STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056008	A. Building B. Wing	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Rehabilitation Hospital	533 S. Fairfax Ave Los Angeles, CA 90036

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 0684 Level of Harm - Actual harm 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** 48026 Based on interview and record review, the facility failed to ensure for one of four sampled residents (Resident 1) who had a change in condition (CIC- is a sudden significant deviation from a patient's baseline in physical, cognitive mental ability to make decisions), manifested by chest congestion (abnormal or excessive accumulation of a body fluid), and productive cough, was assessed without a delay in treatment by failing to: 1. Ensure Licensed Vocational Nurse 3 (LVN 3) immediately checked Resident 1's vital signs (blood pressure [BP], heart rate [HR], respirations [RR], oxygen saturation [O2 Sat - amount of oxygen in the blood] and temperature [Temp]) when Certified Nursing Assistant 2 (CNA 2) informed LVN 3 that Resident 1 had a change in condition on [DATE] at around 7:30 AM. 2. Ensure LVN 3 immediately informed a Registered Nurse 1 (RN) on duty when Resident 1 had a CIC and Resident 1's chest was congested and had a productive cough (a cough that produces mucus) on [DATE] at around 7:30 AM. 3. Ensure RN 1 immediately checked and assessed Resident 1's BP, HR, RR, O2 Sat, and Temp, and performed chest auscultation (listening to the sounds of the lungs and heart) in accordance with the resident's care plan (CP- a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient), after LVN 3 informed RN 1 that Resident 1 had a productive cough on [DATE] at 10 AM. 4. Ensure RN 1 immediately notified a medical doctor (MD) or the nurse practitioner (NP- a nurse with advanced clinical education and training) and provided an accurate assessment report that Resident 1 had a CIC with productive cough and chest congestion on [DATE] at around 7:30 AM. These deficient practices resulted in 7 hours 10 minutes delay of necessary medical services for Resident 1. On [DATE] at 2:30 PM, Resident 1 was found unresponsive (when a person does not react or able to react in a normal way when touched, spoken to) in the facility. On [DATE] at 2:40 PM, Resident 1 was transferred to a general acute care hospital (GACH) via 911. The GACH diagnosed Resident 1 with septic shock (a life-threatening condition in which a widespread infection caused organ failure and dangerously low blood pressure), severe dehydration (a life-threatening emergency that happens when the body's response to an infection damages vital organs and, often, causes death). Resident 1 died on [DATE] at 3:23 PM, two days following transfer to the GACH. Findings: (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: 056008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024
NAME OF PROVIDER OR SUPPLIER Guardian Rehabilitation Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 533 S. Fairfax Ave Los Angeles, CA 90036	

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Admission Record (Face Sheet) indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including heart transplant (the patient's own heart is either removed and replaced with the donor heart), immunodeficiency (decreased ability of the body to fight infections and other diseases) due to drugs, essential hypertension (high blood pressure), chronic kidney disease stage 4 (longstanding disease of the kidneys leading to renal failure), and quadriplegia (complete or partial loss of muscle strength that affects all four limbs and body from the neck down). A review of Resident 1's Physician Orders for Life-Sustaining Treatment (POLST - is a medical order that tells emergency health care professionals what to do during a medical crisis where the patient cannot speak for him or herself) dated [DATE], indicated, Resident 1 selected Do Not Attempt Resuscitation/DNR (allow natural death). The POLST Interventions included Selective Treatment - Goal of treating medical conditions while avoiding burdensome measures . Use medical treatment, intravenous (IV - into a vein [blood vessel] antibiotics (medication to prevent or treat infection), and IV fluids as indicated . A review of Resident 1's Physician Order Summary Report dated [DATE], indicated, Resident 1 was able to consent and/or participate in treatment plan. A review of Resident 1's Minimum Data Set (MDS - a required standardized assessment and care planning tool) dated [DATE], indicated, Resident 1 was cognitively intact (mental ability to make decisions on activities of daily living), and was dependent on staff for activities of daily living, and used wheelchair for mobility. A review of Resident 1's Nursing Notes dated [DATE] at 10 AM indicated, LVN 3 documented that Resident 1's O2 Sat was 95% (normal between 95% and 100%) on room air. However, the progress notes did not indicate LVN 3, or RN 1 also checked Resident 1's BP, HR, RR, and or assessed the resident's breath sounds (Respiratory sounds, are specific sounds generated by the movement of air through the respiratory system [lungs etc]. Lungs that are functioning normally create a smooth, soft sound, and clear sounds). A review of Resident 1's Nursing Notes on the Change of Condition (COC - is a clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains that, without intervention, may result in complications or death) dated [DATE] at 10 AM, indicated, the licensed nurses did not describe Resident 1's productive cough such as presence of phlegm (thick substance secreted from the lungs and respiratory passages) and frequency that can be indicative of a respiratory problem. The progress notes indicated LVN 3 informed Family Member for Resident 1 (FMR1) that Resident 1 had a productive cough. A review of Resident 1's Nursing Notes on the COC dated [DATE] at 10 AM, indicated, LVN 3 did not document the character, color, and amount of Resident 1's productive cough in accordance with the resident's CP. The progress notes indicated there were no additional orders to identify the root cause of the resident's symptoms of cough and chest congestion. The progress notes indicated LVN 3 informed Family Member for Resident 1 (FMR1) that Resident 1 had a productive cough. A review of Nurse Practitioner 1 (NP 1) order dated [DATE] at 10:38 AM, indicated RN 1 documented to give Resident 1 Geri-Tussin (medication for cough) 5 milliliters (mL - a unit of measure in fluid volume) by mouth every six hours as needed for cough. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Situation-Background-Assessment-Recommendation (SBAR - a technique that provides a framework for communication between members of the health care team and used as a tool to foster patient safety) Communication form dated [DATE] at 2:30 PM, indicated, LVN 3 documented that Resident 1 had CIC with congestion, cough, SOB, tachycardia (HR over 100 beats per minute [bpm]; normal heart rate ,d+[DATE] bpm), and difficult to arouse (lack of awareness, alertness, and wakefulness). The SBAR form indicated, Resident 1 had a productive cough (consistency and color not indicated). The SBAR indicated Resident 1's BP was ,d+[DATE] millimeters of mercury (mmHg - normal ,d+[DATE]mmHg), HR was 150 bpm (normal ,d+[DATE] bpm), RR was 30 breaths per minute (normal ,d+[DATE] breaths per minute) and Temp was 100.3 degrees Fahrenheit (F - unit of measurement: Average normal body temperature 98.6 degrees F). However, there was no SBAR dated [DATE] from 7:30 AM after CNA 3 informed LVN 3 that the resident had a CIC. A review of Resident 1's Care Plan (CP- a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) titled Alteration in respiratory function, dated [DATE] with a re-evaluation date of [DATE], indicated, Resident 1 had an alteration in respiratory function as evidence by productive cough with SOB and congestion. The CP interventions included to notify the MD to obtain Lab orders, assess Resident 1's productive cough and the character and amount, color, and odor of the sputum, and the resident's breath sounds and RR. A review of MD 1 order documented by RN 1 on [DATE] at 2:50 PM, indicated MD 1 gave an order to transfer Resident 1 to GACH for SOB, lethargy (an unusual decrease in consciousness), desaturation (low oxygen level in the blood) via 911 (the telephone number used to reach emergency medical, fire, and police services). A review of Resident 1's GACH recurring laboratory (Lab) results indicated that on [DATE] at 4:58 PM, Resident 1's blood was drawn for white blood count (WBC - cells responsible for fighting infection). The same Lab results indicated Resident 1's WBC was 11.5 thousand/microliter (thous/mcL-unit of measurement: Normal range is between 4XXX,d+[DATE].5 thousand per mcL). A review of Resident 1's CP titled Periods of lethargy at risk for fall/injury dated [DATE] with a re-evaluation date of [DATE], indicated, Resident 1 had periods of lethargy at risk for fall/injury. The CP interventions included to notify the MD if Resident 1 continued to have change in level of consciousness (a state in one's awareness and alertness). A review of Resident 1's CP titled elevated temperature dated [DATE] with a re-evaluation date of [DATE], indicated, Resident 1 had an elevated temperature. The CP interventions included to administer prescribed medication, provide cooling measures (unspecified) for comfort, Lab orders, monitor vital signs, and report changes to MD. A review of Resident 1's Nursing Notes dated [DATE] at 2:30 PM, indicated that on [DATE] at 2:30 PM, LVN 3 informed FMR1 via telephone, that Resident 1's condition was deteriorating (worsening/declining), and that resident was unresponsive, was desaturation, was receiving supplemental (extra) oxygen, the resident's HR was 150 bpm, and that the resident was transferred to a GACH emergency room (ER) via 911 on [DATE] at 2:30 PM. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's GACH ER records dated [DATE] at 3:15 PM, indicated, Resident 1 arrived to the GACH from the facility on [DATE] (time not specified) The Resident had altered mental status (AMS - a change in mental function) showing symptoms of with lethargy and confusion with a Glasgow Coma Scale (GCS - describes the extent of impaired consciousness; GCS score range from 3 to 15; 15 means fully awake, score of 8 or less means person is in a coma (prolonged unconsciousness brought on by illness or injury) of 7. The ER records further indicated the resident required a Bilevel (a pressure-controlled, time-triggered, time-cycled mode of ventilation that allows unrestricted, spontaneous breathing with or without pressure support) Positive Airway Pressure (BIPAP - a small breathing device that helps a person breathe more easily) machine to assist Resident 1 with breathing. A review of Resident 1's GACH ER Laboratory result dated [DATE], indicated, Resident 1 tested positive for COVID-19 (a highly contagious respiratory disease caused by a respiratory virus). A review of Resident 1's GACH ER Lab records dated [DATE] ordered at 3:16 PM, indicated, Resident 1 was positive for Escherichia coli (E. Coli - a bacterial infection in the intestines that causes damage to the kidneys) in the blood, positive for COVID-19 through a nasal swab, and positive for Pseudomonas Aeruginosa (a bacterial infection that can cause pneumonia, and bloodstream infections) in the urine resulting in urinary tract infection (UTI - infection in the urinary system). A review of Resident 1's GACH ER Lab records dated [DATE] at 3:17 PM, indicated, Resident 1's arterial blood gas (ABG - a test that measures the balance of oxygen and carbon dioxide in the body to see how well the lungs are working) was metabolic acidosis (too much acid in the blood interfering), WBC was 10.68 thous/mcL, and lactic acid (a chemical in the body that ais produced when cells break down carbohydrates for energy) was 4.2 millimoles per Liter (mmol/L - unit of measurement; normal is between 0.5 and 2.2). A review of Resident 1's GACH ER records dated [DATE] at 3:27 PM, indicated, Resident 1 had an electrocardiogram (ECG or EKG - a quick test to check the heart rhythm), with results of sinus tachycardia (Heartbeat greater than 100 bpm; normal 60 to 100 bpm) at 135 bpm. A review of Resident 1's GACH ER diagnostic records dated [DATE] at 3:40 PM, indicated, Resident 1's chest Xray (CXR) indicated Resident 1 had pulmonary vascular congestion/edema (enlargement of the blood vessels in the lungs), and infection, plus minus atelectatic (collapse of the lungs) changes. A review of Resident 1's GACH ER diagnostic records dated [DATE] at 5:41 PM, indicated, Resident 1's computed tomography (CT - an imaging test that helps detect diseases and injuries in the body) scan of the brain, indicated the resident had bilateral (both sides) mastoid (large bone behind the ear) effusions (accumulation of fluid in response to negative pressure or inflammation). A review of Resident 1's GACH ER diagnostic records dated [DATE] at 5:43 PM, indicated, Resident 1's CT scan of the chest, abdomen, and pelvis indicated the resident had bilateral pneumonia, and volume overload which small ascites (accumulation of fluid in the abdomen) and diffused anasarca (extreme swelling throughout the entire body). (continued on next page)

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F 0684

Level of Harm - Actual harm

Residents Affected - Few

A review of Resident 1's GACH ER records dated [DATE] at 6:24 PM, indicated, Resident 1's FMR1, changed Resident 1's code status from DNR to a trial of intubation and aggressive treatment but no chest compressions, shock, or dialysis. The GACH ER records indicated Resident 1 was intubated (tube insertion through mouth or nose down into the windpipe to open the airway so oxygen can get through) due to hypoxemia (low levels of oxygen in the blood), received intravenous (IV- inside a vein) fluid resuscitation of 2, 000 milliliter [mL - there is 1,000 mL in one liter] of Lactated Ringer's solution (LR - fluid used to correct metabolic acidosis [buildup of acids in the body]) used during resuscitation to improve and restore intravascular volume [volume of blood in a person's cells in the body]), antimicrobial therapy for presumed sepsis (high likelihood of body responding improperly to an infection) were ordered, serial laboratory and diagnostic tests were performed.

A review of Resident 1's GACH records dated [DATE] at 6:53 PM, indicated, Resident 1 . was started on remdesivir (an antiviral medication for COVID-19), dexamethasone (aid in reducing swelling in the body), vancomycin (antimicrobial antibiotic; treatment for septic shock), cefepime (antibiotic treatment of UTI) and azithromycin (treatment for COVID-19). Resident 1 was seen by heart transplant team, infection control (prevents or stops the spread of infection) team, and nephrology (kidney) team from [DATE] until [DATE].

A review of Resident 1's GACH ER's History and Physical (H&P) dated [DATE] at 11:48 PM indicated GACH diagnosed Resident 1 with acute (sudden onset) urinary tract infection (UTI - an infection of the any part of the urinary system), septic shock, COVID-19, acute encephalopathy (severe and sudden onset of brain damage), and severe dehydration (excessive loss of body fluid).

A review of GACH ER records dated [DATE] at 11:53 PM, indicated, a central line (used for multiple vasoactive medications (raises the BP), and large amounts of fluids or medicines) insertion was successfully placed to Resident 1's right femoral vein (large blood vessel in the right thigh). Resident 1 was started on vasopressors (medicines that treat severely low blood pressure) after successful insertion of the central line. Resident 1's BP was ,d+[DATE] mmHg.

A review of Resident 1's GACH ER diagnostic records dated [DATE] at 11:59 PM, indicated, Resident 1 underwent a heart ultrasound of the inferior vena cava (IVC - largest vein the in the body) showed IVC diameter collapsed greater than 50% (normal 0 to 5 mmHg).

A review of Resident 1's GACH ER result dated [DATE] at 3:10 AM, indicated, Resident 1's cytomegalovirus DNA (CMV DNA - a test used as an aid in the management of solid organ transplant patients and to detect whether a CMV virus exists in the body) result was detected at less than 500 International Units per milliliter (IU/mL - a unit of measurement commonly used for biological activity of substances; normal range 200 to 100,000,000 IU/ mL).

A review of Resident 1's GACH Coronary Care Unit (CCU - hospital unit that specializes in the care of patients with heart problems) records dated [DATE] at 7:30 AM, indicated, Resident 1's transthoracic echocardiogram (TTE - uses sound waves to create images of the heart to see how the heart beats and for any heart issues) final result was a left ventricular ejection fraction (left side of the heart showed how much oxygen-rich blood was pumped out throughout the body) was severely depressed at 20% to 25% (normal 50% to 70%), bilateral (both sides) pleural effusions (buildup of excess fluid between the layers of the lungs) are seen, and pulmonary artery systolic pressure plus right atrial pressure (right side of the heart collects venous blood from the body) was at 36 mmHg (normal 20 mmHg or less).

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's GACH Death Pronouncement (to make a formal declaration of the death) Note dated [DATE] at 3:24 PM, indicated, On my physician exam, the patient [Resident 1] was found to be without pulses, heart sounds (HR) or breath sounds. Pupils fixed (not reacting to light) and dilated. Patient [Resident 1] was pronounced dead on [DATE] at 3:23 PM . A review of Resident 1's GACH CCU records dated [DATE] at 4:23 PM, indicated, Resident 1 continued to decline even with aggressive medical management. FMR1 decided to transition Resident 1 to comfort care measures (provide physical, emotional, social, and spiritual support to patient and family) and end of life care (control pain and provide comfort). Resident 1 was pronounced dead on [DATE] at 3:23 PM. During a telephone interview on [DATE] at 10:36 AM with FMR1, FMR1 stated that on [DATE] left at around 5:30 pm or so, RN 1 left a voicemail message for FMR1 stating that Resident 1, was not doing well, we (facility) called 911 and [Resident 1] was taken to the hospital. FMR1 stated, no one called me about his change of conditions. FMR1 stated FMR1 returned the telephone call and a nurse (unable to remember) told FMR1 that Resident 1 was found not very responsive and that Resident 1 , seemed to be very, very weak and that was the reason the facility transferred Resident 1 to the GACH. During an interview on [DATE] at 11:11 AM with Resident 2, Resident 2 stated Resident 2 was sharing a room with Resident 1. Resident 2 stated Resident 1 sometimes would cough a lot and then it would be done in a day or two. I think it (cough) started around end of May or early [DATE]. Resident 2 stated he was not in his room when Resident 1 was sent to the GACH on [DATE] at 2:40 PM. During an interview on [DATE] at 2:21 PM with CNA 2, CNA 2 stated that on [DATE] at around 7:30 AM, CNA 2 verbally notified LVN 3 that Resident 1 was already looking off, [Resident 1] wasn't alert as usual, pale, overly tired. CNA 2 stated that on the same day, CNA 2 was feeding lunch around 12 PM and 12:30 PM to Resident 1, but Resident 1 only had a small piece of the food and didn't want any more. CNA 2 stated, I told [LVN 3] that [Resident 1] was quiet and didn't each much of anything at all. CNA 2 stated on the same day between 2:30 PM and 2:40 PM, I observed [Resident 1] to be worse compared to morning. [Resident 1's] breathing was shallow, he looked very tired, his eyes were closed, he responded only after I tried to wake him up so many times, he just gruntled (mumbled-difficult to hear/understand) and spoke softly. It was hard for him to respond. CNA 2 stated, I got the charge nurse [LVN 3] right away. During an interview on [DATE] at 3:01 PM with LVN 2, LVN 2 stated that on [DATE] at 3:01 PM, LVN 2 went to Resident 1's room to assist LVN 3 and took Resident 1's vital signs. LVN 2 stated Resident 1 had elevated temp 100.3 F. [Resident 1] was hot to touch, the breathing was abnormal, was unable to record/get the BP, HR was 150 bpm, and O2 Sat was 80%. LVN 2 stated Resident 1 was started on 15 liters of supplemental (extra) oxygen. During a record review on [DATE] at 8:30 AM of Resident 1's entire medical paper chart, there were no Labs or CXR orders received/documented from NP 1 for [DATE] for Resident 1 when the resident's CIC was reported to NP1. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on [DATE] at 1:44 PM with LVN 3, LVN 3 stated that on [DATE] at 2:30 PM, Resident 1 was difficult to arouse ,I was calling his name with a loud voice, I touched him and shook his shoulders, he did not open his eyes, he did not verbally respond to me and immediately notified RN 1 of Resident 1's CIC condition. LVN 3 stated other nurses came into Resident 1's room to assist. LVN 3 stated he used the sphygmomanometer (manual blood pressure) to check on Resident 1's BP but was not able to get any readings. LVN 3 stated he asked other nurses to check on Resident 1's BP but the nurses was not able to get any BP readings on Resident 1. LVN 3 stated that on the same day at 2:30 PM, Resident 1's HR was 150 bpm, RR 30 per minute, O2 Sat was 82%, Temp was 100.3 F. LVN 3 stated the resident's blood glucose was checked but LVN 3 could not remember the reading. LVN 3 stated Resident 1 was administered supplemental oxygen of 15 liters using the non-rebreather mask (medical device that delivers high concentration of oxygen). LVN 3 stated CPR was not performed because Resident 1 was a do not resuscitate (DNR - no resuscitation attempt when the heart or breathing stops). During an interview on [DATE] at 2:56 PM with RN 1, RN 1 stated LVN 3 did not notify RN 1 that Resident 1 had a productive cough, [LVN 3] told me [Resident 1] is coughing. RN 1 did not ask LVN 3 the description of Resident 1's productive cough. RN 1 stated, if [LVN 3] told me the resident's cough was productive, right away I will request for a chest x-ray (CXR) order, check the lung sounds, do blood draws and .to check on the resident's oxygen saturation. RN 1 stated RN 1 visually assessed Resident 1 for SOB and none was noted. RN 1 stated, I saw [Resident 1's] chest rising and normal breathing. I listened to [Resident 1's] lung sounds and was normal. RN 1 stated RN 1 checked on Resident 1 two times before lunch, there was nothing abnormal . RN 1 stated LVN 3 did not notify RN 1 that Resident 1's Temp was 99.4 degrees F on [DATE] at 11 AM. RN 1 stated a temp of 99.4 degrees F means a possible infection is coming or already here. RN 1 stated she would have requested MD or NP for CXR order to see if Resident 1 had lung infection and blood work to check if his white blood count (white blood cells fight infection) was high. RN 1 stated RN 1 would have checked if Resident 1 was dehydrated (losing more fluid than taking in) when urine output was low, decreased food intake, high HR, and the low BP. During a concurrent observation of the facility's iPad (small computer) and interview on [DATE] at 2:56 PM with RN 1, RN 1 stated nurses use an iPad just for texting doctors or NPs .nothing else. RN 1 searched on the iPad for messages between the nurses and NP 1 on [DATE] for 15 minutes and re-started the iPad three times. When asked RN 1 to show evidence for the conversation between nurses and NP 1, RN 1 stated the text messages, were erased; only messages from [DATE] and after, are available. The other text messages to MDs and NPs messages are all here, just NP 1 messages are gone. RN 1 was not able to show SA any communications made on [DATE] between nurses and NP 1. During a return telephone call on [DATE] at 10:37 AM from NP 1, NP 1 stated the facility's nurses contact NP 1 via text message. When asked if any of the facility nurses reported Resident 1 was having a productive cough with yellowish phlegm (sputum), NP 1 stated that on [DATE] sometime in the morning (unable to state exact time), the text communication stated only that he was congested. When NP 1 was asked if any of the nurses had informed NP 1 that Resident 1 had a fever of 99.4 F, NP 1 stated, I don't recall them (nurses) mentioning it (fever). I don't see any report about a fever for this patient. NP 1 stated that the initial communication was that the patient [Resident 1] had a cough and not a fever. Then in the afternoon, the patient was still coughing and congested, but no fever was mentioned. Labs and CXR were ordered by phone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056008	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Rehabilitation Hospital	533 S. Fairfax Ave Los Angeles, CA 90036

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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 - Actual harm Residents Affected - Few	A review of the facility's undated RN Supervisor job description (a written explanation that outlines the essential responsibilities and requirements for a specific position) indicated, RN supervisor's general duties and responsibilities included performed resident assessment, initiate emergency measures, communicates with the physician the status of the resident condition and carry out any orders. However, CXR was not performed while the resident was in the facility. A review of the facility's P&P titled Emergency Care dated ,d+[DATE] indicated, all resident change of conditions (COC). If the resident's condition has changed, the attending physician should be called and the changes that have been observed should be reported. Emergency care is to be provided as necessary . Resident's family should be notified of a change in the resident's condition . Observation of the resident at regular intervals. A review of the facility's P&P titled Physician Services and Orders dated ,d+[DATE] indicated, verbal orders must be recorded immediately in the resident's clinical record by the person receiving the order and must include the date and time of order. A review of the facility's P&P titled Certified Nursing Assistant (CNA) Notes dated ,d+[DATE], indicated, CNA shall record entries in the resident's health record after .observation of how the resident looks, feels, eats, drinks, reacts, interacts . CNAs must document their observation in the resident's chart and to report all change of conditions to the charge nurse and to document in the daily notes. A review of the facility's policy and procedure (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Licensed Nurses - Assessments and Notes dated ,d+[DATE] indicated, changes in the resident's condition that require a call to the physician shall be recorded by the nurse reporting; the physician shall be notified promptly and the resident representative of any sudden and/or marked adverse change in signs, symptoms or behavior exhibited by a resident. Acute conditions in the resident shall have adequate follow-up notes concerning the progress and resolution of the condition.