

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2025
NAME OF PROVIDER OR SUPPLIER Imperial Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely physician notification for a significant change in condition for one of three sampled residents (Resident 1). This deficient practice had the potential to delay physician evaluation, timely medical intervention, and result in the deterioration of Resident 1's condition. Findings: During a review of Resident 1's admission Record, dated 12/19/2025, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included acute and chronic respiratory failure (a condition in which the lungs are unable to provide enough oxygen to the body or remove carbon dioxide, occurring suddenly and/or over a long period of time), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), congestive heart failure (CHF- a heart disorder which causes the heart to not pump blood efficiently, sometimes resulting in leg swelling), acute pulmonary edema (a sudden buildup of fluid in the lungs that makes breathing difficult), pleural effusion (a buildup of fluid between the lungs and the chest wall that can interfere with breathing), type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN- high blood pressure), end stage renal disease (ESRD- a condition in which the kidneys no longer function well enough to remove waste and excess fluid from the body), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed), and history of renal transplant (a past medical history of receiving a donor kidney to replace failed kidneys). During a review of Resident 1's Admission/readmission Initial Assessment, dated 8/11/2025 at 7:25 p.m., the admission assessment indicated Resident 1 was readmitted to the facility from the general acute care hospital (GACH). The admission assessment indicated Resident 1 had a normal thought process and was oriented to person, place, and time, was able to follow simple commands, had clear speech, understood verbal content, and was understood upon admission. During a review of Resident 1's History and Physical (H&P), dated 8/12/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 8/15/2025, the MDS indicated Resident 1's cognition (ability to think, remember, and reason) was intact. The MDS indicated Resident 1 could eat independently and required moderate assistance (helper does less than half the effort) for toileting, bathing, and personal hygiene. During a review of Resident 1's care plan titled, Resident at risk for cardiac distress related to A-fib, congestive heart failure, hypercholesterolemia, hypertension, and renal failure/end-stage renal disease, initiated on 8/14/2025, the care plan indicated interventions included to monitor Resident 1 for headache, chest pain, irregular pulse, edema, shortness of breath, elevated blood pressure, dizziness, hypotension (low blood pressure), altered level of mentation and to report findings to the physician promptly. During a review of Resident 1's Nursing Progress Note dated 8/20/2025 at 9:42 p.m., the progress note indicated Resident 1 returned from dialysis alert with confusion. During a review of Resident 1's Nursing Progress Note dated 8/24/2025 at 11:57 p.m., the progress note indicated Resident 1 was alert with episodes of confusion. During a review of Resident 1's nursing progress notes from 8/20/2025 through 10/25/2025, the progress notes indicated there was no documented entries Resident 1's physician was notified of the resident's new onset of confusion. The progress notes indicated there was no documented entries a nursing assessment or monitoring was done addressing Resident 1's new onset of confusion. During an interview on 12/30/2025 at 4:39 p.m., with Resident 1's Attending Physician (AP 1), AP 1 stated he was aware Resident 1's baseline laboratory values were abnormal on 8/19/2025. AP 1 stated it was common for residents to have abnormal laboratory values at baseline. AP 1 stated when laboratory values or a resident's condition changed from baseline, the facility was expected to notify the physician. AP 1 stated Resident 1 was alert and oriented at baseline and new onset confusion represented a change of condition. AP 1 stated on 8/20/2025, he would have wanted to be notified of Resident 1's confusion. AP 1 stated if he had been notified of Resident 1's confusion he would have sent Resident 1 to the emergency room for evaluation immediately. During a concurrent interview and record review on 12/31/2025 at 10:00 a.m., with Registered Nurse (RN) 1, Resident 1's nursing progress notes dated 8/11/2025 and 8/20/2025, were reviewed. Resident 1's nursing progress note dated 8/11/2025, indicated Resident 1 was alert and oriented upon admission to the facility. Resident 1's nursing progress note dated 8/20/2025 at 9:42 p.m., indicated Resident 1 was alert with confusion upon her return from dialysis. RN 1 stated this was a new onset of confusion for Resident 1 and represented a change of</p>		