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	01/30/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on observation, interview, and record review, the facility failed to ensure two of seven sampled residents (Residents 49 and 54) received appropriate services to prevent a decline in range of motion (ROM, full movement potential of a joint) and mobility by failing to: -For Resident 49, put on a left knee splint correctly during the 1/28/25 Restorative Nursing Aide (RNA, nursing aide program that help residents to maintain their function and joint mobility) treatment session as ordered by a physician. -For Resident 49, provide an appropriate RNA order for wearing both knee splints for no more than three hours as determined by physical therapy. -For Resident 54, provide resident with active range of motion (AROM, movement at a given joint when the person moves voluntarily) exercises to both upper extremities and both lower extremities during the 1/28/25 RNA treatment session as ordered by a physician. These deficient practices had the potential for injury and worsening of contractures (a stiffening / shortening at any joint, that reduces the joint's range of motion) in Resident 49 and a decline in strength and functioning in Resident 54. CROSS REFERENCE TO F726 Findings: a. A review of Resident 49's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including severe sepsis (a life-threatening blood infection) with septic shock (life-threatening drop in blood pressure), muscle wasting and atrophy (gradual decline), and generalized osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). A review of Resident 49's History and Physical (H&P) dated 11/14/24 indicated the resident lacked the capacity to make medical decisions. (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 01/30/2025
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 49's Contractures Care Plan revised 11/21/24, indicated the resident was at risk for contractures related to limited mobility with impaired ROM of BUE and BLE. The care plan interventions indicated to report any abnormality to physician, RNA program as ordered, and physical therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) and occupational therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) evaluation and treatment. A review of the Physician's Order Summary Report dated 12/13/24 indicated for RNAs to perform donning (put on) and doffing (take off) of bilateral (both sides) knee splints four to six hours as tolerated for Resident 49, to prevent further tightness / contracture once a day seven days a week. A review of Resident 49's Minimum Data Set (MDS - a resident assessment tool) dated 10/29/25, indicated the resident had severe cognitive impairments (difficulty with or unable to make decisions, learn, remembering things), had functional limitations in ROM on both sides of the lower extremities (LE, hip, knee, ankle, foot) and did not have any functional limitations in ROM on the upper extremities (UE, shoulder, elbow, wrist, hand). The MDS indicated Resident 49 required dependent assistance from staff with toileting hygiene, showering, lower body dressing, sit to lying, sit to stand, and bed-to-chair transfers. During an observation on 1/28/25 at 10:38 a.m., in Resident 49's room, Resident 49 was sitting up in a wheelchair. RNA 1 took two splints from the closet and put the knee splints on Resident 49's left and right knees. RNA 1 put the left knee splint low on the Resident 49's leg and the knee portion of the splint was on the lower part of the leg and not over the left knee. RNA 1 put the right knee splint over the right knee. RNA 1 then indicated the RNA treatment was complete and left the room. During an observation and concurrent interview on 1/28/25 at 11:07 a.m., in Resident 49's room, Physical Therapist (PT) 1 observed the left knee splint on Resident 49's left leg and stated the left knee splint was too low and should be put on higher. PT 1 proceeded to take off the left knee splint and placed it higher on Resident 49's leg and the knee portion of the splint was over the left knee. PT 1 stated splints should be put on correctly because otherwise the splints were not serving its purpose, and the contracture could get worse. During an interview on 1/29/25 at 2:22 p.m., the Director of Nursing (DON) stated RNAs need to place splints on residents correctly so that residents did not develop contractures and have limitations in ROM. A review of the facility's policy and procedure (P&P) titled, Splint Application, revised 5/17 indicated, Splints must be applied correctly to maintain the resident's range of motion and prevent contractures and further loss of range of motion. b. A review of Resident 49's Physical Therapy Evaluation and Plan for Treatment dated 11/14/24, indicated the resident had impairments in ROM in both knees in extension (cannot fully straighten both knees). The PT Evaluation indicated a long-term goal for Resident 49 to safely wear a knee extension splint on left knee and right knee for up to four hours with minimal signs and symptoms of redness, swelling, discomfort or pain. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 49's PT Treatment Encounter Notes dated 11/19/24, indicated the resident tolerated both knee splints for 30 minutes. The PT Treatment Encounter Notes indicated on : -11/26/24, Resident 49 tolerated both knee splints for 45 minutes. -11/27/24, Resident 49 tolerated both knee splints for 45 minutes. -12/2/24, Resident 49 tolerated both knee splints for 45 minutes. -12/3/24, Resident 49 tolerated both knee splints for one hour -12/4/24, Resident 49 tolerated both knee splints for one hour. -12/5/24, Resident 49 tolerated both knee splints for two hours. -12/6/24, Resident 49 tolerated both knee splints for two and a half hours. -12/9/24, Resident 49 tolerated both knee splints for three hours without signs of skin breakdown or redness. -12/10/24, Resident 49 tolerated both knee splints for three hours without adverse skin effects. -12/11/24, Resident 49 tolerated both knee splints for three hours. A review of the PT Discharge Summary dated 12/11/24, indicated Resident 49's maximum tolerance for the goal of wearing a knee extension splint on left and right knee with minimal signs and symptoms of redness, swelling, discomfort or pain was three hours. During a concurrent interview and record review on 1/29/25 at 9:19 a.m. with PT 1, Resident 49's Physical Therapy records were reviewed. PT 1 stated PT established the maximum time Resident 49 could tolerate both knee splints without the splints bothering her was three hours. PT 1 stated three hours was the safe wearing time for Resident 49 without the splints causing skin irritation or breakdown or pain. PT 1 stated Resident 49's current RNA order was to wear both knee splints for four to six hours as tolerated. PT 1 stated the RNA order should not be to wear both knee splints for four to six hours, it should be to wear both knee splints for three hours maximum. PT 1 stated because Resident 49 was tolerating the knee splints for three hours with PT, Resident 49 should not wear the knee splint for more than three hours, because Resident 49 could have skin irritation, pain, skin breakdown, and soreness. A review of the facility's P&P titled, Splint Application, revised 5/17, indicated splints be applied correctly to maintain the resident's range of motion and prevent contractures and further loss of range of motion. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. A review of Resident 54's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death) affecting left non-dominant side and bilateral primary osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of knee. A review of Resident 54's MDS dated [DATE], indicated the resident had no cognitive impairment, had functional limitation in ROM impairment on one side of the upper extremity, and did not have any functional limitation in ROM on the lower extremities. The MDS indicated Resident 54 required setup or clean-up assistance with eating and oral hygiene, moderate assistance with bed mobility, sit to stand, bed-to-chair transfers, and walking, and dependent assistance with toileting hygiene and lower body dressing. The MDS also indicated Resident 54 received six days of RNA for active ROM and six days of RNA for walking. A review of the Physician's Order Summary Report dated 1/28/25, indicated the following orders for Resident 54: -RNAs to perform ambulation using front-wheeled walker (FWW, type of mobility aid with wide base of support and two wheels in the front) once a day, six times a week as tolerated dated 7/2/24. -RNAs to perform AROM to BLE every day six times a week as tolerated dated 7/2/24. -RNAs to perform AROM to BUE every day six times a week as tolerated dated 7/2/24. -RNAs to supervise resident using stationary bike (personal bike) for 10 minutes every day six times a week as tolerated dated 12/9/24. A review of Resident 54's Musculoskeletal Care Plan revised 12/12/24, indicated the resident was at risk for impaired mobility and function related to limited mobility, impaired ROM of RUE, and left sided hemiplegia. The care plan goal indicated to maintain current level of function without any signs and symptoms of complications daily for 90 days. The care plan interventions included RNA program as ordered. A review of Resident 54's Contractures Care Plan, revised 12/12/24, indicated the resident was at risk for impaired contractures related to limited mobility and impaired ROM of RUE. The goal indicated to minimize incidence of contractures daily for 90 days and the care plan interventions included RNA program as ordered and encourage participation to exercise and activity program. During an observation and concurrent interview on 1/28/25 at 8:50 a.m., Resident 54 was sitting up in a wheelchair in Resident 54's room. Resident 54 stated she walked with RNA, would like to keep doing exercises for her arms and legs, and now only walked. Resident 54 stated walking did not help with the arms and legs. Resident 54 was able to move both arms a little past shoulder level, and was able to straighten and bend both elbows, wrist and fingers. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of Resident 54's RNA treatment session and interview on 1/28/25 at 9:51 a.m., Resident 54 was sitting in a WC in the hallway. RNA 1 and RNA 2 assisted Resident 54 to stand up. RNA 1 walked with Resident 54 with FWW while RNA 2 followed behind with the wheelchair. Resident 54 ambulated down two and a half hallways and sat down to rest for about four minutes. Resident 54 proceeded to walk with the FWW down half a hallway back into Resident 54's room. RNA 1 assisted Resident 54 in setting up the personal leg exercise stepper and Resident 54 completed the exercise for 10 minutes. RNA 1 left Resident 54's room and went to another resident's room to complete the RNA treatment for a different resident. Resident 54 did not perform any AROM exercises with RNA. During an interview and record review on 1/28/25 at 10:28 a.m., RNA 1 reviewed Resident 54's RNA orders and stated Resident 54 had RNA orders for AROM for BUE and BLE six times a week. RNA 1 stated RNA 1 did not complete the AROM exercises yet for BUE and BLE and would go back to Resident 54 to complete those exercises. During an observation and concurrent interview on 1/28/25 at 10:38 a.m., Resident 54 was sitting up in a wheelchair in Resident 54's room. RNA 1 put his hand on Resident 54's elbow and wrists and performed passive range of motion (PROM, movement at a given joint with full assistance from another person) to Resident 54's right shoulder, right elbow, right wrist, right fingers followed by PROM to Resident 54's left shoulder, left elbow, left wrist, and left fingers. RNA 1 then left Resident 54's room. RNA 1 did not complete any AROM exercises for Resident 54's BUE or BLE. RNA 1 stated Resident 54 had orders for AROM for BUE and BLE. On 1/28/25 at 10:51 a.m., during an interview, PT 1 stated residents were discharged after therapy to an RNA program depending on each resident's capacity. PT 1 stated if residents had the cognition and strength to complete AROM exercises, then residents would be put on an RNA program for AROM exercises. During an interview on 1/28/25 at 11:07 a.m., PT 1 stated RNAs should be following the AROM exercise RNA orders as written in order for the residents to use their muscles and maintain their strength. PT 1 stated residents who could perform AROM exercises should not do passive ROM exercises, because the residents could get weaker or develop contractures. During an interview on 1/29/25 at 10:07 a.m., the Director of Staff Development (DSD) stated Resident 54 had an order for RNA for AROM for BUE and BLE. The DSD stated that RNAs should perform AROM exercises for BUE and BLE for Resident 54 because that was the physician's order and that was the specific program that the rehabilitation department determined was appropriate for Resident 54. The DSD stated it was important for Resident 54 to perform the BUE and BLE AROM exercises herself because otherwise Resident 54 would rely on equipment or others to move their joints. During an interview on 1/29/25 at 2:22 p.m., the Director of Nursing (DON) stated the RNA program was to help residents maintain their strength, endurance, and abilities so that the residents did not decline in ambulation and function. The DON stated the RNA program was established by rehabilitation department for each resident. The DON stated it was important for RNAs to follow the RNA program and RNA orders. The DON stated it was important for RNAs to communicate if they were not completing AROM exercises for the resident. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Limitations in Range of Motion and Mobility and Referrals for Therapy, revised 10/17, indicated a resident who enters the facility without limited range of motion did not experience a reduction in range of motion. A resident with limited range of motion would be provided appropriate treatment and services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43851 Based on observation, interview, and record review, the facility failed to implement interventions to prevent accident risks and hazards for one of five sampled residents (Resident 77. Resident 77 was not provided supervision and assistance with transfers. This deficient practice resulted in Resident 77 sustaining a fall on 1/27/2025, which had the potential for the resident to develop an injury. Findings: A review of Resident 77's Admission Record indicated the facility admitted the resident on 1/9/2025 with diagnoses including hemiplegia (severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (mild or partial weakness or loss of strength on one side of the body), difficulty in walking, lack of coordination (a condition that affects the body's ability to control and execute smooth, precise movements), cerebral infarction (stroke, injury to part of the brain that can affect the use of the body and the ability to speak and walk), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities of living), and unspecified mood affective disorder (a group of mental health conditions characterized by significant and persistent disturbances in mood). A review of Resident 77's Minimum Data Set (MDS, a resident assessment tool) dated 1/16/2025, indicated the resident had severe cognitive impairment (ability to think, understand, and reason) and normally used a walker and a wheelchair. The MDS indicated Resident 77 required substantial / maximal assistance (helper does more than half the effort) with toileting hygiene, required partial / moderate assistance (helper does less than half the effort) with walking 10 feet, with sitting to standing, and with transferring to and from a bed to a chair or wheelchair. The MDS further indicated Resident 77 did not have any fall history on admission to the facility. A review of Resident 77's Fall Risk Evaluation dated 1/23/2025, indicated the resident was considered a high risk for potential falls. A review of Resident 77's care plan revised 1/23/2025, indicated the resident had an actual fall on 1/22/2025 and an unwitnessed fall on 1/23/2025. The care plan indicated the goal for Resident 77 was to be free from future falls and complications. The care plan interventions included frequent visual monitoring, placing the call light within easy reach, encouraging the resident not to get up without assistance, keeping the resident's surroundings free from clutter, and applying a bed alarm. During a concurrent observation and interview on 1/27/2025 at 12:38 AM, in Resident 77's room, the resident was observed sitting on floor, a wheelchair was observed near the resident, and the resident's call light was lying on the bed. Resident 77 stated he did not know how he got on the floor. There were no injuries observed on Resident 77's head or body. Resident 77 stated he was not in pain. Further observation indicated there were no facility staff present in Resident 77's room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/27/2025 at 1 PM, Registered Nurse Supervisor (RNS) 1 stated Resident 77 fell from his wheelchair. RNS 1 stated Resident 77 was brought into his room by wheelchair from the dining room prior to the fall. RNS 1 stated that she assessed Resident 77, and the resident did not have any visible physical injuries. RNS 1 stated Resident 77 was not in pain but could not recall what happened. RNS 1 stated Resident 77's Nurse Practitioner (NP) was at bedside assessing the resident and provided orders to transfer the resident to the General Acute Care Hospital (GACH). RNS 1 stated there were no staff that saw Resident 77 fall. RNS 1 stated Resident 77 was a high risk for falls and normally needed assistance with transferring from the wheelchair, the bed, and with ambulation to the bathroom. RNS 1 stated if Resident 77 had assistance with transferring the resident would not have attempted to get out of the wheelchair by themselves and would not have fallen. RNS 1 stated there was a potential Resident 77 could have injured himself because of the fall. A review of Resident 77's SBAR (situation, background, assessment, recommendation - a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form dated 1/27/2025, indicated the resident had a fall, was awake, verbally responsive, and had no shortness of breath. The form indicated Resident 77 was found sitting on the floor, was assessed and denied any pain or discomfort. The form indicated Resident 77 was able to move both upper and lower extremities without difficulty and had no new skin breakdown. The form indicated Resident 77 answered incoherently and the Nurse Practitioner was notified. A review of the Physician's Order dated 1/27/2025 at 1:46 PM, indicated Resident 77 was transferred to GACH 1 for further evaluation status post fall. A review of Resident 77's GACH After Visit Summary dated 1/27/2025, indicated the resident was seen in the emergency department when he was found fallen out of his wheelchair. The summary indicated Resident 77 had a Computed Tomography (CT - diagnostic imaging procedure that uses a computer linked x-ray machine to create detailed images of the inside of the body) scan of the brain and neck which did not show any internal bleeding or injuries. The summary indicated Resident 77's blood work did not show any acute abnormal findings. The summary further indicated it was safe for Resident 77 to return to the facility. During an interview on 1/30/2025 at 2:45 PM, the Director of Nursing (DON) stated Resident 77 was a high risk for potential falls and had fallen before at the facility. The DON stated Resident 77 needed assistance transferring and was not safe to ambulate on their own. The DON stated Resident 77 needed frequent visual monitoring and supervision to prevent falls. The DON stated there was a potential for Resident 77 to fall again and develop an injury if the resident would not be adequately monitored and supervised. A review of the facility's policy and procedure titled, Fall Risk & Prevention of Injury to Include Pathological Fractures, reviewed 1/14/2025 indicated, It is the policy of the facility to identify residents that are at risk for falls and to implement a plan of care in an attempt to prevent falls. This include minimizing risk for pathological fractures .If the Fall Risk Assessment score is ten (10) or above, the resident is at risk for falls and a plan of care will be developed with approaches in an attempt to prevent falls, including falls with serious injury .Approaches to prevent falls and/or fracture may include: . Encouraging the resident to ask for assistance .scheduled toileting programs .assisting residents with ambulation as appropriate.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50296 Based on observation, interview and record review, the facility failed to ensure one sampled resident (Resident 230) receiving oxygen therapy had properly labeled nasal cannula (tubing that provides additional oxygen through the nose), pre-filled humidifier (a medical device that adds water vapor to oxygen to help prevent dry air from irritating the sinuses and lungs), and a physician's order to administer the oxygen therapy. This deficient practice caused an increased risk in Resident 230 having skin breakdown and exacerbation of symptoms. Findings: A review of Resident 230's admission record indicated the resident was admitted to the facility on [DATE] with a diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), cerebral infarction (a medical condition where blood flow to the brain is interrupted, causing brain tissue to die), and nicotine dependence. A review of Resident 230's Minimum Data Set (MDS - a resident assessment tool), dated 1/31/25, indicated no acute change in mental status, resident was alert and oriented, and had no indicators for psychosis. During a concurrent observation and interview on 1/27/25 at 9:35 am with Licensed Vocational Nurse (LVN) 2 in Resident 230's room, Resident 230 was lying in bed on her cell phone with the call light was within reach. During the observation, Resident 230 received oxygen at two liters via nasal cannula with a pre-filled humidifier. LVN 2 confirmed and stated Resident 230's nasal cannula and humidifier were not labeled, and both should be labeled. During concurrent interview and record review on 1/28/25 at 9:48 am with the Director of Staff Development (DSD), Resident 230's physician's orders were reviewed. The physician's orders indicated Resident 230 did not have an order for oxygen. The DSD stated she did not see the order for oxygen for Resident 230. The DSD stated there must be a physician's order for oxygen for residents diagnosed with COPD. The DSD stated the risk to Resident 230 was the special parameters for residents with COPD on oxygen may be missed. A review of the Physician's Order dated 1/28/25 timed at 10:07 am, indicated Resident 230 to receive oxygen via nasal cannula on continuous flow to maintain the oxygen saturation (measure of how well the body is oxygenating the blood) above 94% for diagnosis of COPD. During an interview on 1/29/25 at 9:07 am, the Director of Nursing (DON) stated both the nasal cannula and humidifier should be labeled with date and initials of the nurse who prepped the oxygen. The DON stated the risk to Resident 230 without labeling the nasal cannula and humidifier would be skin breakdown and the humidifier could run out which caused Resident 230 to have an exacerbation of symptoms such as shortness of breath. The DON stated when there was a respiratory diagnosis, there was a standard as needed oxygen order that was used, unless the nurse practitioner or physician had other oxygen orders. The DON stated for Resident 230, the standing order should have been initiated but it was missed upon the resident's admission. The DON stated the risk to Resident 230 without a physician's order would be the nurses could not administer the required oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 3/2017, indicated to verify there was a physician's order for oxygen administration. A review of the facility's P&P titled, Oxygen Concentrators, dated 6/2017, indicated pre-filled humidifiers should be dated and replaced weekly or as needed.

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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. 41379 Based on observation, interview, and record review, the facility failed to ensure annual competencies were completed for six of six sampled Restorative Nursing Aides, who perform RNA program tasks including putting on and taking off splints and braces. This deficient practice had the potential to result in injury, worsening contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion), and skin breakdown for residents who require splints and braces for physical therapy. CROSS REFERENCE TO F688 Findings: A review of Restorative Nursing Aide (RNA) 2's RNA Competency Evaluation dated 8/23/24 indicated there was no skills performance check on how to put on and take off splints and braces. A review of RNA 1's RNA Competency Evaluation dated 11/18/24 indicated there was no skills performance check on how to put on and take off splints and braces. A review of RNA 3's RNA Competency Evaluation dated 11/29/24 indicated there was no skills performance check on how to put on and take off splints and braces. Further review of RNA 4, 5 and 6's competency evaluations indicated there was no skills performance check on how to put on and take off splints and braces. During an observation on 1/28/25 at 10:38 a.m., in Resident 49's room, Resident 49 was sitting up in a wheelchair. Restorative Nursing Aide (RNA) 1 took two knee splints from the closet and placed knee splints on Resident 49's left and right knees. RNA 1 put the left knee splint low on the Resident 49's leg and the knee portion of the splint was on the lower part of the leg and not over the left knee. RNA 1 put the right knee splint over the right knee. RNA 1 indicated the RNA treatment was complete and left the room. During an observation and interview on 1/28/25 at 11:07 a.m. in Resident 49's room, Physical Therapist (PT) 1 observed the left knee splint on Resident 49's left leg and stated the left knee splint was too low and should be placed higher on the left leg. PT 1 proceeded to take off the left knee splint and placed it higher on Resident 49's leg where the knee portion of the splint was over the left knee. PT 1 stated splints should be put on correctly because otherwise the splints were not serving its purpose and Resident 49's contracture could get worse. (continued on next page)

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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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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 1/29/25 at 10:07 a.m., the Director of Staff Development (DSD) stated she was the supervisor for the RNAs and the RNA competencies were completed annually with the therapy department. The DSD reviewed RNA 1 and RNA 2's annual competency dated 11/18/24 and 8/23/24 and stated there was no competency check for how to put on and take off splints and braces. The DSD stated there should be a competency check for how to put on and take off splints and braces, because the facility needed to make sure the RNAs were putting the splints and braces on properly and in the correct place, to ensure it did not cause any injury to the residents. The DSD stated the RNA annual competency checklist did not include splints or braces. During an interview and record review on 1/29/25 at 2:48 p.m., the DSD reviewed annual competencies for RNA 3 4, 5 and 6 and confirmed the RNAs did not receive an annual competency for putting on and taking off splints and braces. During an interview and record review on 1/30/25 at 8:12 a.m., PT 1 reviewed the annual RNA competency checklist and confirmed PT 1 did not review and evaluate RNAs on splinting and brace skills. A review of the facility's policy and procedure titled, Policy for Staff Competencies, revised 1/2017, indicated, performance evaluations are to ensure that staff has the appropriate competencies and skills to assure resident safety and to provide care which includes assessing, evaluating, planning and implementing resident care plans and responding to resident needs, performance evaluations of staff will be completed annually. A review of the facility's policy and procedure titled, Splint Application, revised 5/2017, indicated, it is the policy of the facility that splints be applied correctly to maintain the resident's range of motion and prevent contractures and further loss of range of motion.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on observation, interview, and record review, the facility failed to maintain complete and accurate documentation for one of six sampled residents (Resident 49), when Resident 49's tolerance of both knee splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) were not documented with the accurate time. This deficient practice had the potential for inaccurate medical documentation and reporting of RNA treatments, which can minimize the facility's ability to recognize a change of condition and reassess Resident 49's tolerance for knee splints. Findings: A review of Resident 49's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including severe sepsis (a life-threatening blood infection) with septic shock (life-threatening drop in blood pressure), muscle wasting and atrophy (gradual decline), generalized osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). A review of Resident 49's History and Physical (H&P) dated 11/14/24 indicated the resident lacked the capacity to make medical decisions. According to a review of Resident 49's Care Plan for Contractures revised 11/21/24, the resident was at risk for contractures related to limited mobility with impaired ROM of BUE and BLE. The care plan goal indicated Resident 49 would minimize the incidence of contractures daily for 90 days. The interventions indicated to report any abnormality to physician, RNA program as ordered, and physical therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) and occupational therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) evaluation and treatment. A review of Resident 49's Minimum Data Set (MDS - a resident assessment tool) dated 10/29/25, indicated the resident had severe cognitive impairments (difficulty with or unable to make decisions, learn, remembering things), had functional limitations in range of motion (ROM) on both sides of the lower extremities (hip, knee, ankle, foot), and did not have any functional limitations in ROM on the upper extremities (UE, shoulder, elbow, wrist, hand). The MDS also indicated Resident 49 required dependent assistance from staff with toileting hygiene, showering, lower body dressing, sit to lying, sit to stand, and bed-to-chair transfers. A review of the Physician's Order Summary Report dated 1/28/25, indicated on 12/13/24 for RNAs to perform donning (put on) and doffing (take off) of bilateral (both sides) knee splints four to six hours as tolerated to prevent further tightness / contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) once a day seven days a week. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 49's January 2025 RNA flowsheet, there was no indication of how many hours Resident 49 wore both knee splints from 1/1 to 1/27/25, for the RNA task to perform donning/doffing of bilateral knee splints 4 to 6 hours as tolerated to prevent further tightness/contracture once a day, seven times a week. During an observation and interview on 1/28/25 at 10:17 a.m., in Resident 49's room, Resident 49 was sitting up in a wheelchair next to the bed. Restorative Nursing Aide (RNA) 1 performed ROM exercises to Resident 49's BUE and BLE. RNA 1 stated he could not find the knee splints and did not put on the knee splints for the resident. At the conclusion of the RNA treatment, RNA 1 reviewed Resident 49's January 2025 RNA flowsheet documentation and stated, yesterday on 1/27/25, Resident 49 tolerated both knee splints for two hours only. RNA 1 did not document the splint wearing time on the RNA flowsheet. RNA 1 reviewed the front and back of the RNA flowsheet and confirmed it was not documented. RNA 1 stated Resident 49 sometimes could tolerate the splints for four hours, but sometimes she could only tolerate two hours. RNA 1 stated it should be documented how long Resident 49 was wearing the knee splints each day. RNA 1 stated there were other days Resident 49 could only tolerate two hours, but he could not remember which days because he did not document it. RNA 1 could remember that yesterday, 1/27/25, Resident 49 could tolerate wearing both knee splints for two hours. During an interview and record review on 1/28/25 at 10:51 a.m., the Physical Therapist (PT)1 stated if an RNA order indicated to put on the splints for 4 to 6 hours, it meant that the RNAs should put on the splints for 4 to 6 hours. PT 1 stated if the resident could not tolerate the splints for 4 or 6 hours, it should be documented and it should be reported to the therapy department, because it could mean that the resident may need to have therapy again to assess and adjust the splints. During a concurrent interview and record review on 1/29/25 at 9:51 a.m. with the Director of Staff Development (DSD), Resident 49's January 2025 RNA flowsheet was reviewed. The DSD stated RNA 1 did not document Resident 49 tolerated wearing both knee splints for two hours on 1/27/25. The DSD stated the RNA order for Resident 49 was to wear both knee splints for four to six hours and RNAs should document how long Resident 49 tolerated the splints each day. The DSD stated the RNA documentation should be accurate and include how long Resident 49 could tolerate the splints, because documentation should reflect what happened to the resident during RNA treatment. During an interview on 1/29/25 at 2:22 p.m., the Director of Nursing (DON) stated the RNA program was established by therapy and the program helped the residents to maintain their strength and function. The DON stated it was important for the RNAs to follow the RNA orders. The DON stated RNAs needed to document accurately to reflect what was happening during RNA treatment including how long a resident was wearing a splint. A review of the facility's policy and procedure (P&P) titled, Documentation Principles, dated 11/17, indicated resident's health record shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each resident. Entries must be accurate .specific - definite . descriptive - adequately explained.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 41379 Based on observation, interview, and record review, the facility failed to maintain six of six electrical rehabilitation therapy (given to restore an individual back to their highest possible level of physical, mental, and psychosocial well-being) equipment for resident use. This deficient practice had the potential for injury to residents using the therapy equipment during therapy treatment. Findings: A review of the upper and lower extremity bicycle - Therapy Equipment (TE) 1 and TE 2's User Manual (UM) revised 12/8/2020, indicated a Certificate of Conformance Inspection, consisting of an electrical safety check, was recommended to be performed at least biannually (every two years). Users should follow and complete the following recommendations on an ongoing basis: routinely check for power cord fraying or any other damages to the power cord. Check to ensure that the cycle ergometer was operating smoothly. Always check that the power cord, cardia pickup and display control cables were properly routed and were not in danger or being snagged/pulled by the lower or upper cycle operation. Always keep the system clean and keep any debris, such as paper, string, cloth, or clothing away from the cycle moving parts. A review of the automatic parallel bars (TE 4's) undated Operation and Service Guide (OSG) indicated, under Preventative Maintenance, to frequently inspect the power cord and plug for frayed wires and/or damaged insulation. Gears should be checked every six months for adequate grease. During an observation on 1/28/25 at 11:07 am, in the facility's Occupational Therapy (OT) gym, a resident was observed using an upper and lower extremity bicycle, (TE 1). During a concurrent interview, Physical Therapist (PT) 1 stated the facility's rehabilitation department had six different electrical equipment items for residents to use during therapy treatment sessions. PT 1 stated in the OT gym, there was a TE 1 and an adjustable work table (TE 3). PT 1 proceeded to walk to the gym on the other side and stated there was another upper and lower extremity bicycle (TE 2), automatic parallel bars (TE 4), an exercise leg stepper (TE 5), and an adjustable therapy mat (TE 6). PT 1 stated the rehabilitation department did not calibrate or check any of the six electrical therapy equipment items. During an interview on 1/28/25 at 3:15 pm, in the PT and OT gym, the facility's Maintenance Director (MTD) stated the staff did not have any logs or documentation of any preventive or general maintenance performed on the six therapy equipment items. The MTD stated he had not performed any maintenance checks on TE 3, TE 6, or TE 4 and had checked TE 1, TE 2, and TE 5 as needed, if the therapists reported any issues. During an interview on 1/29/25 at 8:40 am, the Administrator (ADM) stated the facility did not have any policy regarding maintenance of electrical equipment for the rehabilitation department. The ADM stated the facility's policy was to follow the manufacturer's manual for each equipment item. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 1/29/25 at 10:25 am, the ADM stated it was important to perform maintenance on electrical rehabilitation equipment because residents could be injured by the equipment. The ADM stated the facility did not have a manufacturer's user manual for TE 3 (the adjustable work table). On 1/29/25 at 2:22 pm, during an interview, the Director of Nursing (DON) stated it was important to maintain the rehabilitation equipment, because many of the residents use the equipment during therapy to regain their strength and endurance to return to the community. The DON stated the rehabilitation equipment needed to be safe for the residents to use. A review of TE 5's undated UM indicated do not attempt any servicing or adjustments other than those described in this manual. All else must be left to trained serviced personnel familiar with electro-mechanical equipment and authorized under the laws of the country in question to carry out maintenance and repair work. TE 5's UM indicated under Maintenance to check the pedal to make sure they are tight (monthly), all bolts that were installed during assembly need to be tightened as much as possible. A review of TE 6's Operating and Technical Manual (OTM) revised 1/2016, indicated under Quality Assurance, It is recommended that a program of regular and appropriate quality assurance including electrical safety inspections be utilized for this equipment. A qualified service personnel or third party service organization should be capable of performing the necessary testing and documentation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851 Based on observation, interview and record review, the facility failed to ensure two of 32 sampled resident rooms (room [ROOM NUMBER] and 125) met the minimum space requirements of 80 square feet for each resident in multiple resident bedrooms. This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for the residents in rooms [ROOM NUMBERS]. Findings: During an initial tour observation of the facility on 1/27/2025 from 9 AM to 11:20 AM, nursing staff were observed with enough space to provide care to the residents in each facility room. A review of a facility letter submitted to the Department, dated 1/27/2025, by the Administrator (ADM), indicated the facility requested a room variance for two resident rooms (room [ROOM NUMBER] and room [ROOM NUMBER]). The letter indicated that upon measurement, the rooms were slightly smaller than required, but the rooms had adequate space for the residents. The letter indicated the rooms were in accordance with the special needs of residents and would not have an adverse effect on the residents' health and safety or impede the ability of any resident in the room to attain his/her highest practicable well-being, The minimum square footage for a two (2) bedroom was 160 square feet. The minimum square footage for a three (3) bedroom was 240 square feet. The room waiver indicated rooms [ROOM NUMBERS] measurements were as follows: Room number Room size Number of Beds 102 158.35 square feet 2 125 229.54 square feet 3 During an interview on 1/30/2025 at 7:50 AM, Licensed Vocational Nurse (LVN) 1 stated he was taking care of the residents in room [ROOM NUMBER]. LVN 1 stated the room was a bit smaller when compared to other rooms but that the space was not an issue. LVN 1 stated the space in room [ROOM NUMBER] did not interfere with his ability to care for the residents in the room. During an interview on 1/30/2025 at 1:28 PM, Certified Nursing Assistant (CNA) 1 stated he was taking care of the residents in room [ROOM NUMBER]. CNA 1 stated he did not have any concerns about the amount of space in room [ROOM NUMBER] and that he felt the room was a good size. During a concurrent observation and interview on 1/30/2025 at 1:41 PM, in room [ROOM NUMBER], Resident 25 was observed being assisted by CNA 2 to her wheelchair. A dresser and bedside table were observed next to Resident 25's bed. Resident 25 stated she had no complaints about the space in her room and that she felt she had a good amount of space for her belongings. CNA 2 stated she was able to move Resident 25 in and out of her wheelchair without problems. CNA 2 stated she was fine with the amount of space in room [ROOM NUMBER]. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During a concurrent observation and interview on 1/30/2025 at 2:10 PM, in room [ROOM NUMBER], Resident 27 was observed sitting on the side of his bed. A dresser and bedside table were observed next to Resident 27's bed. A wheelchair was observed on the wall across from Resident 27's bed. Resident 27 stated he had no problems with his room or the space in his room. Resident 27 stated the nursing staff was able to move him around in his wheelchair in the room.