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	07/03/2025

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a comprehensive and resident-centered dental care plan for one of one sampled resident (Resident 81). This deficient practice had the potential to result in delay in necessary dental care and services for Resident 81. Findings: During a review of Resident 81's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included, but not limited to encephalopathy (a change in brain function due to injury or disease), compression fracture (when a bone in your spine breaks and collapses) of the ninth to tenth thoracic vertebrae (bones that make up the middle part of your spine), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), panic disorder (an anxiety disorder that involves multiple unexpected panic attacks), and malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets). During a review of Resident 81's Minimum Data Set (MDS-a resident assessment tool), dated 5/4/2025, the MDS indicated the resident was able to participate in assessments and setting goals. The MDS indicated Resident 81 can be understood and had the ability to understand others. The MDS indicated Resident 81 required substantial to maximal assistance (helper does more than half the effort) with activities of daily living (ADL- tasks people need to do every day to take care of themselves, such as eating, dressing, bathing, and using the toilet), and transfers. During a review of Resident 81's Social Services Evaluation admission note, dated 5/5/2025, the Social Services Evaluation admission note indicated Resident (Resident 81) has missing teeth and [Social Services Director] SSD will refer the resident to dental consultation as needed and/or if clinically indicated. During an interview and a review of Resident 81's Care Plan Report (in general) on 7/3/2025 at 8:33 AM, with Registered Nurse Supervisor (RN) 4, RN 4 stated there was no care plan developed for oral/dental health problem for Resident 81 upon admission. RN4 stated if missing teeth was a potential problem for Resident 81, then the missing teeth problem should be included in Resident 81's care plan. RN 4 stated it was important to initiate a care plan immediately to set goals for the resident and to provide proper care and treatment for the resident (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/3/2025 at 9:03 AM, with Social Services Director (SSD), the SSD stated dental status should be included in the care plan so that proper dental care and treatment can be provided to Resident 81. SSD stated the care plan is also a good way to communicate between ancillary (providing necessary support to the primary activities or operation of an organization, institution, industry, or system) departments regarding the resident's status. SSD stated it would have been beneficial to have initiated a dental care plan for Resident 81 on admission. During an interview on 7/3/2025 at 9:19 AM, with the Director of Nursing (DON), the DON stated Resident 81's dental problem should have been communicated and a care plan initiated/created to address the resident's dental problem. The DON stated initiating a dental care plan was important to ensure Resident 81 received proper care, follow-ups, and consultations regarding her dental status. During a review of the facility policy and procedures (P&P) titled Care Plan - Comprehensive, reviewed 1/2024, the P&P indicated An individualized Comprehensive Care Plan that includes measurable objectives and timetables to [NAME] the resident's medical, nursing, mental and psychological needs is developed for each resident .The resident's Comprehensive Care Plan is developed within seven (7) das of the completion of the resident's comprehensive assessment (MDS).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to conduct quarterly review and revise a care plan for one of six residents (Resident 107) who was on Remeron (medication to treat treatment of major depressive disorder [MDD-persistent feeloing of sadness, loss of interest in activities, and changes in sleep, appetite, and energy levels). This failure had the potential to cause confusion related to the dosage of Remeron for Resident 107. Findings: During a review of Resident 107's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included MDD, muscle weakness, and need for assistance with personal care. During a review of Resident 107's Care Plan Report dated 6/12/2024, the Care Plan Report indicated the resident uses antidepressant (used to treat depression) related to feelings of hopelessness and worrying about his life status. The Care Plan Report interventions included to administer antidepressants medications (Remeron) as ordered by physicians, monitor/document side effects and effectiveness every shift for Remeron 15 milligrams (mg- unit of measurement). During a review of Resident 107's Order Summary Report dated 3/10/2025, the Order Summary Report indicated Resident 107 was prescribed Remeron 7.5 milligrams for depression manifested by feelings of hopelessness and worrying about his life status. During a review of Resident 107's Minimum Data Set (MDS - a resident assessment tool), dated 6/13/2025, indicated that the resident did not present with inattention, disorganized thinking, or altered level of consciousness. The MDS indicated Resident 107 presented with feeling down, depressed, or hopeless with little interest in doing things two to six days out of the week. During an observation on 6/30/2025 at 9:54 AM in Resident 107's room, Resident 107 was lying in bed, head of the bed up at 90 degrees. The resident denied feeling sad, lonely or depressed. The resident stated the facility care was fine, he had no complaints. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/2/2025 at 1:42 PM with the Minimum Data Set Nurse (MDSN), Resident 107's Care Plan Report and Physician's Orders were reviewed. The MDSN stated Resident 107's MDS triggered MDD, and therefore a care plan should be triggered. The MDSN stated Resident 107's MDS was revised on 6/13/2025 for MDD, and therefore MDSN would review the care plan to ensure that the care plan for MDD was updated. The MDSN reviewed the Physician Order which indicated Resident 107 was prescribed Remeron 15 mg which was discontinued on 3/10/2025. The MDSN agreed and stated that Resident 107 care plan for antidepressants related to feelings of hopelessness and worrying about life status should have been reviewed and revised after the order for Remeron 15 mg was changed to 7.5 mg. The MDSN stated Resident 107's current care plan on antidepressants related to feelings of hopelessness and worrying about life status was out of date and not revised since 6/10/2024. The MDSN confirmed and stated that all of Resident 107's care plans were reviewed on 6/10/2025 but the individual care plan for antidepressants related to feeling hopeless and worrying about life status must be revised. The MDSN stated that any licensed nurse can update Resident 107's care plan for depression. The MDSN stated the risk for not updating the care plan can cause confusion related to the Remeron dosage for Resident 107. During an interview on 7/2/2025 at 2:08 PM with the Director of Nursing (DON), the DON stated the nurse who received the order to change Remeron from 15 mg to 7.5 mg should have updated the care plan for Resident 107. The DON confirmed that care plans are reviewed and revised quarterly and whenever there is a change with a physician order. The DON stated the risk to Resident 107 could be lack of monitoring in the reduction of the medication and effectiveness. During a review of the facility policy and procedures (P&P) titled, Care Plan - Comprehensive, dated 01/2024, indicated, care plans are revised as changes in the resident's condition dictate. Care plans are reviewed at least quarterly.

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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 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** Based on interview and record review, the facility failed to ensure the insulin (a hormone that works by lowering levels of glucose-sugar in the blood) injection sites were rotated when administered (given) to one of four sampled residents (Resident 99). This deficient practice had the potential to result in injection site reactions such as pain, redness, itching, hives (red and sometimes itchy bumps on the skin), swelling, inflammation, lipodystrophy (defect in the breaking down or building up of fat below the surface of the skin, resulting in lumps or small dents in the skin surface which may be caused by repeated injections of insulin in the same spot), lipoatrophy (wasting of fat under the skin which can be unsightly), and lipohypertrophy (buildup of fat under the skin which can slow the absorption of insulin) that may result in ineffective management of the residents' diabetes mellitus (DM - high blood sugar). Findings: During a review of Resident 99's admission Record, the admission Record indicated Resident 99 was admitted to the facility on originally admitted on [DATE] and readmitted on [DATE] with diagnoses that inlcuded type 2 diabetes mellitus, peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), long-term use of insulin, acquired absence of left leg above the knee (someone has lost their left leg due to an injury or surgery, and the amputation was done above the knee) and acquired absence of right leg above the knee. During a review of Resident 99's Minimum Data Set (MDS - a resident assessment tool) dated 5/16/2025, the MDS indicated Resident 99 had the ability to make himself understood and had the ability to understand others. During a review of Resident 99's history and physical (H&P) dated 6/19/2025, the H&P indicated Resident 99 had the capacity to understand and make decisions. During a review of Resident 99's Order Summary Report dated 7/2/2025, the Order Summary Report indicated a physician wrote an order for Resident 99 to receive Humulin R regular insulin (a short-acting man-made insulin that is used to control high blood sugar in adults and children with diabetes mellitus) 100 units/ml (a unit of measurement) inject per sliding scale (a method used to adjust insulin dosages based on blood sugar levels) subcutaneously (SQ- beneath, or under, all the layers of the skin) two times a day related to type 2 diabetes mellitus as needed as follows: -Inject 0 units for blood sugar 0 to 199 -Inject 2 units for blood sugar 200 to 250 -Inject 4 units for blood sugar 251 to 300 -Inject 6 units for blood sugar 301 to 350 -Inject 8 units for blood sugar 351 to 400 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Inject 10 units for blood sugar greater than 401 and recheck blood sugar after 15 t0 30 minutes and if still greater than 400 call MD (medical doctor) The same Order Summary Report also indicated Resident 99 to receive Lantus (long-acting) insulin 100 unit/ml, inject 8 units subcutaneously in the morning for DM. During a concurrent interview and record review on 7/2/2025 at 9:54 AM with Licensed Vocational Nurse (LVN) 1, Resident 99's Location of Administration Report (LAR) dated 7/2/2025 was reviewed. The LAR indicated Resident 99 received SQ injections of Lantus insulin on two consecutive days to the right lower quadrant (RLQ - refers to the lower-right section of the abdominal area) on 6/1/2025 at 10:11 AM and again 6/2/2025 at 9:52 AM, on the left deltoid (is a triangular-shaped muscle located on the shoulder) on three consecutive days on 6/9/2025 at 9:43 AM, 6/10/2025 at 8:12 AM, and 6/12/2025 at 9:16 AM, and on the left lower quadrant (LUQ - refers to the lower-left section of the abdominal area) on two consecutive days on 5/5/2025 at 10:55 AM and 5/6/2025 at 11:21 AM. LVN 1 stated the facility staff should have rotated (changed locations) Resident 99's insulin injection sites and should not have given the insulin on the same location on consecutive injections. LVN 1 stated she did not know the term for what happened if the insulin injection sites were not rotated. During a concurrent interview and record review on 7/2/2025 at 10:11 AM with Registered Nurse (RN) 1, Resident 99's LAR dated 7/2/2025 was reviewed. The LAR indicated Resident 99 received SQ injections of Lantus insulin on two consecutive days to the RLQ on 6/1/2025 at 10:11 AM and again 6/2/2025 at 9:52 AM, on the left deltoid on three consecutive days on 6/9/2025 at 9:43 AM, 6/10/2025 at 8:12 AM, and 6/12/2025 at 9:16 AM, and on the LUQ on two consecutive days on 5/5/2025 at 10:55 AM and 5/6/2025 at 11:21 AM. RN 1 stated the facility's electronic medical record (EMR) showed at the bottom of the screen where Resident 99's insulin injection was previously to alert staff to prevent staff from giving insulin on the same site consecutively. RN 1 stated Resident 99 could get lipohypertrophy if staff do not rotate insulin injection sites. During a concurrent interview and record review on 7/2/2025 at 2 PM with the Director of Nursing (DON), Resident 99's LAR dated 7/2/2025 was reviewed. The LAR indicated Resident 99 received SQ injections of Lantus insulin on two consecutive days in the RLQ on 6/1/2025 at 10:11 AM and again 6/2/2025 at 9:52 AM, on the left deltoid on three consecutive days on 6/9/2025 at 9:43 AM, 6/10/2025 at 8:12 AM, and 6/12/2025 at 9:16 AM, and in the left upper quadrant (LUQ) on two consecutive days on 5/5/2025 at 10:55 AM and 5/6/2025 at 11:21 AM. The DON stated Resident 99 could have tissue damage if the resident's (Resident 99) insulin site is not rotated. During a review of the facility policy and procedures (P&P) titled Insulin Administration, dated 1/2025, the P&P indicated, the purpose of the P&P was to provide guidelines for the safe administration of insulin. The P&P indicated the staff would inject into the subcutaneous tissue of the upper arm and the anterior (toward the front of the body) or lateral (to the side or away from the middle of the body) areas of the thighs and abdomen. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to set the low air loss mattress (LALM - a specialized air mattress designed to prevent bedsores) to the correct settings for two out of two sampled residents (Resident 1 and Resident 36) This deficient practice placed the Resident 1 and Resident 36 at risk of discomfort, slow wound healing, and development of new pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence related to a medical or other device). Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included need for assistance with personal care (getting help with daily activities that involve taking care of yourself and your well-being, especially when you find it difficult to do those things on your own), pressure induced deep tissue damage (occurs when sustained pressure on the skin and underlying tissues, especially over bony areas, cuts off blood supply and damages the tissue underneath the skin's surface) unspecified site, dementia (a progressive state of decline in mental abilities), peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), personal history of healed traumatic fracture (a broken bone, caused by a strong impact or injury, that has successfully mended and become whole again) and history of falling. During a review of Resident 1's history and physical (H&P) dated 12/24/2024, indicated Resident 1 does not have the capacity to understand and make decisions. The H&P indicated Resident 1 had peripheral artery disease with chronic insufficiency (narrowed blood vessels carrying blood away from your heard are narrowed or blocked in the arms or legs), PVD, and chronic ulcers (persistent sores or open wounds that develop on your legs or feet because those areas aren't getting enough oxygen-rich blood). The H&P indicated Resident 1 needed a wound doctor consult. During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 usually had the ability to make herself understood and usually had the ability to understand others. The MDS indicated Resident 1 was dependent for toileting, showering/bathing, dressing, personal hygiene (combing hair, applying makeup, washing/drying face/hands), and for rolling left and right. During a review of Resident 1's care plan titled Alteration in Skin Integrity (when skin is damaged, broken, or not as healthy as it should be), dated 5/25/2025, the care plan indicated a goal for Resident 1 not to have complications from PVD and have no signs and symptoms of infection. The care plan indicated an intervention (a specific action taken by a healthcare professional, like a nurse, to help a patient improve their health or manage a condition) for a LALM. During a review of Resident 1's SBAR (Situation, Background, Assessment, Recommendation - a framework for clear and concise communication, especially in urgent or important situations) dated 6/2/2025 indicated resident was in hospice care family decided to dis- continue hospice care for they want evaluation of wound in the Hosp., left heel, right foot toes and left and right heel (PVD) peripheral vascular disease. (continued on next page)

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	056244	A. Building B. Wing	07/03/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's progress note dated 6/5/2025, the progress note indicated Resident 1's responsible party (person making decisions for the resident) was concerned about Resident 1's wounds and leg condition. During a review of Resident 1's progress note dated 6/11/2025, the progress note indicated Resident 1 had multiple ulcers on both feet and right lower leg. During a concurrent observation, interview and record review on 6/30/2025 at 1:52 PM with Licensed Vocational Nurse (LVN) 1 Resident 1's weight and LALM settings were observed and reviewed. LVN 1 stated the LALM was set to 80. LVN 1 reviewed Resident 1's weight in the Resident 1's electronic medical record (EMR) dated 6/2/2025 and stated Resident 1 weighed 103 lbs. LVN 1 stated the LALM setting at 80 pounds was set too low. LVN 1 was then observed moving the LALM setting to match Resident 1's approximate weight of 103 pounds. LVN 1 stated if the LALM was not set to Resident 1's weight, the LALM would lose its effectiveness. During an interview on 7/1/2025 at 2:07 PM with the Director of Nursing (DON), the DON stated Resident 1's LALM was not set correctly at 80 when Resident 1 weighed 103 pounds. The DON stated the mattress would be less effective. During a review of Resident 1's Order Summary Report dated 7/2/2025, the Order Summary Report indicated Resident 1's physician ordered a low air loss mattress (LALM) every shift for skin management. The Order Summary Report indicated an order to keep both lower extremities (legs) with pillow when in bed to offload (take off) pressure to Resident 1's heels. The Order Summary Report indicated an order for enhanced barrier precautions (an infection control strategy focused on reducing the spread of infections in nursing homes) as well as an order for wound care to Resident 1's right 5th toe, right heel, and right lateral lower leg with peripheral vascular disease. During a review of the undated Drive LALM Operator's Manual (OM) titled Med-Aire Melody Low Air Loss and Alternating Pressure Mattress Replacement System, the OM indicated Pressure Adjust Knob (Pressure Range): Turn the pressure adjust knob to set the mattress to the desired pressure level. Patient weight settings are available along the knob perimeter as a guide. 2. During a review of Resident 36's admission Record, the admission Record indicated the facility re-admitted the resident on 1/27/2025 with diagnoses that included metabolic encephalopathy (a brain disorder caused by chemical imbalances in the blood), muscle weakness, severe protein calorie malnutrition (a serious condition resulting from inadequate intake of both protein and calories), adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and Stage 3 pressure ulcer (Full-thickness loss of skin. Dead and black tissue may be visible) of the sacral region (tailbone area). During a review of Resident 36's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 1/28/2025 to apply a LALM in bed daily for skin management every shift. (continued on next page)

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	056244	A. Building B. Wing	07/03/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 36's Minimum Data Set (MDS, a resident assessment tool) dated 4/15/2025, the MDS indicated the resident had severely impaired cognition (a significant decline in mental abilities, impacting memory, language, judgment, and the ability to perform daily tasks independently). The MDS indicated Resident 36 was dependent for activities of daily living (ADL - oral hygiene, toileting hygiene, showering and bathing herself, upper and lower body dressing, putting on and taking off footwear, and personal hygiene.) The MDS indicated Resident 36 was at risk for developing pressure ulcers/injuries, had a Stage 3 pressure ulcer present on admission to the facility, and utilized a pressure reducing device for bed. During a review of Resident 36s Weight Summary, the Weight Summary indicated the resident weighed 103 pounds (lbs., a measurement of weight) on 6/2/2025. During an observation on 6/30/2025 at 10:12 AM, in Resident 36's room, the resident was observed laying on a Drive LALM with the LALM settings at 150 lbs. A sticker was observed on Resident 36's LALM that indicated the LALM settings be set between 89-109. During a concurrent observation and interview on 6/30/2025 at 10:18 PM with Registered Nurse (RN) 2, in Resident 36's room, the resident was observed on a LALM which indicated Drive. A label was observed on Resident 36's LALM that indicated the LALM settings be set between 89 - 109. Resident 36's LALM was set on the 150 lbs. setting. RN 2 stated and verified Resident 36's LALM was set at 150 lbs. RN 2 stated Resident 36's LALM settings were incorrect. RN 2 stated Resident 36's LALM settings should be between 89-109 per the sticker on the LALM. RN 2 stated LALM settings should be based on Resident 36's weight. RN 2 stated Resident 36 was using a LALM to help prevent further skin breakdown. During an interview on 7/3/2025 at 11:11 AM with the Director of Nursing (DON), the DON stated the LALM settings were based on a resident's weight. The DON stated Resident 36 used a LALM to help prevent further skin breakdown. The DON stated there was a potential for the LALM to not be effective in providing pressure redistribution when on the wrong settings. The DON stated there was a potential for Resident 36 to develop further skin breakdown with the LALM on the wrong settings. During a review of the undated Drive LALM Operator's Manual (OM) titled Med-Aire Melody Low Air Loss and Alternating Pressure Mattress Replacement System, the OM indicated, Pressure Adjust Knob (Pressure Range): Turn the pressure adjust knob to set the mattress to the desired pressure level. Patient weight settings are available along the knob perimeter as a guide.

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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. Based on observation, interview, and record review, the facility failed to complete the smoking risk assessment (smoking safety evaluation, an assessment that helps determine a resident's ability to smoke safely, whether independently or with supervision, and to identify potential fire hazards) for one of eight sampled residents (Resident 133). This failure had the potential to affect Resident 133's safety, causing a smoking related injury and fire hazard in the facility. Findings: During a review of Resident 133's admission Record, the admission Record indicated the facility admitted the resident on 4/28/2025 with diagnoses that included encephalopathy (a condition that causes dysfunction to the brain, affecting its structure or function), type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), need for assistance with personal care, hypertension (high blood pressure), and heart failure (condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen). During a review of Resident 133's Care Plan Report initiated 4/28/2025, the Care Plan Report indicated the resident was at risk for injury due to smoking. The Care Plan Report goal included for Resident 133 to be free from smoking related injury. The Care Plan Report interventions included to re-evaluate Resident 133's smoking privilege per facility policy. During a review of Resident 133's Nursing Risk Evaluations/Assessments dated 4/28/2025 at 9:40 PM, the Nursing Risk Evaluations/Assessments indicated a smoking safety evaluation was not completed because the resident did not smoke. There was no other smoking safety evaluations completed after 4/28/2025. During a review of Resident 133's Minimum Data Set (MDS, a resident assessment tool), dated 5/1/2025, the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 133 required partial/moderate assistance with activities of daily living (ADL - oral hygiene, toileting hygiene, showering and bathing himself, upper body dressing, lower body dressing, and putting on and taking off footwear). The MDS indicated Resident 133 did not currently use tobacco. During a review of Resident 133's Activities - Initial Review dated 5/5/2025 at 10:11 AM, the Activities - Initial Review indicated the resident past activity interests included smoking. During an observation on 7/2/2025 at 2:00 PM on the facility's smoking patio, Resident 133 was observed sitting in a chair. Resident 133 was observed getting a cigarette from the activity staff. The activity staff was observed lighting Resident 133's cigarette. Resident 133 was observed smoking without a smoking apron (a protective garment designed to shield the wearer from potential burns and injuries related to smoking). (continued on next page)

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	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/2/2025 at 2:31 PM with Registered Nurse (RN) 3, Resident 133's Nursing Risk Evaluations/Assessments dated 4/28/2025 Activities - Initial Review dated 5/5/2025 were reviewed. RN 3 stated smoking risk assessments are performed on admission. RN 3 stated smoking risk assessment was not performed for Resident 133. RN 3 stated the Nursing Risk Evaluations/Assessments dated 4/28/2025 indicated that a smoking risk assessment was not done because the resident did not smoke. RN 3 stated Resident 133 smokes cigarettes. RN 3 stated the nursing staff should have updated Resident 133's smoking risk assessment and performed a new smoking risk assessment after knowing the resident smoked cigarettes. RN 3 stated a smoking risk assessment is done to assess if the resident is safe to smoke. RN 3 stated if Resident 133 did not have a smoking risk assessment done the resident's safety is potentially at risk. During an interview on 7/3/2025 at 11:15 AM with the Director of Nursing (DON), the DON stated smoking risk assessments are done on admission, quarterly, and as needed. The DON stated that Resident 133 should have had an updated smoking risk assessment performed when staff realized the resident smoked cigarettes. The DON stated the purpose of performing a smoking risk assessment was to identify if the resident was a smoker and to provide interventions to help the resident smoke safely. The DON stated there was a potential for Resident 133's safety to be affected if a smoking risk assessment was not performed. During a review of the facility Policy & Procedures (P&P) titled Smoking Assessment Policy - Residents dated 1/13/2025, the P&P indicated, This facility shall establish and maintain safe resident smoking practices. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker . A resident's ability to smoke safely will be re-evaluated quarterly, upon significant change (physical or cognitive) and as determined by staff.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure one (1) of four (4) medication carts was locked and secured when it was unattended in the hallway. This deficient practice had the potential for unauthorized access to medications, drug diversion, and/or drug pilferage. Findings: During an observation on 7/1/2025 at 8:25 AM, the licensed vocational nurse (LVN 2) was at the doorway of Resident 96's room preparing medication for administration. During an observation on 7/1/2025 at 8:30 AM, LVN 2 walked into Resident 96's room and left the medication cart unlocked in the hallway. During an observation and concurrent interview on 7/1/2025 at 8:34 AM, LVN 2 exited Resident 96's room and acknowledged that she did not lock the medication cart. During a review of the facility's Policy and Procedures (P&P), Storage of Medication (dated 3/1/2025), the P&P indicated that . Compartments . containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure: 1.The nursing staff (Licensed Vocational Nurse 3 [LVN 3] and Licensed Vocational Nurse 4 [LVN 4]) followed its enhanced barriers precautions (EBP, an infection prevention protocol to reduce the spread of certain drug-resistant bacteria, particularly in nursing homes) policy during the medication administration observation for two (2) of six sampled residents (Resident 36 and 23). 2. One of six residents (Resident 119) was provided with a proper identifier for enhanced barrier precautions. These deficient practices had potential to cause cross contamination, spreading the infection among residents, visitors and staff. Findings: 1. During a medication administration (med pass) observation on 7/01/2025 at 9:01 AM, on the wall behind Resident 36's bed, there was a sign indicating enhanced barrier precautions. LVN 3 was observed performing hand hygiene prior to proceeding to measure Resident 36's blood pressure and heart rate at bedside; however, LVN 3 did not don (to put on) gown. During a med pass observation on 7/01/2025 at 9:34 AM at Resident 23's bedside, there was a sign indicating enhanced barrier precautions. LVN 4 was observed donning gloves without having gown on prior to measuring resident's blood pressure and performing med pass. During an interview on 7/1/2025 at 9:50 AM, when asked about the EBP sign, LVN 4 stated the sign meant facility staff needed to don gloves and gown before providing care to the residents. LVN 4 stated she forgot to don on gown before passing medications to Resident 23. During a review of the facility's Policy and Procedures (P&P), titled Administering Medications (dated 7/1/2023), the P&P indicated . Staff shall follow established facility infection control procedures . During a review of the facility's P&P, titled Infection Control (dated 7/1/2023), the P&P indicated . Educating staff and ensuring that they adhere to proper techniques and procedures . 2. During a review of Resident 119's admission Record, the admission Record indicated Resident 119 was admitted to the facility on [DATE] with diagnoses that included benign prostatic hyperplasia (a common condition in older men where the prostate (a gland in the male reproductive system that produces a milky white substance) enlarges leading to problems urinating), retention of urine, and acute kidney failure (a sudden rapid decline in the function of the kidney). During a review of Resident 119's Order Summary Report dated 5/7/2025, the Order Summary Report indicated Resident 119 was on EBP every shift for the indwelling urinary catheter (flexible tube inserted into the bladder to drain urine). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 119's Care Plan Report dated 5/7/2025, the Care Plan Report indicated Enhanced Barrier Precautions with an intervention to implement appropriate infection control precaution signs next to the door entrance with room number. During a review of Resident 119's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 6/20/2025, the MDS indicated the resident needed partial or moderate assistance with perineal hygiene, adjusting clothes before and after voiding, and the resident had an indwelling catheter. During an observation on 6/30/2025 at 9:42 AM in Resident 119's room, Resident 119 was lying in bed. Resident 119 had an indwelling catheter in a dignity bag (a cover or holder designed to discreetly conceal a urinary drainage bag, often attached to a catheter) hanging from the bed. However, there was no proper identifier to indicate Resident 119 was on EBP per care plan intervention. During a concurrent observation and interview on 6/30/2025 at 12:33 PM with LVN 4 in Resident 119's room, LVN 4 confirmed there was no identifier to indicate that the resident was on EBP. LVN 4 stated the IP nurse places signs on doors and signs above the resident's bed if residents are on EBP. LVN 4 stated the risk to Resident 119 could be that the resident or the staff could catch an infection without proper notification that the resident was on enhanced precautions. During a concurrent observation and interview on 6/30/2025 at 12:38 PM with the Infection Preventionist (IP) in Resident 119's room, the IP confirmed there was no identifier to indicate that the resident was on EBP. The IP stated a sign would have been placed over the resident's bed to indicate Resident 119 was on EBP. The IP stated the risk to Resident 119 without an indicator for EBP could be a risk of transmission of infections. During an interview on 7/2/2025 at 11:16 AM with the Director of Nursing (DON), the DON stated for those residents on EBP, signage or identification goes above the resident's bed on the wall above the bed. The DON stated he would have to go back into the care plan and look at the intervention which indicated the sign should be outside the door entrance with room number. The DON stated the risk to Resident 119 without EBP identifier could be confusion whether visitors or staff should use PPE and could lead to cross contamination to the resident. During a review of the facility's P&P titled, Initiating Enhanced Barrier Precautions, dated 1/13/2025, the P&P indicated when EPBs are implemented, the IP (or designee) determines the appropriate notification so that staff are aware of the need of precautions. The P&P indicated that the facility should make every effort to use a creative communication approach with the staff to maintain a home-like environment.

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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** Based on observation, interview and record review, the facility failed to ensure one of 72 resident rooms (room [ROOM NUMBER]) met the required space at least 80 square feet for each resident. This failure had the potential to affect the delivery of care, safety, and privacy of the residents. Findings: During a concurrent observation and interview on 7/3/2025 at 9:25 AM, in room [ROOM NUMBER], Maintenance supervisor (MS) measured the room. The MS stated the room measured 10'8.5 x 19'9 = 213.69 sq. ft. The room was clean and free from clutter and obstruction. During an interview on 7/3/25 at 9:26 AM with Certified Nurse Assistant 5 (CNA 5) , CNA 5 stated the room feels regular. The room is kept low clutter and easily accessible. During a review of the Client Accommodations Analysis dated 7/3/2025, the Client Accommodations Analysis indicated the room measurements for room [ROOM NUMBER] was 10'8.5 x 19'9 = 213.69 sq. ft., with three beds The square footage requirements for a three-bed capacity room must be at least 240 square feet per Federal regulation. During a review of the facility's Room Variance Waiver Letter dated 4/25/2025, the Letter indicated room [ROOM NUMBER] was less than 80 square feet. The Room Variance Waiver Letter indicated room [ROOM NUMBER] had three beds. During multiple room observations conducted in room [ROOM NUMBER], from 7/1/2025 to 7/3/2025, there were no safety and privacy concerns observed related to space or to the safe provisions of care to the residents residing in the room During a review of the facility's Policy and Procedures (P&P) titled, Bedroom, dated 1/13/25, the P&P indicated the facility provides rooms which measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call lights (a device that alerts healthcare providers that the patient needs assistance) were within residents' reach and easily accessible for two of two sampled residents (Resident 13, Resident 114). This deficient practice had the potential to result in delays in meeting the Resident 13 and Resident 114's needs for assistance, which could lead to accidents including falls. Findings: 1. During a review of Resident 13's admission Record, the admission Record indicated the facility re-admitted the resident on 12/9/2024 with diagnoses that included metabolic encephalopathy (a brain disorder caused by chemical imbalances in the blood), need for assistance with personal care, dementia, psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with reality), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), and a history of falling. During a review of Resident 13's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 6/16/2025, the MDS indicate the resident had severely impaired cognition (impaired ability to think, understand, and reason). The MDS indicated Resident 13 was dependent on help for toileting hygiene, showering and bathing herself, putting on and taking off footwear, and personal hygiene. The MDS indicated Resident 13 required substantial/maximal assistance for lower body dressing. The MDS indicated Resident 13 required partial/moderate assistance for oral hygiene and upper body dressing. The MDS indicated Resident 13 required supervision or touching assistance with eating. During a review of Resident 13's Care Plan Report, the Care Plan Report indicated the resident had an Activities of Daily Living (ADL) self-care performance deficit related to dementia, impaired balance, limited mobility, limited Range of Motion (ROM), and pain on the right hip due to a history of a fall. The Care Plan Report indicated a goal to anticipate and meet Resident 13's needs daily or as needed. The Care Plan Report indicated interventions that included ensuring and providing a safe environment for Resident 13 with the call light in reach. During an observation on 6/30/2025 at 9:13 AM, in Resident 13's room, the resident was observed lying in bed. Resident 13's call light was observed on the floor on the left side of the bed out of the resident's reach. During a concurrent observation and interview on 6/30/2025 at 9:18 AM, with Certified Nursing Assistant 4 (CNA 4), in Resident 13's room, the resident's call light was observed on the floor out of the resident's reach. CNA 4 stated that Resident 13's call light should not be on the floor. CNA 4 stated Resident 13's call light should be next to the resident with the resident's reach. CNA 4 stated the call light should be next to the resident so she (Resident 13) can call the nursing staff for help when needed. (continued on next page)

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	056244	A. Building B. Wing	07/03/2025

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/3/2025 at 11:13 AM with the Director of Nursing (DON), the DON stated call lights should be placed within residents' reach, so residents can call for assistance if they need anything. The DON stated there is a potential for the residents not to be able to call for assistance from nursing staff during an emergency if the call light is not within the resident's reach. During a review of the facility's Policy and Procedures (P&P) titled Call Light dated 5/2023, the P&P indicated When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. 2. During a review of Resident 114's admission Record, the admission record indicated the resident was admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses that included muscle weakness, subarachnoid hemorrhage (a serious condition where bleeding occurs in the space between the brain and the skull), hypertension (HTN-high blood pressure), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and encephalopathy (a change in brain function due to injury or disease). During a review of Resident 114's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognition. The MDS indicated Resident 114 was dependent on staff for self-care activities such as eating, oral hygiene, toileting hygiene, bathing, and dressing. During a review of Resident 114's Order Summary Report, dated 4/15/2025, the Order Summary Report indicated Maintain touch pad call light (a call light with a flattened pad that is activated by slight pressure from the hand, arm or body) to facilitate resident with upper mobility impairment. During a review of Resident 114's Care Plan, reviewed and revised on 5/5/2025, the Care Plan indicated Resident 114 had self-care deficit and was at risk for fall related to impaired mobility, and was incontinent of bowel movement. The Care Plan indicated goals for Resident 114 to maintain the current level of function, have no falls, and minimize the risk for skin impairment. The Care Plan indicated an intervention for Resident 114 to have the call light within reach and answered promptly. During an observation on 6/30/2025 at 10:40 AM, in Resident 114's room, Resident 114 was observed lying in a geri-chair (a large, padded chair that is designed to help seniors with limited mobility) positioned on the left side of the resident's bed. Resident 114's touch pad call light was observed on the bed, out of the resident's reach. Resident 114 was observed stretching out her right hand to reach out for the call light but was not able to do so. During a concurrent observation and interview on 6/30/2025 at 10:50 AM, in Resident 114's room, with CNA 3, CNA 3 confirmed Resident 114's call light was out of reach on the bed while the resident was lying in the geri-chair. CNA 3 stated Resident 114 could fall and staff would not be aware if there was an emergency because the resident would not be able to call for assistance when needed with the call light out of reach. During an interview on 7/3/2025 at 8:21 AM, with Registered Nurse Supervisor (RN) 1, RN 1 stated Resident 114's concerns would not be addressed if the call light was not within reach. RN 1 stated call light should be placed next to the resident at all times. During an interview on 7/3/2025 at 9:11 AM, with the DON, the DON stated Resident 114 would potentially not be able to receive the assistance needed if the call light was not within reach. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Call Light, reviewed 5/2023, the P&P indicated The purpose of this procedure is to respond to the resident ' s request and needs .When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.