STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024
NAME OF PROVIDER OR SUPPLIER: Alcott Rehabilitation Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE: 3551 West Olympic Blvd. Los Angeles, CA 90019	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43851 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect for one of five sampled residents (Resident 51) when Certified Nursing Assistant (CNA) 3 was observed standing over Resident 51 while feeding the resident lunch. This deficient practice had the potential to cause psychosocial harm to the Resident 51 and violated the resident's right to be treated with dignity. Findings: A review of Resident 51's face sheet (admission record), indicated the facility readmitted the resident on 9/25/2024 with diagnoses including dementia (loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that the loss interferes with a person's daily life and activities), lack of coordination (a condition that affects muscle control), muscle weakness (lack of muscle strength), and dysphagia (difficulty swallowing). A review of Resident 51's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/30/2024, indicated the resident had severely impaired cognition (lack of the ability to think, remember, and make decisions). The MDS indicated Resident 51 required partial / moderate assistance with eating and would hold food in their mouth / checks after meals. During an observation on 10/15/2024 at 12:52 PM. CNA 3 was observed feeding Resident 51 lunch. CNA 3 was observed standing up on the right side of Resident 51 next to the resident's bed feeding the resident. CNA 3 was observed looking down at Resident 51 while the resident was looking up at CNA 3. During a concurrent interview, CNA 3 stated Resident 51 was a feeder and required assistance with meals. CNA 3 stated she was supposed to be sitting down while feeding Resident 51, that she usually would sit in a chair. CNA 3 stated she was supposed to be at eye level with the resident. During an interview on 10/27/2024 at 1:06 PM, the Director of Nursing (DON) stated when a staff member was feeding a resident they should be sitting and maintaining themselves at eye level with the resident. The DON stated this was done to protect resident dignity and there was a potential for the resident to not feel respected if staff stood up while feeding 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056293	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alcott Rehabilitation Hospital	3551 West Olympic Blvd. Los Angeles, CA 90019

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Promoting / Maintaining resident Dignity During Mealtimes, reviewed 3/27/2024, indicated to treat each resident with respect and dignity and care for each resident in a manner and in an environment that maintains or enhances his or her quality of life, recognizing each resident's individuality and protecting the rights of each resident. Staff members involved in providing feeding assistance to resident promote and maintain resident dignity during mealtimes. All staff will be seated, if possible, while feeding a resident.

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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** 49836 Based on observation, interview, and record review, the facility failed to update the person-centered care plan for one of three sampled residents (Resident 43), who suffered from depression. Resident 43's care plan did not include the resident's preferred activities. This deficient practice caused an increased risk of Resident 43 having meaningful activity to promote and enhance the resident's quality of life. Findings: A review of the Admission Record indicated Resident 43 was admitted to the facility on [DATE], with diagnoses including major depressive disorder (depression [a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities of living]), dementia (a chronic condition that causes a gradual decline in cognitive abilities, such as thinking, remembering, and reasoning), muscle wasting and atrophy (decrease in size and thinning of muscle tissue). A review of the Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/17/2024, indicated Resident 43 had severe cognitive impairment (problems with a person's ability to think, remember, use judgement, and make decisions) and was totally dependent with bed mobility, transfer, dressing, feeding, toileting, personal hygiene, and bathing. A review of Resident 43's care plan for alteration in activity related to hearing impairment, cognitive impairment, self-care, and mobility deficits, revised on 7/17/2024 indicated the goal was for Resident 43 to participate in activities of resident's choice 3-4 times a week. The care plan interventions included praise efforts for attendance and participation in church service. During an observation on 10/17/2024 at 9:13 AM, Resident 43 was lying in bed awake, was nonverbal and unable to make needs known. While observing Resident 43, church service could be heard from the activities room. There was no attempt from facility staff observed to assist Resident 43 to church service. During an observation on 10/17/2024 at 10:18 AM, Resident 43 was lying in bed watching television and the Rehabilitation Nursing Assistant (RNA 1) was outside of Resident 43's room. During a concurrent interview, RNA 1 was asked if Resident 43 would be going to Church Service and RNA 1 stated that Resident 43 did not like going. RNA 1 stated Resident 43 would become agitated while at Church Service and the family comes and takes Resident 43 out daily. RNA 1 stated Resident 43 enjoyed spending time with family. During an interview on 10/17/2024 at 12:05 PM, the Activities Director (AD) stated Resident 43 used to attend Church Service but no longer enjoyed going. The AD stated Resident 43 preferred to spend time with their family. During a concurrent review of Resident 43's activities care plan, the AD stated the care plan for Resident 43 should have been updated to reflect their current interests of enjoying time with family. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/2024 at 2:45 PM, the family member was called regarding Resident 43's activity preference for attending church service. There was no answer and the family member did not return the message. A review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans, revised 3/27/2024, indicated to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the resident's comprehensive assessment.

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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** 49836 Based on interview and record review, the facility failed to review, update, and/or revise the care plans for two of three sampled residents (Resident 71 and Resident 75). Resident 71 did not have current wound care treatment indicated for the Stage III sacral pressure ulcer and Resident 75's care plan did not include updated interventions for pressure injury prevention. These deficient practices had the potential to affect the provision of necessary care, treatment, and services for Resident 71 and Resident 75. Findings: a. A review of Resident 71's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including dementia (impaired ability to remember, or make decisions that interferes with doing everyday activities) and pressure ulcer of sacral region Stage III. A review of the Physician's Orders dated 9/27/2024, indicated to cleanse the sacro coccyx (tail bone) pressure injury with normal saline (NS-a salt solution), pat dry, apply Santyl (medication that removes dead tissue from a wound) ointment, apply Bacitracin (topical antibiotic used to prevent infection) ointment, and apply foam dressing every day shift. A review of Resident 71's potential for pressure ulcer development related to the sacro coccyx pressure ulcer care plan dated 9/30/2024, indicated the resident's pressure ulcer would show signs of healing and remain free from infection by or through review date. The care plan indicated to administer medications and treatment as ordered. A review of Resident 71's 35's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 10/1/2024, indicated the resident had severe cognitive impairment and did not have the capacity to understand or make their own decisions. The MDS further indicated Resident 71 needed maximum assistance with bed mobility, transfer, and personal hygiene. During an observation on 10/17/2024 at 11:34 AM, the Treatment Nurse (TX 1) performed wound care treatment on Resident 71's sacral pressure ulcer. During a concurrent interview, TX 1 stated Resident 71's wound was healing and had gotten smaller since the resident was first admitted . TX 1 stated if there was a change in the resident's wound status or if a treatment was changed it should be updated in the care plan to ensure continuity of care. TX 1 stated they forgot to revise and update the care plan for Resident 71. During an interview on 10/17/24 12:41 PM, the Minimum Data Set Coordinator (MDS) stated that treatment orders for pressure ulcers should be indicated in the care plan because it was important to know what the recent treatment for the resident was and if the interventions were effective. The MDS also stated the stage of the pressure ulcer should also be indicated in the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures (P&P) titled, Comprehensive Care Plans, revised on 3/27/2024, indicated to develop and implement a comprehensive person-centered care plan for each resident consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 49881 b. A Review of Resident 75's Admission Record indicated the resident was originally admitted to the facility on [DATE] with diagnoses including Type II diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and vascular dementia (a progressive state of decline in mental abilities). A review of Resident 75'S Braden Scale Assessment (a tool used for predicting pressure ulcer/sore risk) dated 5/17/2024 indicated a total score of 14 which placed the resident at moderate risk for developing pressure ulcer. A review of Resident 75's MDS dated [DATE] indicated the resident's cognition (the ability to think and process information) was severely impaired and was at risk for developing pressure ulcers/injuries. A review of the Physician's Order dated 10/14/2024, indicated Resident 75 was to receive the APP overlay for skin and wound management. A review of Resident 75's At Risk for potential skin breakdown and development of pressure injuries care plan, revised 10/14/2024, indicated an intervention for a pressure reduction mattress in bed (low air loss mattress, LAL) and APP (alternating pressure pad) overlay for skin and wound management. During a concurrent observation and interview on 10/16/2024 at 1:25 PM with Registered Nurse 1 (RN 1), Resident 75 was observed in his room. RN 1 stated and confirmed Resident 75 had an alternating pressure pad and did not have a low air loss mattress. RN 1 stated it was important to follow the care plan interventions to prevent any skin injuries from residents who were risk for developing skin issues. During a concurrent record review and interview on 10/16/2024 at 1:45 PM with Treatment Nurse 1 (TX 1), Resident 75's At Risk for potential skin breakdown care plan was reviewed. TX 1 stated the plan was for the resident to have an APP to prevent skin breakdown and that it was confusing to have an intervention for the low loss mattress and alternating pressure pad in the same care plan. TX 1 stated Resident 75's care plan should have been revised to include the APP intervention only. During a concurrent record review and interview with the Director of Nursing (DON) on 10/18/2024 at 9:20 AM, Resident 75's care plan at risk for potential skin breakdown was reviewed. The DON stated Resident 75's care plan should have been updated to resolve the intervention for the LAL mattress because the plan was for the resident to have an APP mattress. The DON stated it was important to resolve the care plan interventions that were no longer needed to ensure the resident was getting the interventions needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans, revised 3/2024, indicated the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, and include measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychological that are identified in the resident's comprehensive assessment.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49881 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 75), who was assessed as a moderate risk to develop pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) was provided with a pillow or heel protectors (pressure relieving devices) to the left and right heels and repositioned every two hours and PRN (as needed), per the resident's care plan. This deficient practice placed Resident 75 at increased risk for developing pressure sores. Findings: A review of Resident 75's Admission Record indicated the resident was originally admitted to the facility on [DATE] with diagnoses including Type II diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and vascular dementia (a progressive state of decline in mental abilities). A review of Resident 75's Braden Scale assessment (a tool used for predicting pressure ulcer/sore risk) dated 5/17/2024 indicated a total score of 14 which placed the resident at moderate risk for developing pressure ulcer. A review of Resident 75's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 8/15/2024 indicated the resident's cognition (the ability to think and process information) was severely impaired and was at risk for developing pressure ulcers/injuries. A review of Resident 75's At Risk for potential skin breakdown and development of pressure injuries care plan revised 10/14/2024 indicated the interventions were turning and reposition Resident 75 every two hours and PRN (as needed) and reducing pressure off heel(s) with pillow(s) or heel protectors. During an interview on 10/16/2024 at 1:06 PM, Certified Nurse Assistant (CNA 2) stated and confirmed she was the nurse assistant assigned to Resident 75. CNA 2 stated she did not know if Resident 75 required heel protectors. CNA 2 stated she was repositioning the resident every two hours but was not keeping track of the repositioning because only the residents with a wound had a repositioning log. During a concurrent observation and interview on 10/16/2024 at 1:25 PM with Registered Nurse 1 (RN 1), Resident 75 was observed in his room. Resident 75 was observed laying in his bed and RN 1 stated and confirmed the resident did not have pillows or heel protectors to reduce pressure from the resident's left and right heels. RN 1 stated it was important to follow the residents care plan interventions to prevent any skin injuries from residents who were at risk for developing skin issues. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Staff Developer (DSD) on 10/16/2024 at 2:46 PM, the DSD stated there was a binder at the nurse's station with a list of residents who needed repositioning ever two hours. The DSD stated the staff have a log for each resident and log repositioning ever two hours and pressure reduction from the heels. The DSD stated Resident 75 was not on the list and there was no documentation that the resident was repositioned every two hours or that staff reduced pressure off his heels from 10/1 to 10/16/2024. The DSD stated it was important to reposition the resident every two hours and use pillows to reduce pressure off the heels to prevent skin breakdown. A review of the facility's policy and procedure (P&P) titled, Pressure Injury Prevention and Management, revised 3/2024, indicated the facility was committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional ulcers/injuries. Interventions for prevention and to promote healing included evidenced-based interventions for prevention would be implemented for all residents who are assessed at risk or who have pressure injury present. The policy indicated basic or routine care interventions could include but are not limited to redistributing pressure (such as repositioning, protecting, and/or offloading heels, etc.).

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F 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49881

Based on interview and record review, the facility failed to provide services for one of two sampled residents (Residents 84) at risk for decline in range of motion (ROM, full movement potential of a joint) and mobility. Resident 84 did not receive Restorative Nursing Aide program (RNA, nursing aide program that help residents to maintain their function and joint mobility) treatments for passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises and left knee extension splint, per the care plan.

This deficient practice had the potential to cause further decline in functional mobility, ROM, and quality of life for Residents 84.

Findings:

A review of Resident 84's Admission Record indicated the resident was originally admitted to the facility on [DATE] with diagnosis including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (condition that causes weakness or an inability to move on one side of the body) following cerebral infarction (occurs as a result of disrupted blood flow to the brain) affecting left non-dominant side, contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of left knee, and age-related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D).

A review of Resident 84's care plan initiated 12/18/2023 indicated the resident was on the RNA program for PROM exercises on BLE, BUE, and bilateral knee extension splint assistance to address potential for decline in range of motion. The interventions included PROM daily five times a week as tolerated to the right and left upper extremity, PROM daily seven times a week as tolerated to the right and left lower extremity, and right and left knee extension splint to be worn two hours daily seven times a week as tolerated.

A review of Resident 84's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 7/11/2024 indicated the resident's cognition (the ability to think and process information) was severely impaired, was dependent with toileting and shower. The MDS indicated Resident 84 had impairment on both sides of the lower extremity and no impairment on both sides of the upper extremity.

A review of Resident 84's Documentation Survey Report for September 2024 indicated the resident received PROM to the right and left lower extremity nine times on the following dates: 9/5, 9/7, 9/9 - 9/12/24, 9/15, 9/26 and 9/30/2024, PROM to the right and left upper extremity seven times on the following dates: 9/5, 9/9 - 9/12/2024, 9/27, and 9/30/2024, and right and left knee extension splint assistance nine times on the following dates: 9/5, 9/7, 9/9 - 9/12/2024, 9/15, 9/27, and 9/30/2024.

A review of Resident 84's Rehab Screen dated 10/10/2024 indicated the resident maintained functional task performances and bilateral upper and lower extremity ROM. The screen indicated Resident 84 would benefit from continued restorative nursing program to maintain current functional task performances.

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 84's Documentation Survey Report for October 2024 indicated the resident received PROM to the right and left lower extremity six times on the following dates: 10/3, 10/5, 10/9, 10/10, 10/14, and 10/17/2024, PROM to the right and left upper extremity five times on the following dates: 10/3, 10/9, 10/10, 10/14, and 10/17/2024, and right and left knee extension splint assistance five times on the following dates: 10/3, 10/5, 10/9, 10/10, 10/14, and 10/17/2024. During a concurrent record review and interview, on 10/18/2024 at 9 AM, Resident 84's Documentation Survey Report for September 2024 and October 2024 were reviewed with the Director of Nursing (DON). The DON stated and confirmed Resident 84 was on the RNA program for the following: PROM to the lower extremity seven times as tolerated, PROM to the upper extremity [NAME] time a week as tolerated, and bilateral knee splint assistance seven times a week for two hours as tolerated. The DON confirmed Resident 84 received RNA services to the lower extremity nine times in the month September 2024, RNA services to the upper extremity seven times in the month of September 2024, and assistance with the knee splints nine times in the month September 2024. The DON stated Resident 84 received RNA services to the lower extremity six times from October 1 to 17, 2024, RNA services to the upper extremity five times from October 1 to 17, 2024, and assistance with the knee splints six times from October 1 to 17, 2024. The DON stated based on the documentation, the staff were not following Resident 84's RNA Program. The DON stated it was important to follow the residents RNA Program to maintain mobility because there was a risk for a decline in mobility. A review of the facility's policy and procedure (P&P) titled, Restorative Nursing Program, revised 3/2024, indicated it was the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. The policy indicated restorative aides will implement the plan for a designated length of time, performing the activities, and documenting the electronic health record.

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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49881

Based on interview and record review, the facility failed to provide an environment free from accident hazards to prevent avoidable accidents for one of two sampled residents (Resident 306), who was admitted to the facility with a history of falls and was at continued risk for falls, by failing to:

-Accurately assess Resident 306's risk for falls dated 9/10/2024.

-Evaluate and analyze fall risk hazards, implement individualized interventions to reduce risk of falling, and monitor for effectiveness of interventions.

-Reevaluate and update individualized interventions to prevent recurrent falls after Resident 306 fell on , d+[DATE] and 9/17/2024.

-Ensure Resident 306 was not left without staff supervision in the facility patio.

As a result, on 9/16/2024 Resident 306 stood up from the wheelchair in front of the nurse's station and fell . On 9/17/2024, Resident 306 was left alone in the wheelchair with a family member and Resident 306 fell again from the wheelchair. These deficient practices placed Resident 306 at increased risk for recurrent falls and complications related to fall injuries such as fractures, cuts, and internal bleeding.

Findings:

A review of Resident 306's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), history of falling, and wedge compression of the second to fourth lumbar vertebrae (a type of spinal compression fracture that occurs when the front of a vertebra collapses, giving it a wedge shape).

A review of Resident 306's Fall Risk assessment dated [DATE] indicated the resident had a total score of 17 and was at risk for falls.

A review of Resident 306's care plan for at risk for fall injury dated 7/13/2024, indicated intervention for facility staff included to monitor the resident for behavioral issues manifested by restlessness and agitation.

A review of Resident 306's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 7/16/2024 indicated the resident's cognition (the ability to think and process information) was severely impaired and had a history of a fall in the month prior to admission to the facility.

A review of Resident 306's Fall Risk assessment dated [DATE] indicated the resident had a total score of 17 which placed the resident at risk for falls. The assessment indicated no falls in past three months under the section titled History of Falls.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alcott Rehabilitation Hospital	3551 West Olympic Blvd. Los Angeles, CA 90019

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 306's care plan regarding 9/10/2024 resident had an actual fall with no injury dated 9/10/2024 indicated to continue interventions on the at-risk plan. A review of Resident 306's Interdisciplinary Team (IDT, a team of health care professions, which include the facility's medical director, Director of Nursing (DON), social worker, registered nurse, and other staff as needed who work together to establish plans of care for residents) Progress Note dated 9/11/2024 indicated the resident had a fall on 9/10/2024 at the nursing station. The IDT progress note indicated Resident 306 was observed standing up from the wheelchair, lost balance, and fell . The IDT Progress Note indicated a recommendation to continue rehab treatment, continue to encourage the resident to call for assistance when transferring, frequently check the resident (did not indicate the frequency) when up in the wheelchair, continue falling star program, and follow up with psychiatric doctor. A review of Resident 306's At Risk for Fall Injury care plan dated 9/11/2024 indicated interventions to continue rehab treatment, continue to encourage the resident to call for assistance when transferring, frequently check the resident when up in the wheelchair, continue falling star program, and follow up with psychiatric doctor. A review of Resident 306's Nurse Progress Note dated 9/16/2024 indicated the resident had a fall by the nurse's station. The note indicated an unidentified staff member observed Resident 306 stand from the wheelchair with an unsteady gait and fall to the floor. A review of Resident 306's Fall Risk assessment dated [DATE] indicated the resident had a total score of 21 and was at risk for falls. A review of Resident 306's Progress Note dated 9/17/2024 indicated the resident was sitting on the wheelchair in the patio with a family member. The note indicated on 9/17/2024 at about 3:30 PM, a staff member found Resident 306 sitting on the ground. The note indicated Resident 306 reported she had fallen. A review of Resident 306's IDT Progress Note dated 9/19/2024 indicated the resident had a fall incident on 9/16/024 and 9/17/2024. The IDT recommended to continue rehab treatment, continue to encourage the resident to call for assistance when transferring, frequently check the resident when she was up in the wheelchair, continue fall star program, and follow up with psychiatric doctor. A review of Resident 306's At Risk for Fall Injury care plan dated 9/19/2024 indicated interventions to continue rehab treatment, continue to encourage the resident to call for assistance when transferring, frequently check the resident when up in the wheelchair, continue falling star program, and follow up with psychiatric doctor. During an interview on 10/17/2024 at 3:40 PM, Registered Nurse (RN) 3 stated Resident 306 had a witnessed fall on 9/16/2024 in front of the nurse's station. RN 3 stated the resident had another fall on 9/17/2024. RN 3 stated on 9/17/2024, Resident 306 was calm and sitting in her wheelchair outside in the patio with a family member. RN 3 stated she did not think Resident 306 needed frequent monitoring. RN 3 stated she saw Resident 306 at 3:30 PM and at about 3:41 PM, another staff member reported Resident 306 had fallen in the patio. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Alcott Rehabilitation Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 3551 West Olympic Blvd. Los Angeles, CA 90019	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview with the Director of Nursing (DON) on 10/18/2024 at 11:01 AM, Resident 306's Fall Risk assessment dated [DATE] was reviewed. The DON stated the fall risk assessment was incorrect because the second question was answered incorrectly and should have indicated 1-2 or more falls in past 3 months and would have resulted in a higher fall risk score. The DON stated the higher number would indicate the resident had a higher risk for falls. The DON stated it was important to have an accurate fall assessment for residents to prevent falls. During a concurrent record review and interview with the DON on 10/18/2024 at 11:15 AM, Resident 306's Interdisciplinary Progress Note dated 9/11/2024 was reviewed. The DON stated the recommendation of frequently checking the resident when up in the wheelchair was included in the care plan. The DON stated frequent checking meant staff would visually check the resident when rounding or providing care. The DON stated the intervention was broad and should have indicated a frequency of how often to check the resident. The DON stated there was no documentation to show that Resident 306 was frequently checked when she was up in the wheelchair. The DON stated it was important to frequently check the resident to prevent falls and to have specific interventions that included a frequency to ensure the resident was getting the supervision needed. During a concurrent record review and interview with the DON on 10/18/2024 at 11:15 AM, Resident 306's Interdisciplinary Progress Note dated 9/19/2024 was reviewed. The DON stated the IDT met to discuss Resident 306's fall on 9/16/2024 and 9/17/2024. The DON stated during the meeting, IDT discussed more frequent visual checking of the resident while in the wheelchair. The DON stated Resident 306's falls occurred while the resident was in the wheelchair. The DON confirmed there were no new interventions from the IDT meeting on 9/19/2024 and there were no new interventions added the care plan. The DON stated it was important to determine new interventions to prevent the resident from falling. A review of the facility's policy and procedures (P&P) titled, Fall Prevention Program, revised 3/2024 indicated each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The policy indicated each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive care plan and the plan of care will be revised as needed. The policy indicated the at-risk protocols included additional services as directed by the resident's assessment, including but not limited to increased frequency of rounds. A review of the facility's P&P titled, Comprehensive Care Plans, revised 3/2024, indicated the comprehensive care plan will describe resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to ensure one opened vial of Novolin R (a medication used to control blood sugar) was labeled with an open date per the manufacturer's requirements in one of two inspected medication carts (West Medication Cart.) The deficient practices of failing to store or label medications per the manufacturers' requirements increased the risk that residents could have received medication that had become ineffective or toxic due to improper storage or labeling possibly leading to health complications resulting in hospitalization or death. Findings: During a concurrent observation on [DATE] at 11:06 AM of [NAME] Medication Cart, with the Licensed Vocational Nurse (LVN 1), the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: -One opened vial of Novolin R was found stored at room temperature and not labeled with an open date. According to the manufacturer's product labeling, once stored at room temperature, vials of Humulin R were to be used or discarded within 42 days. During a concurrent interview, LVN 1 stated the Novolin R was opened, but not labeled with an open date. LVN 1 stated without an open date, there was no way to know when the product would expire because the expiration date could not be determined, nor exactly how long the Novolin R had been stored at room temperature. LVN 1 stated if expired insulin was administered to a resident, expired insulin could cause medical complications due to poor blood sugar control. A review of the facility's policy titled, Medication Storage, revised [DATE], indicated to ensure all medications housed on our premises will be stored in the pharmacy and / or medication rooms according to the manufacturer's recommendations. A review of the facility's policy titled, Labeling of Medications and Biologicals, revised [DATE], indicated labels for multi-use vials must include the date the vial was initially opened or accessed (needle punctured). All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 38740 Based on observation, interviews, and record review, the facility failed to have a policy that addressed how to store and reheat resident's left-over food brought into the facility from outside kitchens / restaurants to ensure safe and sanitary food storage, handling, and consumption. This deficient practice had the potential to cause food borne illness in residents in the facility who were served the food brought by family or visitors. Findings: During an interview on 10/16/2024 at 2:45 PM, Registered Nurse (RN 1) stated resident families were encouraged to bring enough food for one meal and take the leftovers home or discard the leftovers. RN 1 stated the facility did not encourage the storage of resident food brought from outside. RN 1 stated facility policy did not allow storing perishable food (food that needs refrigeration) for residents. During an interview on 10/16/2024 at 3 PM, RN 2 stated there was no refrigerator for residents to keep food brought from the outside. RN 2 stated there was a refrigerator in the Director of Nursing's (DON) office that could be used for resident food if leftovers needed to be stored. RN 2 stated there had been situations where residents insisted on storing leftovers and not discarding the leftovers. RN 2 did not remember the residents or families who requested to store the food. During an interview with Director of Staff Development (DSD) on 10/16/2024 at 3:15 PM, the Director of Staff Development (DSD) stated the facility policy was to not to store leftovers or food brought to residents from outside. The DSD stated if the food required refrigeration facility staff was to encourage the resident to finish the food and discard the rest. The DSD stated if the food was nonperishable then the food could be stored at bedside in the resident room in a container. During an interview on 10/16/2024 at 4 PM, the DON stated facility policy indicated no outside food for residents was to be stored and the facility did not have a refrigerator to store resident food from family or visitors. The DON stated the facility only allowed the family to bring enough food to consume for one meal and family needed to discard or take leftovers back. During a concurrent review of facility policy and interview with the DON on 10/16/2024 at 4:45 PM, the DON stated the policy indicated food would be consumed or discarded and not stored. The DON stated he was not aware of any residents who requested food to be stored for later consumption. The DON stated if residents wanted to store the food, the facility did not have a policy and procedures that addressed how and where to store food safely. A review of facility policy titled, Use and storage of Food Brought in by Family or Visitors, revised 3/27/24 indicated, All food items that are already prepared by the family or visitor brought in, must be eaten within 2 hours of receiving and the remaining food must be discarded, all food items brought in that are manufactured and do not require refrigeration may be kept in the resident room inside a sealed container, it is the responsibility of the resident and representative to maintain container and items in the container.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 43851 Based on observation, interview, and record review, the facility failed to implement and maintain infection control procedures when the facility did not screen family members and visitors for three day on signs and symptoms of Coronavirus (COVID-19, a contagious and infectious disease that is characterized by fever and cough and is capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) during a COVID-19 outbreak (a sudden increase in occurrences of a disease when cases are in excess of normal expectancy for the location or season) in the facility. This deficient practice had the potential to result in the spread of COVID 19 to residents and staff. Findings: During an observation on 10/17/2024 at 11:50 AM, Family Member (FM) 1 was observed entering the facility unmasked. Upon entering the facility, FM 1 was observed entering Resident 15's room. FM 1 did not screen themselves for sign and symptoms of COVID-19. During an interview on 10/17/2024 at 12 PM, FM 1 stated they did not sign in on the visitor screening log and stated she was not screened for COVID-19. FM 1 stated they were not informed of the screening process and stated she just walked into the facility. During an observation on 10/17/2024 at 12:45 PM, the facility's visitor screening log was observed on a table at the entrance of the facility. There was no designated staff observed to screen visitors upon entrance. During a concurrent review of the facility's visitor screening log dated 10/15 to 10/17/2024, the facility had 26 visitors on 10/15/2024, 26 visitors on 10/16/2024, and 23 visitors on 10/17/2024. The visitor screening log indicated the visitors who signed the log on 10/15/2024 to 10/17/2024 did not indicate if they had any signs and symptoms of COVID 19. During a concurrent interview and record review on 10/17/2024 at 1:03 PM, the Infection Preventionist (IP) stated the outbreak of COVID-19 in the facility started on 10/15/2024. The IP stated there were two residents who were positive for COVID-19 and no staff were positive for COVID-19. The IP stated the facility had a log for visitors to sign in prior to entering the facility and visitors were supposed to fill out the log before entering the facility. The IP stated the log had visitors sign their name, indicate the resident they were visiting, the room number, the visitors COVID-19 test results, and asked if the visitors had any signs and symptoms of COVID-19. The IP stated the facility did not have a designated staff to screen visitors coming into the facility. The IP reviewed the visitor screening log for 10/15 - 10/17/2024 and confirmed visitors did not indicate whether the visitors had signs and symptoms of COVID-19 on the visitor screening log. The IP stated visitors were supposed to be screened for signs and symptoms of COVID-19. The IP stated there was a potential for COVID-19 to be spread to more residents and staff if visitors were not screened prior to entering the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of an e-mail from the Department of Public Health (DPH) to the IP titled, Department of Public Health - COVID-19 Outbreak, dated 10/17/2024, indicated the following recommendations: Please complete symptom check for all visitors before entering the facility. Masking is required at all times during visitation. During a concurrent interview and record review with the Director of Nursing (DON) on 10/18/2024 at 1:06 PM, the facility's visitor screening log was reviewed. The DON stated and confirmed visitors were not being screened for signs and symptoms of COVID-19. The DON stated the facility currently had an outbreak of COVID-19 and the residents at the facility were long term care residents and did not really leave the facility, so there was a possibility the residents may have gotten COVID-19 from the visitors. The DON stated there were no facility staff who were positive of COVID-19 and there was a potential for COVID-19 to spread amongst residents if visitors were not screened prior to entering the facility. A review of the facility's policy and procedures titled, Infection Prevention and Control Program, Reviewed 3/27/2024 indicated resident/Family/Visitor Education and Screening: Residents, family members, and visitors were provided information relative to the rationale for the isolation, behaviors required of them in observing there precautions, and conditions for which to notify the nursing staff. More active screening, such as the completion of screening tools or questionnaires that elicits information related to recent exposures or current symptoms may be used as per facility policy.

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	056293	A. Building B. Wing	10/18/2024

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Alcott Rehabilitation Hospital	3551 West Olympic Blvd. Los Angeles, CA 90019

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836 Based on observation, interview, and record review the facility failed to meet the requirement for no more than four residents per room for one of 63 resident residential rooms (room [ROOM NUMBER]). This deficient practice had the potential to result in inadequate space to provide necessary and safe nursing care and privacy for the residents in room [ROOM NUMBER]. Findings: During a concurrent observation and interview 10/17/2024 at 9:56 AM of room [ROOM NUMBER], a total of five residents were in the room. Certified Nursing Assistant (CNA), CNA 1 stated the facility staff had no issues when providing care in the resident's rooms. CNA 1 stated if the facility staff needed to use a Hoyer lift (mechanical device that helps caregivers safely transfer patients who have limited mobility), for example, there was enough space to provide care and the Hoyer lift did not invade the space of any of the other residents. During an interview on 10/17/2024 at 10:16 AM, Registered Nurse (RN 1) stated she believed there was enough space in room [ROOM NUMBER] to provide care for the residents and did not have any complaints. RN 1 stated if a resident had any complaints about the size of the room, the facility would move them to a bigger room or a single occupancy room if it was available. RN 1 stated she was not aware of any residents who had any complaints about the size of their room. A review of the facility's policy and procedures (P&P) titled, Resident Rooms, revised on 3/27/2024, indicated resident bedrooms must be designed and equipped for adequate nursing care, comfort and privacy of resident and will measure at least 80 square feet per resident in multiple resident bedrooms.

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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. 49836 Based on observation and interview the facility failed to ensure 24 out of 63 rooms (Rooms 4, 6, 8, 12, 19, 24, 26, 30, 32, 37, 39, 40, 41, 45, 48, 50, 54, 56, 58, 59 61, 52, 62, and 63) met the required 80 square feet per resident. This deficient practice had the potential to result in inadequate space necessary to provide safe nursing care and privacy for residents. Findings: During an observation on 10/17/24 at 11:07 AM, the Maintenance Supervisor (MS) measured rooms 4, 6, 8, 12, 19, 24, 26, 30, 32, 37, 39, 40, 41, 45, 48, 50, 54, 56, 58, 59 61, 52, 62, and 63. The rooms measured as follows: Room No: Room Sq. Resident Capacity: Square Ft. 4 216 sq ft 3 beds 19.16x11.25 6 223 sq ft 3 beds 20.5x11 8 377 sq ft 5 beds 22.16x17 12 223 sq ft 3 beds 19.25x11.58 19 142 sq ft 2 beds 11.41x12.41 24 218 sq ft 3 beds 19.25x11.33 30 218 sq ft 3 beds 19.25x11.33 32 216 sq ft 3 beds 19.16x11.25 37 228 sq ft 3 beds 20x11.41 39 222 sq ft 3 beds 19.5x11.41 40 222 sq ft 3 beds 19.5x11.41 41 222 sq ft 3 beds 19.5x11.41 45 222 sq ft 3 beds 19.5x11.41 46 222 sq ft 3 beds 19.5x11.41 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	48 222 sq ft 3 beds 19.5x11.41 50 218 sq ft 3 beds 19.41x11.25 54 218 sq ft 3 beds 19.41x11.25 56 222 sq ft 3 beds 19.5x11.41 58 221 sq ft 3 beds 19.33x11.41 59 222 sq ft 3 beds 19.5x11.41 61 221 sq ft 3 beds 19.33x11.41 62 225 sq ft 3 beds 19.58x11.5 63 222 sq ft 3 beds 19.5x11.41 The measurements were compared to the client accommodation analysis dated 10/17/2024 and all measurements indicated in the client accommodation analysis matched the measured taken by the MS on 10/17/24 at 11:07 AM. During an interview on 10/17/2024 at 9:56 AM, the Certified Nursing Assistant (CNA) 1 stated that facility staff had no issues when providing care in the resident's rooms. CNA 1 stated if facility staff needed to use a Hoyer lift (mechanical device that helps caregivers safely transfer patients who have limited mobility), for example, there was enough space to provide care and the Hoyer lift did not invade the space of any of the other residents. During an interview on 10/17/2024 at 10:16 AM, Registered Nurse (RN 1) stated she believed there was enough space in the resident's rooms to provide care for the residents and did not have any complaints. RN 1 stated if a resident had any complaints about the size of the room, the facility would move them to a bigger room or a single occupancy room if it was available. RN 1 stated she was not aware of any residents who had any complaints about the size of their room. A review of the facility's policy and procedures (P&P) titled, Resident Rooms, revised on 3/27/2024, indicated resident bedrooms must be designed and equipped for adequate nursing care, comfort and privacy of resident and will measure at least 80 square feet per resident in multiple resident bedrooms.