STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056244	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Park Convalescent Hospital	2312 West 8th Street Los Angeles, CA 90057

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 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** 36395 Based on interview and record review, the facility failed to ensure resident records were complete and accurate in accordance with accepted professional standard and practice for one of three sampled residents (Resident 1). For Resident 1, the facility failed to ensure Resident 1's discharge plan was reflected in Resident 1 ' s medical record. This deficient practice resulted in incomplete and inaccurate record for Resident 1 ' s discharge plan and goals. Findings: During a review of the Admission Record indicated Resident 1 was admitted on [DATE] and was readmitted on [DATE] with diagnoses including osteoarthritis (progressive disorder of the joints, caused by a gradual loss of cartilage) and abnormities of gait and mobility. During a review of the Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/15/24 indicated Resident 1 was cognitively intact. Resident 1 moderate assistance (helper does less than half the effort) with toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, supervision with oral hygiene, upper body dressing and independent with eating. The same MDS indicated Resident 1 ' s overall goal for discharge was to discharge to the community. During an interview on 10/30/24 at 9:49 a.m., Resident 1 stated he wants to be discharged and live in an apartment. Resident 1 stated he was homeless before coming to the facility and does not want to be homeless again once he is discharged . During concurrent interview and record review on 10/30/24 at 10:11 a.m., with Registered Nurse Supervisor 1 (RNS 1) the social services notes were reviewed. RNS 1 stated social services was looking for placement for Resident 1. However, RNS 1 stated she was unable to find SSD documentation about Resident 1 ' s discharge plan. (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
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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	During a telephone interview on 10/30/24 at 10:41 a.m. Social Service Designee 1(SSD 1) stated Resident 1 wants to be discharged to an assisted living. SSD stated Resident 1 had an application submitted for the assisted living waiver (ALW, program for residents who require a nursing facility level of care and wish to live in a residential care setting or in publicly funded senior and/or disabled housing) and the application is currently on hold. SSD 1 stated she had discussed with Resident 1 ' s next of kin (NOK) regarding Resident 1 ' s discharge plan on 10/14/24 but SSD stated she did not document. During an interview on 10/30/24 at 11:20 a.m., the Director of Nursing (DON) stated, it is important to document the discharge plan for [Resident 1] to prove that the facility is actually doing something . for Resident 1. During a review of the facility's Policy and Procedures (P&P) titled Charting and Documentation reviewed on 1/29/24, indicated, all services provided to the resident, progress toward the care plan goals or any changes in the resident ' s medical, physical, functional, or psychosocial condition shall be documented in the resident ' s medical record. The medical record should facilitate communication between the interdisciplinary team regarding resident ' s condition and response to care. The following information is to be documented in the resident medical record that included treatments or services performed and progress toward or changes in the care plan goals and objectives.