STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056115	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Healthcare Center	11926 LA Mirada Blvd LA Mirada, CA 90638

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on interview and record review, the facility failed to ensure a complete set of vital signs (a group of the four to six most crucial medical signs that indicate the status of the body's vital functions) were taken, documented, and monitored as ordered by the physician for one out of three sampled residents (Resident 1). This deficient practice had the potential to delay the care provided to Resident 1, who exhibited an acute episode of desaturation (respiratory distress) and tachycardia (fast heart rate). Resident 1 was sent to the general acute care hospital (GACH) on 5/20/2024, and diagnosed with acute renal failure (occurs when your kidneys suddenly become unable to filter waste products from your blood), hyperkalemia (elevated potassium [an electrolyte] in the blood) , and sepsis (an infection in the blood). Findings: A review of Resident 1's Admission Record indicated Resident 1 was initially admitted to the facility on [DATE], and readmitted on [DATE]. Resident 1's diagnoses included acute respiratory failure (difficulty breathing) and hypoxia (low oxygen in the blood), hypertension (when the force of blood flowing through your blood vessels continues to be too high over time), heart failure (a condition that develops when your heart does not pump enough blood for the body's needs), a history of cerebral infarction (disruption in blood flow in the brain), contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints), unstageable pressure ulcer (a type of bed sore that occurs due to prolonged pressure on a specific area of the skin) of the sacral region (area on the posterior side of the body's pelvis), gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), urinary tract infection (infection of the tube through which urine leaves the body), and sepsis. A review of Resident 1's Minimum Data Set ([MDS]- a standardized assessment and care planning tool), dated 2/16/2024, indicated Resident 1's cognition (ability to think and reason) was severely impaired. The MDS indicated Resident 1 was completely dependent on staff for all activities of daily living and personal hygiene needs. The MDS indicated Resident 1 had a feeding tube (tube inserted directly in the stomach for nutrition). A review of Resident 1's Physician Orders, dated 2/12/2024, indicated to monitor Resident 1's vital signs every night shift. (continued on next page)

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
	056115	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Healthcare Center	11926 LA Mirada Blvd LA Mirada, CA 90638

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Hypertension Care Plan (undated), indicated the facility was to monitor Resident 1's vital signs every night shift. A review of Resident 1's Risk for Dehydration or Potential for Fluid Deficit Care Plan (undated), indicated the facility was to monitor and record Resident 1's vital signs as ordered. A review of Resident 1's Weights and Vitals Summary, dated 5/2024, indicated Resident 1 did not any vital sign entries for 5/17/2024, 5/18/2024, and 5/19/2024. A review of Resident 1's Situation, Background, Assessment, Recommendation ([SBAR]- a note that is relayed to the physician that describes the resident's change of condition) note, dated 5/20/2024, indicated Resident 1 was noted on 5/20/2024 to have increased work of breathing (difficulty breathing), with Resident 1's oxygen saturation (amount of oxygen that is circulating in the resident's blood [normal range 95% to 100%]), measuring in the low 80's . The SBAR indicated the physician was made aware and ordered for Resident 1 to be sent out to the general acute care hospital (GACH). The SBAR indicated Resident 1 had the following vital signs: Respiratory (breathing) Rate of 22 breaths per minute (normal respiratory rate 12 to 20 breaths per minute). Blood Pressure was 87/54 millimeters of mercury ([MM HG]- unit of measurement that describes the amount of force blood uses to get through the vessels of the body [normal range of 120-129 [top number] and 80-84 [bottom number]]). Heart Rate of 100 beats per minute (normal range 60-100 beats per minute). Temperature of 98.4 Fahrenheit (normal range 97 to 99 degrees Fahrenheit [a unit of measurement]). A review of Resident 1's GACH History and Physical, dated 5/21/2024, indicated Resident 1 exhibited acute renal failure, hyperkalemia, and sepsis. A review of Resident 1's GACH Infectious Disease Progress Note, dated 5/22/2024, indicated Resident 1 had bacteremia (blood infection) with septic shock (a dramatic drop in blood pressure that can damage the lungs, kidneys, liver and other organs). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056115	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Healthcare Center	11926 LA Mirada Blvd LA Mirada, CA 90638

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview, on 5/30/2024, at 2:35 p.m., with Licensed Vocational Nurse (LVN 1), Resident 1's Weights and Vitals Summary , dated 5/2024, and Physician Orders, dated 5/2024, were reviewed. LVN 1 stated vital signs were usually taken each shift and monitored to prevent in a decline in a resident. LVN 1 stated that the vital signs for Resident 1 should have been taken on 5/17/2024, 5/18/2024, and 5/19/2024. LVN 1 stated she had been assigned to care for Resident 1 on 5/19/2024 and should have noticed that a complete set of vital signs were not taken for Resident 1. LVN 1 stated Physician Orders were important to be followed because it guides the care for the resident. LVN 1 stated the facility did not follow the physician orders if a complete set of vitals were not taken for three days before Resident 1 was sent out to the GACH. LVN 1 stated that there was a potential for a delay in care for Resident 1 because the resident could have exhibited changes in her medical condition long before Resident 1 exhibited overt (obvious) signs of respiratory distress. LVN 1 stated Resident 1 lacked the ability to make her needs known, and display typical signs of distress (facial grimacing or grunting), therefore, a complete set of vital signs were imperative to effectively monitor Resident 1 for any acute changes of condition. During an interview on 5/30/2024, at 2:40 p.m. with Nurse Practitioner 1 ([NP]- a nurse who has advanced clinical education and training), NP 1 stated, Vital signs are very important and are a part of basic nursing. It does not matter if the resident appears to be stable. Vital signs need to be taken at least once a day, and if the resident is unstable, the vitals may need to be taken more frequently. The vital signs are used to establish a baseline (an initial measurement of a condition that is taken at an early time point and used for comparison over time to look for changes) for the resident and are used to determine whether an intervention needs to be implemented. It is a part of monitoring the resident . NP 1 stated it was very important that Resident 1 have her vital signs taken at least once a day because Resident 1 was unable to display the typical signs of decline or distress and could not speak for herself. The NP stated that the lack of taking a complete set of vital signs (blood pressure, heart rate, respiratory rate, oxygen saturation, and temperature) could have led to a delay in care and harm for Resident 1. During an interview on 5/30/2024, at 2:58 p.m. with Registered Nurse (RN) 2, RN 2 sated that a complete set of vital signs were important so that that the nursing staff could establish the baseline condition of the resident. RN 2 stated that it was important for the vital signs to be taken and monitored for Resident 1 because Resident 1 was known to be nonverbal and only opened her eyes. RN 2 stated that the facility should have taken a complete set of vital signs for Resident 1 because there was a possibility that Resident 1 could have exhibited a change of condition that could have been identified sooner. RN 1 stated that it was possible that any Certified Nursing Assistant (CNA) or LVN could have missed a physical change of condition in Resident 1 because Resident 1 did not have the ability to display overt, typical signs of pain, or respiratory distress. RN 1 stated that if the nursing staff did not take the vital signs of Resident 1 once a shift, then the facility did not follow the Physician Orders, which could have led to a delay in care for Resident 1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056115	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Healthcare Center	11926 LA Mirada Blvd LA Mirada, CA 90638

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent review and interview, on 5/31/2024, at 12:31 p.m., with RN 1, Resident 1's Nursing progress notes, Physician Orders (prior to discharge on 5/20/2024), and Medication Administration Record (MAR), dated 5/2024, were reviewed. The nursing progress notes indicated physical assessments were not documented from 5/17/2024 to 5/19/2024. The MAR indicated Resident 1's systolic blood pressure ([SBP]-the pressure caused by your heart contracting and pushing out blood) was the only vital sign measurement taken from 5/17/2024 to 5/19/2024. RN 1 stated the single measurement of a SBP, did not account for a complete set of vital signs, as ordered by the Physician. RN 1 stated that there was a potential for a delay in care for treatment for Resident 1 due to lack of physical assessments and monitored vital signs, and the possibility that Resident 1 exhibited undetected signs of respiratory distress, dehydration, or sepsis prior to the noted changes of condition on 5/20/2024 at 1:00 p.m. RN 1 stated that all staff nurses shared the responsibility of ensuring that all the vital signs were taken and documented, as ordered by the Physician. During an interview, on 5/31/2024, at 1:02 p.m., with the Director of Nursing (DON), The DON stated that it was best practice to monitor the residents for any change of condition every shift , and to take vital signs on a weekly basis for the residents in the facility. The DON stated Resident 1's vital signs were not documented from 5/17/2024 to 5/19/2024 because the supplemental documentation boxes did not populate in Resident 1's electronic medical record (EMR) for the LVNs to input the values. The DON stated the LVNs should have noticed that the vital signs were missing in the EMR and they should have documented the values. A review of the facility's Policy and Procedure (P&P), titled, Vital Signs, Measuring , dated 9/2022, indicated a resident must have temperature, pulse, respiratory rate, and blood pressure recorded every time vital sign procedures are to be performed and the facility was to review the resident's care plan to assess for any special needs for the resident. A review of the facility's Registered Nurse Job Description, dated 5/2017, indicated the Registered Nurse was to ensure treatment is provided in a proficient manner per direction from the physician. A review of the facility's LVN Job Description, dated 10/2020, indicated the LVN's were to provide licensed nursing care that is consistent with the written plans of care for each resident.