STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview and record review, the facility failed to remove the intravenous (IV-a thin, flexible tube inserted into a vein, usually in the back of the hand, the lower part of the arm, or the foot to draw blood or give fluids) catheter for one of three sampled residents (Resident 2) after Resident 2 completed the IV antibiotic (medication used to treat infection) on 5/21/2026.This deficient practice had the potential to cause infection and discomfort to Resident 2.Findings:During a review of Resident 2?s admission Record, the admission Record indicated the facility admitted Resident 2 on 2/14/2025, with diagnoses that included metabolic encephalopathy (a change in how your brain works due to an underlying condition. It can cause confusion, memory loss and loss of consciousness), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and essential hypertension (HTN- high blood pressure).During a review of Resident 2's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 2/14/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.During a review of Resident 2's Physician Order, dated 5/18/2026, the Physician Order indicated ceftriaxone sodium (medication used to treat infection) solution one gram IV in the morning for back abscess (a painful, swollen lump filled with pus [collection of germs, dead tissue, and white blood cells that rushed to the area to battle the germs]) for three days.During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 6/5/2026, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 2 was dependent on staff for all activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 2's IV Administration Record (IVAR- flowsheet that indicates IV medications given to a resident), dated 5/2026, the MAR indicated Registered Nurse 1 (RN 1) administered the first and second dose of ceftriaxone on 5/19/2026, and 5/20/2026. The MAR indicated RN 2 administered the third and last dose on 5/21/2026.During an observation on 6/12/2026, at 8:40 a.m., at Resident 2's bedside, gauze 24 (a very thin, small-diameter needle) IV noted and dated 5/19/2026.During a concurrent observation and interview on 6/12/2026, at 9 a.m., with Licensed Vocational Nurse 1 (LVN1) at Resident 2's bedside, Resident 2's IV site dated 5/19/2026. LVN 1 stated IV should be changed every three days.During an interview on 6/12/2026, at 9:11 a.m., with the Assistant Director of Nursing (ADON), the ADON stated IV should be changed every 72 hours to prevent infection in the blood. The ADON stated the last time IV was used was on 5/21/2026. The ADON stated RN should be changing the IV every 72 hours. The ADON stated there was no physician order to continue the IV.During an interview on 6/16/2026, at 8:17 a.m., with the Director of Nursing (DON), the DON stated the night RN should have removed the IV after the last dose of antibiotic on 5/21/2026. The DON stated infection could result if IV was left for too long.During a review of facility's policy and procedure (P&P) titled, Infusion Guidelines and Procedures, undated, and last reviewed on 5/23/2025, the P&P indicated, 8. Peripheral Infusion devices shall be removed routinely every 72 hours. Residents with limited peripheral venous access may be maintained at longer intervals with a physician's order.25. Label the dressing with the date and time the site was inserted, the gauge and length of the catheter inserted, and the initials of the inserting nurse.

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