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	01/15/2025

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 0684 Level of Harm - Minimal harm or potential for 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** 47858 Based on observation, interview and record review, the facility failed to provide services for and monitor a resident with a pacemaker (a device that delivers electrical impulses to control the rhythm of the heart) for one out of three sampled residents (Resident 1), by failing to: 1. Ensure Resident 1's pacemaker information (insertion date, paced rate, type of pacemaker, the name of the cardiologist, type of leads [an insulated wire that is connected to the pulse generator in the heart], manufacturer and model, and serial number) was obtained upon admission, as indicated in the facility's policy, Resident 1's pacemaker care plan, and physician orders. 2. Ensure effective and timely management of Resident 1's pacemaker and blood pressure medications were assessed and monitored when the facility could not obtain any information regarding Resident 1's assigned cardiologist and pacemaker details before and after Resident 1's two hospitalization s due to syncope (a brief loss of consciousness that occurs due to a sudden drop in blood pressure). These deficient practices placed Resident 1 at risk for undetected episodes of pacemaker malfunction, recurring episodes of hypotension (low blood pressure), and subsequent syncopal episodes (a brief loss of consciousness that occurs due to a sudden drop in blood pressure), which had the potential lead to falls, death, and injury for Resident 1. Findings: During an observation, on 1/14/2025, at 1:30 p.m., of Resident 1, in Resident 1's room, Resident 1 had a left upper chest pacemaker. During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted [DATE]. Resident 1's diagnoses included implanted cardiac pacemaker, sick sinus syndrome (a disease in which the heart is unable to generate normal heartbeats at the normal rate), and hypertension (high blood pressure). During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 12/17/2024, the MDS indicated Resident 1's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making were severely impaired. The MDS indicated Resident 1 was entirely dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's History and Physical (H&P), dated 11/4/2024, the H&P indicated that Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Order Summary, dated 1/15/2025, the Order Summary did not indicate Resident 1's pacemaker information (diagnosis for pacemaker, date implanted, serial number, type, model, set rate, power source, cardiologist name, cardiologist contact number, and pacemaker check frequency). The Order Summary did not indicate a cardiology consult (a meeting with a cardiologist [a doctor who specializes in the treatment of heart diseases] to discuss heart health, symptoms, and risk factors) was ordered. During a review of the Resident 1's Nursing Admission Note, dated 11/4/2024, the Nursing Admission Note indicated Resident 1 was admitted with a left upper chest pacemaker. There was no documentation to indicate Resident 1's pacemaker information was obtained. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR -a communication tool used by healthcare workers when there is a change of condition among the residents), dated 11/27/2024, the SBAR indicated Resident 1 became unresponsive in the dining room during lunch time, and was found drooling and leaning over to the right side of her wheelchair. The SBAR indicated Resident 1 had a blood pressure of 70/44 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]). The SBAR indicated Resident 1 was transferred to the general acute care hospital (GACH). During a review of the Resident 1's Nursing Readmission Note, dated 11/29/2024, the Nursing Readmission note indicated Resident 1 was readmitted from the GACH due to a syncopal episode and hypotension (low blood pressure). There was no documentation to indicate attempts were made to obtain Resident 1's pacemaker information, or Resident 1's Nurse Practitioner (NP) 1 or attending physician (MD 1) had been made aware of the missing pacemaker information. During a review of Resident 1's pacemaker care plan (CP), initiated 1/1/2025, the CP indicated the facility was to obtain and maintain record of Resident's 1 Pacemaker information (manufacturer, model, serial number, date implanted, and name of cardiologist). The CP interventions were left incomplete and did not specify the listed pacemaker information. During a review of Resident 1's SBAR note, dated 1/4/2025, the SBAR indicated Resident 1 attempted to get up from the wheelchair, and fell forward, on her face. The SBAR indicated Resident 1 was sent to the GACH for further evaluation. During a review of Resident 1's Readmission Progress Note, dated 1/11/2025 to 1/12/2025, the notes indicated Resident 1 was readmitted from the GACH due to a fall and sustained a fracture to maxillary sinus (hollow spaces in the bones around the nose). There was no documentation to indicate Resident 1's pacemaker information was obtained. During a review of Resident 1's Progress Notes, dated 12/13/2024 to 1/14/2025, there was no documentation to indicate follow up attempts were made to obtain Resident 1's pacemaker information or attempts were made to seek a cardiology consult or guidance (from NP 1, MD 1, or the Medical Director) for the management of Resident 1's pacemaker. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 1/14/2025, at 2:20 p.m., with Registered Nurse (RN) 1, RN 1 stated the process for providing care for a resident with a pacemaker was to obtain information on the resident's pacemaker upon admission. RN 1 stated it was important to know when the pacemaker was implanted, last checked to ensure that the pacemaker was functioning properly and to keep the resident safe from any adverse effects of a malfunctioning pacemaker. RN 1 stated pacemaker information should be obtained upon admission and if the information was not available, the licensed nurses were expected to notify the attending physician and request for an order for a cardiology consult right away. RN 1 stated Resident 1's heart rate would be uncontrolled and could suffer from shortness of breath, sudden weakness, light headedness, or even a syncopal episode. During a concurrent record review and interview, on 1/14/2025, at 2:40 p.m., with RN 1, Resident 1's Nursing Progress Notes, dated 11/2024 to 1/14/2025, were reviewed. The nursing progress notes did not indicate there was documentation the facility made continued attempts to contact the medical director or obtain a cardiology consult for the management of Resident 1's pacemaker. During an interview, on 1/15/2025, at 8:30 a.m., with MD 1, MD 1 stated he would have expected the licensed nurses to obtain Resident 1's pacemaker information right away to know the pacemaker was viable (functioning properly). MD 1 stated he was not made aware by NP 1 or the facility Resident 1's pacemaker information was missing. MD 1 stated if he had known, he would have put in orders for an electrocardiogram ([EKG]- a noninvasive test that measures the electrical activity of the heart), and for a cardiologist to come evaluate Resident 1's cardiac medications and pacemaker. MD 1 stated if Resident 1's cardiac medications were not evaluated and the pacemaker was not monitored regularly there was a potential for Resident 1 to suffer pacemaker malfunction, hypotension, abnormal heart rhythm, syncopal episodes, which could lead to falls or a fracture from a fall. During an interview, on 1/15/2025, at 10:20 a.m., with the Director of Nursing (DON), the DON stated she was aware Resident 1's pacemaker information was unknown prior to Resident 1's admission. The DON stated there could have been more efforts to obtain an order for a cardiologist consult or to notify the Medical Director for further management of Resident 1's pacemaker. The DON stated cardiac care was important because of the unknown details of Resident 1's pacemaker and syncopal episodes. During a review of the facility's Policy and Procedure (P&P), titled, Pacemaker, Care of a Resident with a, dated 12/2015, the P&P indicated the following: 1. The pacemaker battery will be monitored remotely through the telephone or an in tern et connection. The resident's cardiologist will provide instructions on how and when to do this. 2. The resident will have an EKG annually, or as ordered, to monitor for changes in the heart's electrical activity. 3. The facility was to ensure the resident has a medical identification card that indicates he or she has a pacemaker. The medical record must contain this information as well. When the resident is transferred to another facility, this information was to be communicated to the receiving facility in the discharge summary. 4. The facility was to document the following in the medical record and on a pacemaker identification card upon admission: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. The name, address, and telephone number of the cardiologist. b. Type of pacemaker. c. Type of leads. d. Manufacturer and model. e. Serial number. f. Date of implant; and g. Paced rate.