear and toilet transfer. The MDS indicated Resident 13 required partial assistance for mobility and ambulation (walking from room to room). According to a review of the Fall Risk assessment dated [DATE], Resident 13 had never fallen, had more than one diagnoses, was not using ambulatory aids (wheelchairs, walkers, canes, and crutches), and exhibited normal gait (the pattern that you walk). The fall risk assessment indicated Resident 13 had a score of 15 and a score from 1 - 24 indicated a low risk for falls. A review of Resident 13's Situation Background Assessment and Recommendation Form (SBAR - a form that was a documentation of a complete assessment in response to a change in condition) dated 1/20/2024, indicated Resident 13 had pain to his left leg due to a witnessed fall while ambulating in the hallway, near the nurse's station. The SBAR form indicated Resident 13 fell on his left side. A review of Resident 13's left hip X-Ray result dated 1/20/2024, indicated there was no acute fracture or dislocation of Resident 13's left hip. According to review of the Post Fall assessment dated [DATE], Resident 13 went to smoke in the patio and while returning back to his room, he attempted to ambulate independently, tripped while wearing slippers, and fell on the floor on 1/20/2024. Resident 13 was found on the floor in the hallway next to the nurse's station. A review of Resident) Post Event / Fall Assessment Form dated 1/22/2024, indicated the following factors contributed to Resident 13's current fall: improper use or failure to use assistive device, mobility issues, taking psychoactive (medications that affect the brain) anti-hypertensive medications (used to treat high blood pressure), and diagnoses of schizophrenia and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). A review of Resident 13's Fall Event / Interdisciplinary Team (IDT, health care professionals who work together to establish plans of care for residents) Progress Note dated 1/22/2024, indicated the root/cause analysis (technique that helps people answer the question of why the problem occurred in the first place) of the resident's fall on 1/20/2024, was improper use of footwear, impulsiveness, and unsteady gait. The IDT progress note indicated that on 1/24/2024, during rounds, Resident 13 reported to Social Service Director (SSD) and Activity Director (AD) that he had pain to his left leg rating 6-7 out of 10 (using pain rating scale of zero being no pain and 10 being the worst pain possible) when trying to get up. The IDT progress note indicated a registered nurse on duty notified Resident 13's physician and received an order for left pelvis (lower part of the trunk, between the abdomen and the thighs) X-Ray. A review of Resident 13's left hip X-Ray result dated 1/24/2024, indicated an acute left femoral neck fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 13's SBAR Communication Form dated 1/24/2024, indicated the resident complained of left hip pain 8/10, and the staff noted a swelling (an abnormal enlargement of a part of the body) to Resident 13 left hip. The SBAR communication form indicated Resident 13's physician ordered to transfer the resident to GACH 1 for further evaluation and treatment of acute left femoral neck fracture. According to a review of GACH 1 Physician Progress Notes dated 2/1/2024, Resident 13 underwent left hip hemiarthroplasty surgery (a surgery to replace half of a hip joint). A review of Resident 13's active care plans on 4/27/2024, indicated the licensed staff did not develop a care plan with person-centered interventions for Resident 13's risk for fall. During a concurrent interview and record review, on 4/27/2024 at 4:40 PM, with the MDS Coordinator (MDSN), Resident 13's care plans were reviewed. The MDSN stated licensed nurses did not develop a care plan for Resident 13's risk for fall. The MDSN stated on 1/20/2024, Resident 13 was wearing slippers while he was walking towards the nurse's station and fell on the floor. During a concurrent interview and record review, on 4/27/2024 at 4:48 PM, with Registered Nurse Supervisor 1 (RN 1), Resident 13's medical record was reviewed. RN 1 stated Resident 13 was taking anti-depressant, anti-psychotic medications and anti-hypertensive medications. There is a risk for fall if a resident is taking these types of medications. RN 1 stated, Seems like there is no care plan with specific goals and person-centered interventions for Resident 13's risk for fall in his medical chart. During a concurrent interview and record review, on 4/27/2024 at 5:05 PM, with the Director of Staff Development (DSD), Resident 13's Fall Risk Assessments were reviewed. The DSD stated Resident 13's fall risk assessments dated 11/3/2023, indicated he was considered a low risk for potential falls and the licensed nurses documented Resident 13 had normal gait. The DSD stated Resident 13's gait was not normal. The DSD stated, Resident 13 had a history of surgery and pain to his left leg and both knees. Resident 13 was limping. The DSD further stated licensed staff should have documented weak gait instead of normal gait when completing Resident 13's fall risk assessments dated 11/3/2023. The DSD stated Resident 13 was not considered a high risk for fall based on the incorrect fall risk assessments. Therefore, appropriate interventions were not implemented to prevent his fall. The DSD stated, Resident 13 was wearing an open toe slipper and that is why he tripped and fell . During an interview on 4/30/2024 at 11:35 AM, Licensed Vocational Nurse (LVN) 3 stated Resident 13 was a risk for falls because of his abnormal gait because of his knee pain. The resident was bowlegged (having legs that curve outward at the knee) and was walking fast. LVN 3 stated Resident 13 was wearing a pair of open-toe slippers and he fell because he tripped on his open toe slippers. Those slippers were not safe for the resident and Resident 13 was insisting to wear them. LVN 3 further stated, We could have prevented Resident 13's fall on 1/20/2024, by not letting him wear those slippers. LVN 3 stated licensed staff did not develop a care plan for Resident 13's non-compliance (not obeying a rule) of wearing inappropriate footwear. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	b. A review of Resident 29's admission record indicated the facility readmitted the resident, on 5/25/2021, with diagnoses including atrial fibrillation (an irregular and often very fast heartbeat that can lead to blood clots, stroke and heart failure), liver failure and dementia (is a brain disorder that affects a person's ability to carry out daily activities and that may cause changes in mood and personality). A review of the High Risk for Falls care plan, initiated 6/1/2022, indicated Resident 29 was at high risk for falls due to psychoactive drug use, unaware of safety needs and his gait/balance problems. The care plan interventions included to follow the facility's fall protocol and for staff to review information on past falls and attempt to determine cause of falls, to record possible root causes and educate family/resident/caregivers as to the causes of his falls. A review of the SBAR Communication Form dated 6/24/2023, indicated Resident 29 had an unwitnessed fall with a skin tear on the left forearm. A review of the IDT meeting, dated 9/12/2023, indicated Resident 29 required limited to extensive assistance with activities of daily living (ADLs -essential and routine activities include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet) and supervision to limited assist with eating. According to a review of the Fall Risk Assessments, the most recent was dated 12/8/2023 with a score of 55, indicating a high risk for falls. There was no quarterly fall assessment for March 2023. A review of the Quarterly MDS dated [DATE], indicated Resident 29 had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement. A review of the April 2024 Medication Administration Record (MAR) indicated Resident 29 was administered Seroquel (a psychoactive medication-any medication capable of affecting the mind, emotions, and behavior) 25 milligrams (mg) by mouth at bedtime for behavioral or psychological symptoms of dementia at 9 PM for from 4/1/2024 to 4/25/2024. A review of National Library of Medicine (NLM)'s DailyMed a searchable database provides the most recent labeling submitted to the Food and Drug Administration (FDA), revised date of 1/27/2022, manufacturer's labeling for Seroquel indicated, the medication could cause low blood pressure and sleepiness which may lead to falls. During an observation on 4/26/2024 at 6:55 PM, a star on a red piece of paper was located on Resident 29's nameplate. Resident 29 was sleeping and lying in a low bed. During an interview on 4/27/2024 at 1:19 PM, CNA 2 stated the red star next to Resident 29's name indicated the resident was on fall precautions. CNA 2 stated at times, Resident 29 tried to get out of bed and go to the restroom on his own. CNA 2 stated Resident 29 was in a low bed to prevent falls. During an interview on 4/27/2024 at 1:45 PM, Licensed Vocational Nurse 3 (LVN 3) stated Resident 29 had a fall during the 3 PM to 11 PM shift on 6/24/2023. LVN 3 stated Resident 29's last fall risk assessment was completed in December 2023 and the resident should have one completed in March 2024. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	c. A review of Resident 36's Admission Record indicated the facility admitted the resident on 3/7/2023, with diagnoses including difficulty in walking, lack of coordination, and repeated falls. A review of the Fall Risk assessment dated [DATE], indicated Resident 36 had fallen before, had more than one diagnoses, was using ambulatory aids, exhibited impaired gait and forgets his limits. The assessment indicated Resident 36 had a score of 90 and that a total score was 45 and higher, the resident was considered a high risk for potential falls. A review of Resident 36's Fall Risk assessment dated [DATE], indicated 36 had fallen before, had more than one diagnoses in his chart, was using ambulatory aids (tools like wheelchairs, walkers, canes, and crutches to help in walking), exhibited impaired gait and knows his limit. The assessment indicated Resident 36 had a score of 75 and was a high risk for fall. A review of Resident 36's MDS dated [DATE], indicated the resident had severely impaired cognition, required partial/moderate staff assistance with personal hygiene, required staff supervision or touching with oral hygiene, toileting hygiene, showering and upper and lower body dressing. During a concurrent interview and record review on 4/27/2024 at 1:31 PM, with RN 1, Resident 36's fall risk assessments were reviewed. RN 1 stated licensed staff did not develop any fall risk assessment for Resident 36 after 12/15/2023 and the fall risk assessments were completed by licensed staff quarterly, and after each incident of fall. RN 1 stated the potential outcome of not developing a fall risk assessment quarterly was the inability to deliver required care and services and consequently repeated falls and injuries. During an interview on 4/27/2024 at 1:40 PM, the MDSN stated, I am in charge of completing assessments for the residents and I am behind. The MDSN stated no fall risk assessment was initiated and documented for Resident 36 after 12/15/2023. A review of the facility's policy and procedures (P&P) titled, Fall Prevention Program, revised 1/18/2024, indicated all residents will be assessed for risk for fall in order to facilitate fall prevention and reduction program. If a resident is at risk for falls, it will be identified on the care plan. A review of the facility's P&P titled Fall Risk Assessment, revised 1/18/2024, indicated the facility will complete a fall risk assessment on admission, and update after any falls or change of condition and with quarterly and annual MDS assessment. All residents will be assessed for risk for fall in order to facilitate fall prevention and reduction program. A review of the facility's policy and procedure titled, Post Fall Management Program, dated 12/2016, indicated all residents will be assessed for risk of fall in order to facilitate fall prevention and reduction program. To ensure that all residents are assessed following an incident of fall. It also indicated Seroquel was a prescription medication that increases the risk for fall for patients 65 and older.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. 44309 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 27) received the necessary care and services to prevent complications from an Ileostomy (an opening in the abdominal wall that's made during surgery, and it is used to move waste out of the body) in accordance with the resident's comprehensive (complete/detailed) person-centered care plan. This deficient practice had the potential for Resident 27 to suffer from infection, skin breakdown, and pain. Findings: A review of Resident 27's Admission Record indicated the facility admitted the resident on 10/18/2023, with diagnoses including ileostomy and lack of coordination. A review of Resident 27's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 3/22/2024, indicated Resident 27 had intact cognition (decisions consistent/reasonable). The MDS indicated that Resident 27 required partial/moderate staff assistance (helper does less than half the effort) from facility staff with personal hygiene, dressing upper and lower body, and oral hygiene. The MDS indicated that Resident 27 required maximal facility staff assistance (helper does more than half the effort) with showering. The MDS indicated that Resident 27 had ileostomy. A review of Resident 27's History and Physical dated 10/18/2023, indicated the resident had the capacity to understand and make decisions. A review of Resident 27's Physician's Orders dated 3/17/2024, indicated facility staff was to monitor the resident's ileostomy site for any swelling, redness, pain, abdominal distention (a visible increase in abdominal girth [the measure around anything]), and skin breakdown during every shift. The physician order indicated facility staff was to document the sign (+) if the above symptoms were present, and document (-) if the symptoms were absent. The physician order indicated facility staff were to notify the physician for any significant changes. A review of Resident 27`s Care Plan dated 3/18/2024, indicated Resident 27 had an alteration in bowel elimination (a change in the process of getting rid of waste from the body) secondary (due to) to ileostomy. The care plan goal for the resident was to maintain skin integrity (health of the skin) surrounding stoma (a surgically made hole in the abdomen that allows body waste to be removed). The care plan interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) were to provide ileostomy care during every shift, assess bowel sounds (sounds produced by the movement of fluid and air in the abdomen), assess for any abdominal distention, encourage adequate (enough) hydration, and to monitor and manage the stoma. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 27's Treatment Administration Record (TAR) for the months for February, March, and April 2024, indicated there was no documentation present regarding assessing Resident 27's bowel sounds. The TARs for February, March, and April 2024 indicated there was no documentation indicating the presence and/or absence of swelling, redness, pain, abdominal distention, and skin breakdown as indicated in the physician order dated 3/17/2024. During a concurrent interview and record review on 4/27/24 at 1:13 PM, Registered Nurse Supervisor 1 (RN1) reviewed Resident 27`s care plan for ileostomy and TARs for February, March, and April were reviewed. RN1 stated one of the ileostomy care plan interventions was to assess Resident 27`s bowel sounds. RN1 stated that the licensed staff did not document anywhere in Resident 27`s medical records that the assessment of bowel sounds was implemented. RN1 stated licensed staff were required to implement all interventions specified in the resident`s person-centered care plan. RN1 stated licensed staff documented in Resident 27`s January, March, and April TAR Resident 27's stoma site was monitored for swelling, redness, pain in the TAR. RN1 stated that the licensed staff did not display (+) if any symptoms occurred or (-) if symptoms were absent as ordered by the resident`s physician. RN1 stated the potential outcome of not following physician orders for ileostomy care and not implementing care plan interventions was insufficient care and a potential for skin breakdown and injury to the resident. During an interview on 4/30/2024 at 1:44 PM, with the facility's Administrator (ADM), the ADM stated licensed nurses were required to follow physician's orders and the licensed nurses were required to implement all the interventions specified in the residents care plans. The ADM stated the potential outcome of not following physician orders for ileostomy care and not implementing care plan interventions was insufficient care and risk for injuries. A review of facility's policy and procedure titled, Colostomy and Ileostomy Care, dated February 2024, indicated the purpose of this policy is to maintain resident`s hygiene, control odor, prevent skin irritation or breakdown and provide supporting care to the residents. Colostomy and ileostomy care is provided to all residents requiring ostomy care unless contraindicated by the physician. Stoma and surrounding skin will be monitored for irritation for routine care and as part of licensed nurses' weekly assessment.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on observation, interview, and record review ,the facility failed to ensure one of two sampled residents (Resident 144), who was at risk for unplanned severe weight (wt.) loss (a body weight loss of greater than five [5] percent [% - unit of measure] in one month) received the care and services necessary to prevent severe weight loss. By failing to implement Resident 144's physician's orders for weekly weights dated 4/1/2024. These deficient practices placed Resident 144 at risk for nutritional decline, dehydration, impaired healing, and weight loss. Findings: A review of Resident 144's Admission Record indicated the facility originally admitted the resident on 3/11/2020 and readmitted the resident on 4/1/2024, with diagnoses including but not limited to colon cancer, liver failure and dementia (loss of memory, thinking and reasoning). A review of Resident 144's Nutritional Assessment, dated 3/52024, indicated the resident's weighed 110 pounds (lbs.) on 3/5/2024. The Nutritional Assessment indicated the resident was on speech therapy for dysphagia (difficult swallowing) and had a significant weight loss during the last 3 and 6 months. The intervention (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) section of the nutritional assessment indicated staff were to monitor the resident's weight, intake, and diet tolerance. A review of Resident144's Nutrition/Dietary Note dated 3/26/2024, indicated from 9/4/2023 to 3/26/2024 Resident 144 had a weight loss of 23 lbs. (18.11% weight loss in six months). The note indicated the plan was to monitor the resident's weight, intake, diet tolerance, skin integrity, labs as ordered, hydration status, adjust diet as needed for Resident 144. A review of Resident 144's physician orders dated 4/1/2024 indicated the facility was to weigh Resident 144 weekly for four weeks then every month. A review of Resident 144's initial Minimum Data Set (MDS, standardized assessment and care-planning tool) dated 4/6/2024, indicated the resident had moderate cognitive (ability to acquire and understand knowledge) impairment. The MDS indicated Resident 144's weight was 114 lbs.; the resident had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months and the resident was not on a prescribed weight-loss regimen. A review of Resident 144's Alteration in Nutritional Status Care Plan developed on 4/2/2024 indicated the resident was at risk for weight loss. The care plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) indicated the resident was below ideal body and was malnourished. The care plan indicated Resident 144 had a body weight twenty percent or more under ideal weight. The interventions to prevent weight loss included to adhere to food preferences, offer substitute for any meals refused or poor intakes and to monitor weights. The care plan indicated the registered dietician (RD) was to follow up as indicated. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 144's Nutritional assessment dated [DATE], indicated Resident 144 weighed 94 lbs. on 4/4/2024. The Nutritional Assessment indicated the resident had significant weight loss possibly due to multiple medical problems. The intervention section of the assessment indicated staff were to monitor weight, intake, and diet tolerance. During a concurrent observation inside Resident 144's room and interview on 4/26/2024 at 6:30 PM, Resident 144 was observed sitting in bed in a darkened room, with a fan blowing and a wash basin lined with plastic on the overbed table. Resident 144 stated she did not know what was wrong with her and felt nauseated. Resident 144 stated the dark room and fan helped with the nausea. A review of Resident 144's Weights and Vitals Summary dated 4/27/2024, indicated Resident 144's weights were: -109 lbs. on 3/18/2024. -104 lbs. on 3/252024 (a 5 lbs. (4.59%) weight loss in 1 week). -94 lbs. on 4/4/2024 (a 10 lbs. (9.62%) weight loss in 10 days and 14.55% in one month weight loss. There were no weights entered after 4/4/2024. During a concurrent observation in Resident 144's room and interview on 4/26/2024 at 6:42 PM, Resident 144 was observed lying in bed with a pink wash bin lined with a plastic bag on her overbed table. There was a fan running on the floor and the room was dark. Resident 144 stated she felt nauseated and dark room helped with the nausea. During an interview on 4/27/2024 at 11:32 AM, Registered Nurse Supervisor 1 (RN 1) stated Resident 144's had been recently hospitalized because she (Resident 144) was not eating, and the resident was on weekly weights due to poor oral intake. RN 1 stated Resident 144's weight was to be monitored weekly, so facility staff closely monitor the resident's weight. RN 1 stated Resident 144's weight had to be monitored weekly and RN 1 did not know what happened, but the last weight was on 4/4/2024. RN 1 stated monitoring the resident's weight was part of the nutrition risk care plan. RN 1 stated not weighing the resident weekly as ordered placed the resident at risk of continuing to lose weight and the weight loss going unnoticed. During a phone interview on 4/28/2024 at 11:55 AM, Registered Dietician 1 (RD 1) stated Resident 144 was a high risk for weight loss due to her cancer diagnosis. RD 1 stated the weight variance committee was following Resident 144 and Resident 144 was on weekly weights to evaluate the resident's weight loss. RD 1 stated if weekly weights were not done, the facilty would not know what to monitor for. During an interview on 4/30/2024 at 1:32 PM, the facility Administrator (ADM) stated Resident 144 had a physician order for weekly weights. The ADM stated the facility staff were to follow physician orders and not following physician orders could lead to poor quality of care. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy and procedures (P&P) titled, Unplanned Weight Loss, reviewed 1/18/2024, indicated It is the policy of the facility to identify conditions and potential causes of weight loss that places the residents at risk. The purpose of this procedure is to provide appropriate intervention for any unplanned weight loss. The P&P indicated The Physician, with input from the staff, will determine the most appropriate intervals for weight assessments, weights will be documented in the progress notes.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851 Based on observation, interview, and record review, the facility failed to ensure three of six sampled residents (Residents 9) received the appropriate treatment and services needed to maintain and prevent tube feeding (TF, a form of nutrition that is delivered into the digestive system as a liquid) complications, as evidenced by: -Failing to ensure TF was not disconnected from Resident 9's gastrostomy tube (also known as g-tube, a small tube placed through the skin into the stomach to medicines and liquids, including liquid foods). -Failing to ensure Resident 9 was wearing an abdominal binder (a wide compression belt that encircles the abdomen; that can be used minimize inadvertent pulling or tugging of a g-tube) to secure the g-tube as per the plan of care. These deficient practices had a potential for Resident 9 to pull out his g-tube and to not to receive the full dose of TF as ordered by the physician. Findings: A review of Resident 9's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included severe protein-calorie malnutrition (when the body doesn't get enough nutrients caused by a poor diet, digestive conditions, or another disease), gastrostomy (g-tube insertion), type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy) and adult failure to thrive (a decline in older adults that manifests as a downward spiral of health and ability). A review of Resident 9's physician order dated 1/5/2024 indicated the resident was to receive Glucerna 1.5 (a type of tube feeding formula used for individuals with type 2 diabetes) at 70 milliliters (ml) per hour (hr) via g-tube pump two times a day. A review of Resident 9's Minimum Data Set (MDS, a standardized assessment and care screening tool) dated 3/30/2024, indicated the resident had moderately impaired cognition (the ability to think, understand, and make decisions). The MDS indicated Resident 9 required partial/moderate assistance from facility staff with showering/bathing, upper body dressing, and personal hygiene. The MDS indicated Resident 9 required substantial/maximal assistance from facility staff with oral hygiene, toileting hygiene, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 9 was dependent on facility staff for eating. The MDS indicated Resident 9 had a feeding tube and was on a therapeutic diet (a meal plan that controls the intake of certain foods or nutrients and is part of the treatment of a medical condition). (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 9's Care Plan reviewed 4/24/2024, indicated the resident was at risk for injury secondary to a tendency to pull out life-sustaining tubes, a g-tube. The care plan indicated a goal to minimize the risk of Resident 9 pulling out life sustaining tube daily through the review date. The care plan indicated interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) that included to apply an abdominal binder as ordered, and release as needed; assess for proper placement during care time, assess for signs and symptoms of anxiety or restlessness and notify the medical doctor as indicated. During an observation in Resident 9's room on 4/26/2024 at 6:12 PM, Resident 9 was observed lying in bed watching television (TV). A feeding pump (a pump that moves liquid nutrition from a bag, through a feeding tube, into the stomach) was observed turned on indicated the resident was receiving Glucerna 1.5 at 70 ml/hr. The TF was disconnected from Resident 9, and the resident's bed was observed saturated (soaked) by the TF. Resident 9 stated he could feel his bed wet from the TF, but stated he didn't know how long the TF was disconnected. During a concurrent observation in Resident 9's room and interview on 4/26/2024 at 6:15 PM, Licensed Vocational Nurse (LVN) 4 verified Resident 9's TF was disconnected, and the bed was saturated with TF. LVN 4 stated he did not know how long the TF was disconnected from the resident. LVN 4 stated Resident 9 needed to be changed and cleaned up. LVN 4 stated Resident 9 tended to pull and disconnect himself from the TF. LVN 4 stated Resident 9 was not wearing an abdominal binder. LVN 4 stated Resident 9 should have been connected to the TF so the resident could receive the TF per the physician's order. LVN 9 stated there was a potential Resident 9 would not receive the full dose of TF if the resident was disconnected from the TF. During a concurrent interview and record review on 4/27/2024 at 1:57 PM, the Minimum Data Set Nurse (MDSN) stated Resident 9's g-tube care plan indicated to apply an abdominal binder as ordered. The MDSN stated Resident 9 was not wearing an abdominal binder. The MDSN stated Resident 9 tended to disconnect the TF and had pulled out the g-tube before. The MDSN stated an abdominal binder would keep the TF connected and help prevent Resident 9 from disconnecting the TF and pulling out his g-tube. The MDSN stated there was a potential for Resident 9 to not receive the full dose TF and to remove the g-tube again if the care plan was not followed. During a concurrent interview and record review on 4/28/2024 at 1:49 PM, Registered Nurse (RN 1) stated Resident 9 had a history of pulling out his g-tube and disconnecting the TF. RN 1 stated Resident 9's care plan indicated the resident was to wear an abdominal binder to help prevent the resident from disconnecting the TF and pulling out the g-tube. RN 1 stated Resident 9 was not currently wearing an abdominal binder. RN 1 stated there was a potential for Resident 9 to disconnect himself from the TF and pull out the g-tube. RN 1 also stated there was a potential for Resident 9 not to receive the full dose of TF as the physician ordered. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Comprehensive Plan of Care, reviewed 1/18/2024, indicated It is the policy of this facility to provide each resident with a comprehensive plan of care developed that includes, goals, measurable objectives and timetables to meet their medical, nursing, mental, psychosocial needs identified during comprehensive assessment. The comprehensive care plan must describe services that are provided to the resident to attain or maintain the resident's highest physical, mental, and psychosocial well-being. The comprehensive plan of care will include: address the resident's individual needs, strengths, and preferences; reflect current standards of professional practice; include treatment goals with measurable objectives' reflect interventions to meet both short and long-term resident goals. Develop goals and approaches for each problem and/or condition that are realistic, specific, measurable, and include interventions/approaches that related to each stated long or short term goal. A review of the facility's policy and procedure titled Enteral Feeding Via Pump Administration, reviewed 1/18/2024, indicated It is the facility's policy to ensure that care is given to residents receiving enteral feeding via pump administration. Check the label on the enteral formula against the physician order. Verify placement prior to enteral feeding administration according to gastrostomy placement procedure. Initiate enteral feeding. After verifying placement and checking GRV, attach the primped feeding pump set to enteral tube and unclamp tube. Hand feeding bag on IV pole. Connect the infusion pump, set rate and press start for continuous feeding.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 43851 Based on interview and record review, the facility failed to perform required annual staff competency evaluation (an evaluation of the skills, knowledge, and abilities of a staff member) for three of seven sampled staff (Registered Nurse (RN) 2, Licensed Vocational Nurse (LVN) 1, and LVN 2). This deficient practice had the potential for residents to not receive the appropriate care and services needed, which could affect the quality of care received, and potentially lead to resident harm. Findings: During a record review on 4/28/2024 at 4:30 PM, RN 2's employee file was reviewed. The file indicated the facility hired RN 2 in 2018. The file indicated RN 2 had a skill competency evaluation on 11/20/2020, there were no evaluations observed in RN 2's employee file for 2021, 2022, 2023, or 2024. During a concurrent interview and record review on 4/28/2024 at 5:03 PM, RN 2's employe file was reviewed with the Director of Staff Development (DSD). The DSD verified the last skill competency evaluation in RN 2's employee file was dated 11/20/2020. The DSD stated skill competency evaluations were done 90 days after hire and then annually. The DSD stated skill competency evaluations were done to ensure staff knew their job responsibilities and could perform the responsibilities correctly and safely. The DSD stated residents could potentially be at risk for harm if staff were not evaluated for skill competencies annually. During a record review on 4/29/2024 at 10:43 AM, LVN 1's employee file was reviewed. The file indicated the facility hired LVN 1 on 3/7/2022. There were no competencies available for review in LVN 1's employee file. During a record review on 4/29/2024 at 11:00 AM, LVN 2's employee file was reviewed. The file indicated the facility hired LVN 2 on 7/1/2008. There were no competencies available for review in LVN 2's employee file. During an interview on 4/29/2024 at 2:04 PM, the Director of Staff Development (DSD) stated she was unable to locate the annual competencies for LVN 1 and LVN 2. During an interview on 4/29/2024 at 2:10 PM, LVN 2 stated she was not sure when her last skill competency evaluation was done. During an interview on 4/29/2024 at 2:20 PM, LVN 1 stated she did not remember the date or the last time she had a skill competency evaluation. LVN 1 stated It's been a while; we're supposed to have it done every year. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/30/2024 at 1:30 PM, the Administrator stated the skill competency evaluations for LVN 1, LVN 2, and RN 2 could not be located. The Administrator stated skill competency evaluations were required to be done annually for licensed staff. The Administrator stated the quality of care for the facility residents could be affected (negatively) if staff were not evaluated for skill competencies annually. A review of the facility's policy and procedures titled, Competency Evaluation, reviewed 7/20/2023, indicated It is the facility's policy to performance competency evaluation for all employees. Annually, each employee's competency will be review during performance evaluation review.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851 Based on observation, interview, and record review, the facility failed to ensure professional standards of practice and facility policy and procedures (P&P) for Disposal of Medications and Medication-Related Supplies reviewed [DATE] were followed. By failing to ensure unused medications were stored in a securely locked area. This deficient practice had the potential to result in diversion (the illegal distribution or abuse of prescription drugs or their use for purposes not intended by the prescriber), overdose, and death. Findings: During a concurrent and interview on [DATE] at 10 AM, the facility's medication room was observed with Registered Nurse (RN) 1. The medication room was observed with a container bin that contained the following: 1. Hydralazine (medication used to treat high blood pressure) 10 milligrams (mg) 30 tablets. 2. Dorzolamide Hydrochloride and Timolol Maleate Ophthalmic Solution (medication used to treat increased pressure in the eyes) 2%/0.5% 8 packages. 3. Latanoprost (medication used to lower pressure inside the eye) 0.005% eye drops 1 bottle. 4. Brimonidine (medication used to lower pressure inside the eye) 0.2% eye drops 1 bottle. 5. Atorvastatin (medication to help lower cholesterol levels in the blood) 20 mg 3 tablets. 6. Cyclobenzaprine (medication used to relax muscles) 5 mg 40 tablets. 7. Gabapentin (medication used to treat nerve pain) 100 mg 50 capsules. 8. Risperidone (medication used to treat schizophrenia, a mental illness that affects how a person thinks, feels, and behaves) 0.25 mg 8 tablets. 9. Metformin (medication used to lower blood sugar levels) 1,000 mg 21 tablets. 10. Mirtazapine (medication used to treat depression, a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily life) 15 mg 4 tablets. 11. Memantine HCL (Medication that is used to treat the symptoms of Alzheimer's disease; a brain disease that slowly destroys the memory and the ability to think) 10 mg 13 tablets. 12. Folic Acid (a supplement that is used to treat low levels of folate which is an important part of red blood cell formation) 1 mg 18 tablets. (continued on next page)

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Angels Nursing Health Center	415 S Union Avenue Los Angeles, CA 90017

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	13. Celecoxib (a medication used to treat mild to moderate pain) 100 mg 3 capsules. RN 1 stated the medications stored in the container were supposed to have been disposed of in the medication waste bin. RN 1 stated medication was disposed of with a second licensed nurse and then documented on the medication disposition record with the name of the medication, the method and date of disposition, and a signature of both licensed nurses. RN 1 stated the medication was then disposed of in the waste bin. RN 1 stated the medication was supposed to be disposed of immediately. RN 1 stated he did not know how long the medication had been ion the container. RN 1 stated there was a risk for misuse of medications if medications were not disposed of immediately. During an interview on [DATE] at 1:30 PM, the Administrator stated medication that was wasted had to be disposed of immediately. The Administrator stated there was risk the medication could be misused if not disposed of immediately. A review of the facility's policy and procedure titled, Disposal of Medications and Medication-Related Supplies, reviewed [DATE] indicated When medications are expired, discontinued by a prescriber, a resident is transferred or discharged and does not take medications with him/her, or in the event of a resident's death, the medications are marked as discontinued or stored in a separate location and later destroyed. Medications awaiting disposal are store in a locked secure area designated for that purpose until destroyed. Internal and external medications shall be stored separately. Medications are removed from the medication cart or storage area prior to expiration and immediately upon receipt of an order to discontinue.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on observation, interview, and record review, the facility failed to ensure therapeutic diets (a meal plan prescribed by a physician that controls the intake of certain foods or nutrients) were served for one of six sampled residents (Resident 6). By failing to ensure Resident 6 received a mechanical soft (diet is designed for people who have trouble chewing and swallowing) fortified (addition of one or more essential nutrients to a food) finely chopped diet (cut into very small and thin pieces) as per physician's orders dated 11/23/2023. This deficient practice had the potential to result in the risk for decreased nutritional intake, aspiration (accidentally inhaling your food or liquid through your vocal cords into your airway, instead of swallowing through your food pipe), and weight loss. Findings: A review of Resident 6's Admission Record indicated the facility originally admitted the resident on 11/30/2003, and readmitted the resident on 8/1/2023, with diagnoses including dementia (short-term memory loss, confusion, personality, and behavior changes), history of falling, and chronic pain syndrome (occurs when pain remains long after an illness or injury has healed). A review of Resident 6's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 8/7/2023, indicated the resident had moderately impaired cognition (decisions poor, cues/supervision required). The MDS indicated the resident required extensive assistance from facility staff with walking, and personal hygiene. The MDS indicated the resident required supervision with eating. The MDS indicated Resident 6 did not have a swallowing disorder and did not have any weight loss or weight gain in the last six months. A review of Resident 6's physician order dated 11/23/2023, indicated the diet order was mechanical soft fortified finely chopped diet. A review of the Resident 6's Nutritional assessment dated [DATE], indicated that the resident`s current diet was mechanical soft, fortified, finely chopped diet for weight management, and to ease with chewing and swallowing. During an observation in the dining room on 4/27/2024 at 12:20 PM, Resident 6 was observed coughing. Resident 6 observed to had been served chopped pasta, carrots in a circle shape, and chunks of beef in a sauce. During a concurrent observation of Resident 6's lunch tray and interview on 4/27/2024 at 12:22 PM, Licensed Vocational Nurse 3 (LVN3) stated Resident 6`s carrots and beef served were not finely chopped. LVN3 then went to the kitchen and requested a new lunch tray for the resident. LVN3 stated the potential outcome of not serving a finely chopped diet to Resident 6 would be the resident's inability to consume the food and a potential for aspiration and weight loss. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/2024 at 1:40 PM, the facility's Administrator (ADM) stated staff were required to check the residents` meal trays with the physician orders to make sure that the correct diet was served to the residents. The ADM stated the potential outcome of not providing a finely chopped diet to a resident was the risk for aspiration and the resident`s inability to consume the food. A review of the facility's policy and procedure titled, Therapeutic Diet, reviewed 1/18/2024, indicated it is the policy of the facility to provide therapeutic diets in accordance with physician orders. The master menu will include therapeutic modification for nutrient and/or texture modified diets.

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F 0813 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on interview and record review, the facility failed to ensure one of three sampled resident (Resident 43), who had difficulty swallowing and was at risk for aspiration (accidentally inhaling your food or liquid into your airway), received care and monitoring of the resident's food consumption within the guidelines of the diet order by failing to: - Implement the facility's policy and procedure (P&P) titled, Food for Residents from Outside Sources, that food brought in from outside the facility for a resident would be first shown to the Charge Nurse for approval that the food was within the diet order (therapeutic and texture). - Implement the facility's P&P titled, Food for Residents from Outside Sources, by providing the family of Resident 43 with the information sheet, Bringing in Food for A Resident. - Ensure facility staff had ongoing communication and coordination to support the nutritional well-being and safety of Resident 43, when Family Member (FM) 1 brought food into the facility. -Report to charge nurse when Certified Nursing Assistant (CNA) 1 observed Resident 43 eating regular textured food brought by FM 1. As a result, on [DATE] at 12:38 AM, after eating a regular textured food brought in by the family, around six hours prior, Resident 43 became congested, had difficulty breathing, and cyanotic (blue- indicating reduced blood oxygen levels). Resident 43 soon became unresponsive, required cardiopulmonary resuscitation (CPR - medical intervention used to restore circulatory and/or respiratory function that has stopped) and at 1 AM on [DATE], Resident 43 was pronounced dead (nine days after his admission). On [DATE] at 8:11 PM, an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the Administrator (ADM), regarding the facility's failure to identify and ensure Resident 43, who had difficulty swallowing and was at risk for aspiration, received necessary care and services in accordance with professional standards of practice. On [DATE] at 1:12 PM, while onsite at the facility, the IJ was removed in the presence of the ADM, after the ADM submitted an acceptable Removal Plan (interventions and implementation to correct the deficient practices) which was verified and confirmed through observation, interview, and record review. The acceptable removal plan was as follows: -On [DATE], the Minimum Data Set (MDS - a standardized assessment and care screening tool) Nurse reviewed the diet orders of all current residents (42) to determine if their diet texture (qualities of a food that can be felt with the fingers, tongue, palate, or teeth) and fluid consistency (refers to the thickness of the liquid) needed to be clarified with the physician. Thirty-nine residents needed clarification of their diet orders. The MDS Nurse completed the clarification of diet orders on the same day. (continued on next page)

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F 0813 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Starting [DATE], the Nurse Consultant provided an in-service to six Interdisciplinary Team (IDT members Activities Director, MDS Nurse, Director of Rehab, Dietary Supervisor, Administrator, Social Services Director, and Director of Staff Development) to inform the resident's family, during the initial IDT meeting and subsequent IDT meetings as needed, about the resident's prescribed diet order and the facility's policy on Food for Resident from Outside Sources. The resident's family would be asked to sign a form acknowledging they received this information. The DON was the only remaining IDT member who would be provided with an in-service by the Nurse Consultant upon their return to work. -Starting [DATE], the IDT reviewed 36 current residents who were on a therapeutic diet (meal plan that controls the intake of certain foods or nutrients in the treatment or management of certain diseases, illnesses, or medical conditions) and informed their family members via telephone conversation about the resident's prescribed diet order and the facility's policy on Food for Resident from Outside Sources. The information was provided using the family members' native language. The IDT members documented in the resident's chart that the family has been informed. -Consultant provided an in-service to Registered Nurses (RNs), Licensed Vocational Nurses (LVN), Certified Nursing Assistants (CNA) and Restorative Nurse Aides (RNA), 60% of staff, regarding the facility's policy on Food for Resident from Outside Sources and the different diet textures available in the facility. The in-service emphasized the following: -Diet orders will be printed daily by the licensed nurse and will be made available as a reference at the nurses' station. -Food brought in by family from outside sources must be consistent with the resident's prescribed diet; -Food brought in by family from outside sources should be shown to the licensed nurse for evaluation if it matches the resident's prescribed diet. -The licensed nurse must be notified if the resident is observed to be eating food that does not match the diet order or when the family is observed to have brought in food for the resident that is different from the diet order. -The licensed nurse will check on residents who have food brought in by family every 2 hours and as needed; and, -The licensed nurse will record both the evaluation of the food brought from outside and every two-hour visual checks in a log that would be submitted to the DON or designee for further review. -Licensed nurses and CNAs were asked questions at the end of the in-service to evaluate their knowledge of the information provided in the in-service. In-services would be completed for all the active nursing staff by the Nurse Consultant on or before [DATE]. Staff who were currently on vacation or on leave will be provided the in-service upon their return to work. (continued on next page)

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F 0813 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Starting [DATE], the Nurse Consultant checked competencies of two RNs, eight LVNs and 16 CNAs, as in identifying different diet textures by presenting them with different sample meal trays and asking them to correctly identify different diet textures and fluid consistencies. Competency evaluations would be performed by the Nurse Consultant and completed for all active nursing staff by [DATE]. Staff who were currently on vacation or on leave would have their competencies evaluated upon their return to work. -On [DATE], the Nurse Consultant provided a one-to-one in-service with CNA 1 regarding the facility's policy on Food for Resident from Outside Sources, emphasizing the importance of reporting to the licensed nurse when the resident was observed to be eating food that was different from the diet order. At the end of the in-service, the CNA was asked questions to evaluate his knowledge about the information provided to him and was able to answer questions correctly. -On [DATE], the Nurse Consultant provided an in-service to 15 CNAs and 2 RNAs (50%) regarding the importance of immediately reporting to the licensed nurse any observed changes in the resident's condition and acting upon any actions that do not match the facility's policy on Food for Resident from Outside Sources. The Nurse Consultant would complete the in-service for all the active CNAs and RNAs by [DATE]. Staff who were currently on vacation or on leave would be provided the in-service upon their return to work. -The RD would review diet orders once a week to ensure diet orders were clear and correct. She would conduct rounds once a week to ensure that residents were provided the correct diet texture and fluid consistency. Findings would be reported to the Director of Nursing (DON) and Administrator weekly for follow-up. Findings: A review of Resident 43's Admission Record indicated the facility admitted the resident, on [DATE], with diagnoses including but not limited to history of stroke, adult failure to thrive, and presence of cardiac pacemaker. A review of Resident 43's Admission Assessment, dated [DATE], indicated the resident was alert and oriented x 1, had a regular heartbeat with a strong pulse, he did not have a cough and breath sounds were clear. A review of the Physician's Order Summary Report, dated [DATE], indicated Resident 43 was to receive a pureed diet texture. regular consistency. According to a review of Resident 43's Nursing Progress Notes, dated [DATE], the resident was able to make his needs known, responsive to all stimuli, and had no complaints of pain or discomfort. A review of Resident 43's Alteration in Oral / Dental Status care plan initiated [DATE], indicated the resident did not have teeth and the goal was for Resident 43 to not have unrecognized signs and symptoms of oral or dental problems daily. The care plan interventions indicated to provide the diet as ordered and monitor percentage of intake, ensure good oral hygiene and for staff to assess for tolerance of prescribed diet. (continued on next page)

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F 0813 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Activities of Daily Living care plan, dated [DATE], indicated Resident 43 required limited assistance with eating and the interventions included to monitor the resident for any changes in condition and inform the physician. A review of the Nursing Progress notes, dated [DATE], indicated Resident 43 was able to make his needs known, responsive to all stimuli, there were no significant changes, was calm and compliant, denied pain or discomfort, and the resident's breathing was even and unlabored. A review of Resident 43's Admission Interdisciplinary Team (IDT) conference record dated [DATE], indicated Resident 43's diagnoses, physical therapy and the resident's pain were discussed. The IDT conference record indicated Resident 43's diet and diet texture was not mentioned. A review of Resident 43's Minimum Data Set (MDS, standardized assessment and care-planning tool) dated [DATE], indicated Resident 43 had moderately impaired cognition (problems with a person's ability to think, learn, remember, use judgement), required setup or clean up assistance with eating and had a mechanically altered diet (required change in texture of food or liquids [pureed food, thickened liquids]). The MDS indicated the resident did not have a problem with vomiting, had complaints of difficulty or pain with swallowing and the resident had no natural teeth or tooth fragment(s). A review of the Physician's Order, dated [DATE], indicated Resident 43 was to receive Speech Therapy (ST) three times a week for dysphagia (difficulty swallowing) and the treatment included diet assessment, compensation strategies (learning new ways to perform tasks in an alternative manner) and resident / caregiver education. According to a review of the Speech-language pathologist (SLP) Evaluation and Plan of Treatment, dated [DATE], Resident 43's oral motor structure (movements of the muscles in the mouth, jaw, tongue, lips and cheeks) and function was impaired and the recommendation was for Resident 43 to receive pureed food. A review of the Skilled Speech Therapy care plan dated [DATE], indicated the goals for Resident 43 included to demonstrate improved oral motor strength for functional swallowing, the progression of his diet and for Resident 43 to tolerate his diet without signs and symptoms of aspiration. The care plan interventions included safe swallowing strategies, ongoing assessment of swallow efficiency and skilled ST evaluation and treatment. A review of the Nutritional Assessment, dated [DATE], indicated Resident 43's current diet order was a mechanically altered diet (foods that can be safely and successfully swallowed) pureed with regular consistency liquids due to dysphagia. (continued on next page)

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F 0813 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to a review of the Situation, Background, Assessment, Recommendation (SBAR - a technique that can be used to facilitate prompt and appropriate communication between the different disciplines caring for the resident) dated [DATE] at 11:21 PM, it was reported by the prior shift (3 -11 PM staff) that Resident 43 vomited a large amount of undigested food (around 5pm). At 12:38 AM, on [DATE], Resident 43's had congestion which worsened manifested by an acute change in the resident's level of consciousness (LOC), shallow and labored breathing with cyanotic nail beds and cold / clammy skin. The SBAR indicated code blue was announced, 911 (a telephone number used to reach emergency medical, fire, and police services) was called and pulmonary resuscitation (CPR) with high flow oxygen support through ambu bag (type of device known as a bag valve mask, which is used to provide respiratory support to patients) was initiated, while active chest compression was performed by a trained support staff. At 12:55 AM, paramedics arrived and assumed care. A review of Resident 43's Certificate of Death indicated the resident expired on [DATE] at 1 AM, with the cause of death as acute cardiopulmonary arrest (the heart and lungs suddenly and unexpectedly stop working), with acute myocardial infarction (heart attack). The Certificate of Death indicated Resident 43 passed away at the facility. During an interview on [DATE] at 10:21 AM, Registered Nurse 1 (RN 1) stated on [DATE], RN 1 worked the 11 PM to 7 AM shift, and the prior shift nurse, Registered Nurse (RN) 2, told RN 1 that during the 3PM to 11 PM shift, Resident 43 had eaten foods with a regular texture including a tortilla, and subsequently vomited a large amount of undigested food. RN 1 stated Resident 43 later became congested with difficulty breathing. After review of Resident 43's electronic chart, RN 1 stated RN 2 had not documented any progress notes, had not completed an SBAR and had not notified the primary physician regarding any of these changes of condition for the resident (eating regular textured food, vomiting). RN 1 stated he left a message for the primary physician due to Resident 43's congestion and difficulty breathing, the resident became more congested and then was unresponsive around 12:38 AM, on [DATE]. RN 1 stated he started CPR, called emergency services and the paramedics took over the CPR upon their arrival. Resident 43 was pronounced dead several minutes later. RN 1 stated Resident 43's congestion may have resulted from the resident ingesting regular textured foods. During an interview on [DATE] at 12:06 PM, the Registered Dietician (RD) 1 stated Resident 43 was on a pureed diet and if Resident 43 received a regular texture while prescribed a puree diet, this would make the resident at risk for aspiration or choking. During an interview on [DATE] at 12:53 PM, the Dietary Supervisor (DS) stated a pureed diet was to be creamy soft, as it was placed in a food processor to have a smooth texture with no pieces inside of it. RN 2 did not respond to voicemail requests for interview. During a phone interview on [DATE] at 4:35 PM, Certified Nursing Assistant 1 (CNA) 1 stated he saw from outside the room that the family brought in food for Resident 43. CNA 1 stated he saw Resident 43 eating the food and did not attempt to stop the resident. CNA 1 stated he did not enter the room because he was busy. CNA 1 further stated Resident 43 then vomited about 30 minutes later and that was when he notified RN 2 that Resident 43 had eaten the wrong texture food. (continued on next page)

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F 0813 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:03 AM, during an interview, the DSD stated the facility policy indicated that food brought in by family should be shown to the charge nurse or RD prior to giving it to the resident. The DSD stated when CNA 1 knew Resident 43 was eating the wrong diet, he should have gone in and reminded the resident and his family that the resident was eating the wrong food. Resident 43 had difficulty swallowing, choking could be very imminent, and the food could go to the lungs. During a phone interview on [DATE] at 12:26 PM, Family Member (FM) 1 stated he called the facility and received permission to bring in food for Resident 43. FM 1 stated he brought in chicken quesadillas for Resident 43, and no one educated him on any special diet or texture that Resident 43 was to receive. A review of the facility's policy and procedure (P&P) titled, Food for Residents from Outside Sources, reviewed [DATE], indicated food brought in from outside the facility kitchen for residents' consumption would be monitored. This was done to measure the effectiveness of this intervention in residents with low food intake, to be sure the food was within the guidelines of the diet order, and to better assess nutrient intake. Nursing and/or Admissions would provide the family of new admits with the information sheet, Bringing in Food for A Resident (Section 6, page 6.24). The P&P indicated the following was to be done to ensure the above was accomplished: -Food brought in from outside the facility for a resident would be first shown to the Charge Nurse for approval that the food was within the diet order (therapeutic and texture). If there were any questions, the Nurse would consult with the FNS Director or the Facility Registered Dietitian. -The Nurse would alert the resident's CNA to the food brought in. The CNA would be responsible for recording the food and the amount consumed, in accordance with the facility meal percentage documentation standard.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 44253 Based on observation, interview, and record review, the facility failed to maintain a safe, sanitary environment to help prevent the spread of airborne infections (infectious agents/organisms that remain infectious over long distances when suspended in the air) by failing to fit test (check whether a respirator properly fits the face of someone who wears it) six of six sampled staff (Registered Nurse 1 (RN 1), Licensed Vocational Nurse 1 (LVN 1), LVN3, Certified Nursing Assistant 2 (CNA 2), Restorative Nurse Aide 1 (RNA 1) and Cook 1 (CK 1) for their N95 mask (respirator: a respiratory protective device designed to achieve a very close facial fit and provide efficient filtration of airborne particles). This deficient practice had the potential to result in respiratory infections for all residents in the facility. Findings: During a record review of facility provided Respirator Fit Test Records on 4/29/2024 at 10:12 AM, the fit test records of RN1, LVN 1, LVN3, CNA 2, RNA 1 and CK 1, indicated the most recent fit test was completed 8/26/2022. During an interview on 4/29/2024 at 2:18 PM, the Director of Staff Development (DSD) stated the last fit test the facility had was in 2022. The DSD stated the last COVID-19 (coronavirus disease 2019 is an infectious disease caused by virus that can result in different symptoms from mild to severe respiratory illnesses and it spread during close contact and through the air from person to person) outbreak (a disease or illness that spreads rapidly among individuals in an area or population at the same time) was in July 2023. The DSD stated fit testing was required to be done yearly. The DSD stated not fit testing facility staff yearly could spread respiratory disease to the residents in the building. During a concurrent interview and record review on 4/29/2024 at 2:38 PM with RNA 1, RNA 1's fit test record was reviewed. RNA 1 stated his last fit test was done on 8/26/2022. RNA 1 stated fit tests had to be completed yearly. During an interview on 4/30/2024 at 10:54 AM, LVN 3 stated her last fit test was on 8/26/2022 fit test. LVN 3 stated fit testing had to be completed yearly. During an interview on 4/30/2024 at 1:30 PM, the facility Administrator (ADM) stated the facility did not have an Infection Preventionist (IP). The ADM stated no other fit tests were completed since 8/262022 because the fit test was scheduled the day after the former IP resigned. (continued on next page)

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	055704	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Angels Nursing Health Center	415 S Union Avenue Los Angeles, CA 90017

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedures (P&P) titled, N95 Fit Testing Policy, dated 1/10/2020, indicated employees who must wear respiratory protection to guard against aerosol transmissible pathogens will use NIOSH-certified N95 respirators that have been fit tested . The P&P indicated the facility shall make N95 respirators or equivalent available to employees who work near residents requiring droplet precautions or for high hazard procedures performed on residents requiring droplet precautions (procedures in place to prevent the spread of infection from one person to another by droplets of moisture released from the upper respiratory tract either by sneezing or coughing). The P&P indicated the facility shall conduct fit testing for employees before they are required to wear a respirator and the facility shall conduct fit tests for each employee according to the following schedule: - at the time of the initial fitting - when a different size, make, model or style of respirator is used; and - at least annually.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055704	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Angels Nursing Health Center	415 S Union Avenue Los Angeles, CA 90017

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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44253 Based on interview and record review, the facility failed to employ an Infection Preventionist Nurse (IP) at least part time as per the facility assessment (the facility's self-evaluation of its resident population and identification of the resources needed to provide the necessary person-centered care and services the residents require) dated January 2024. This deficient practice had to potential to affect the facility's ability to prevent and manage the spread of infection and diseases. Findings: A review of the facility assessment dated [DATE] indicated the full-time equivalent (FTE - measures the total amount of full-time employees working at any one organization) of required IP for the facility was 1. During an interview on 4/27/2024 at 3:48 PM, the Medical Records Designee (MRD) stated Licensed Vocational Nurse 3 (LVN 3) was the facility's IP. During an interview on 4/30/2024 at 10:54 AM, LVN 3 stated, I am a charge nurse, 7[am] to 3[pm] shift. I am not the IP at this time. LVN 3 stated the IP was responsible for preventing infections in the facility not only during COVID-19. LVN 3 stated it was important to have an IP to not only provide updates on immunizations and antibiotics, but it was for the safety and health of the residents. LVN 3 stated the IP prevented contamination in the facility that could harm the residents and staff. During an interview on 4/30/2024 at 1:30 PM, the facility Administrator (ADM) stated the facility did not have an IP. The ADM stated the last IP quit after one day of work. A review of the facility's policy and procedure titled, Scope of Infection Control Program, dated 6/2022, indicated, the infection preventionist refers to the person(s) designated by the facility to be responsible for the infection prevention and control program. It also indicated the infection control policies and procedures implementation and oversight are facilitated by the Infection Control Preventionist.