STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555069	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Convalescent Hospital	2190 W Adams Blvd Los Angeles, CA 90018

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on interview and record review, the facility failed to promptly notify the physician of a change of condition (COC) for one of three residents (Resident 1) who was observed with slurred speech (damage to the brain or nerves that cause the muscles used for speaking to become weak and uncoordinated and can be a symptom of a cerebral infarction ([stroke] loss of blood flow to part of the brain). This deficient practice resulted in delayed medical care and had the potential to result in the physical decline and death for Resident 1. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 ' s diagnoses included hemiplegia (one-sided weakness) and hemiparesis (one-sided paralysis) following cerebral infarction, presence of cerebrospinal fluid ([CSF] clear, watery fluid that flows in and around the brain and spinal cord) drainage device ([shunt] drain excess CSF from the brain to another part of the body), and intracerebral hemorrhage (hematoma formed within the brain). During a review of Resident 1 ' s Care Plan titled, Self-care deficits related to: history of CVA with left hemiparesis dated 1/25/2024, the Care Plan goal indicated Resident 1 would minimize the risk of decline daily. The care plan interventions indicated nurses would notify the physician for any change in condition and as indicated. During a review of Resident 1 ' s History and Physical (H&P) dated 10/1/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 10/8/2024, the MDS indicated Resident 1 was able to understand be understood by others. The MDS indicated Resident 1 was dependent (staff does all the effort) for Activities of Daily Living (ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side). (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s COC dated 10/15/2024 at 1:41 a.m., the COC indicated Resident 1 was noted with an altered level of consciousness (ALOC), weakness on the R (right) arm, hand grip on the R arm weakness and was unable to verbally respond on 10/15/2024 at 12:00 a.m. The COC indicated on 10/15/2024 at 11:30 p.m., a Licensed Vocational Nurse ([LVN] unnamed) notified Registered Nurse (RN) 1, that Resident 1 had an episode (of ALOC) during the day shift and nursing staff called 911 however 911 was cancelled. The COC indicated nursing staff observed Resident 1 to be nonverbal when received during the shift and at 12:00 a.m. Resident 1 was less responsive with fixed gaze, unable to scan his environment, unable to raise his R arm and weak hand grip. The COC indicated Resident 1 ' s had a baseline of having a strong hand grip to R hand and was suspected to have a possible stroke. The COC also indicated at 1:00 a. m., 911 was called. During a review of Resident 1 ' s General Acute Care Hospital (GACH) Discharge Summary Report dated 10/17/2024, the Report indicated Resident 1 was brought to the GACH on 10/15/2024 at 1:49 a.m. with ALOC and was last seen normal and verbal on 10/14/2024 at 9:00 a.m. The Report indicated Resident 1 was found to have an acute subdural hematoma (bleeding in the brain). During an interview on 10/25/2024 at 1:00 p.m., with the Certified Nursing Assistance (CNA) 2, CNA 2 stated Resident 1 was confused but he was able to follow commands. CNA 1 stated Resident 1 usually was slow to respond but his speech was clear and verbally able to communicate his needs. CNA 2 stated on 10/14/2024 (during the 3:00 p.m.- 11:00 p.m. shift), Resident 1 was awake but did not speak the whole shift and was not active which was not usual for the resident. During an interview on 10/25/2024 at 1:50 p.m., with LVN 2, the LVN 2 stated on 10/14/2024 he received report from the morning nurse that Resident 1 was lethargic and called 911 however woke up and 911 was cancelled. LVN 2 stated he observed Resident awake with impaired speech and the resident was gazing to the left side on 10/14/2024 at 3:30 p.m. LVN 2 stated around at 7:00 p.m. on the same day, Resident 1 ' s speech remained slurred, and he continued to have steady gaze. LVN 2 stated he did not call the physician that day because the resident still responded to him and did not know he needed to report the resident ' s condition to the physician. LVN 2 stated resident exhibited signs of a stroke and should have called and notified the physician. During an interview on 10/25/2024 at 5:25 p.m., with the Director of Nursing (DON), the DON stated when Residents had a COC, nurses needed to assess the resident and notify the doctor as well as the family. The DON stated, if LVN 2 noticed something wrong with Resident 1, LVN 2 should have notified the Registered Nurse (RN 2) so the physician could be contacted for possible transfer to the hospital or treatment to be done. The DON stated if Resident 1 started having slurred speech it was considered a COC because that was not the resident ' s baseline. The DON stated, having slurred speech could be a sign of a stroke. The DON also stated, if nurses did not notify the physician at the COC, it placed Resident 1 at risk of worsening condition. During a review of facility ' s undated Policy and Procedures (P&P) titled, Change of Condition, the P&P indicated a change of condition is a sudden or marked difference in resident ' s level of consciousness and level of functioning. The P&P indicated, upon a change of condition for any reason, nursing staff members are to take the following actions: Physician shall be called promptly

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 2 had the specific competencies and skill sets necessary to identify and intervene for a one of three sampled residents who had a change of condition (COC). This deficient practice resulted in delayed care and had the potential to cause harm for Resident 1. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 ' s diagnoses included hemiplegia (one-sided weakness) and hemiparesis (one-sided paralysis) following cerebral infarction ([stroke] loss of blood flow to a part of the brain), presence of cerebrospinal fluid ([CSF] clear, watery fluid that flows in and around the brain and spinal cord) drainage device ([shunt] drain excess CSF from the brain to another part of the body), and intracerebral hemorrhage (hematoma formed within the brain). During a review of Resident 1 ' s History and Physical (H&P) dated 10/1/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 10/8/2024, the MDS indicated Resident 1 was able to understand be understood by others. The MDS indicated Resident 1 was dependent (staff does all the effort) for Activities of Daily Living (ADLs) such as dressing, toilet use, personal hygiene, transfer (moving between surfaces to and from bed, chair, and wheelchair) and bed mobility (how resident moves from lying to turning side to side). During a review of Resident 1 ' s COC dated 10/15/2024 at 1:41 a.m., the COC indicated Resident 1 was noted with an altered level of consciousness (ALOC), weakness on the R (right) arm, hand grip on the R arm weakness and was unable to verbally respond on 10/15/2024 at 12:00 a.m. The COC indicated on 10/15/2024 at 11:30 p.m., a Licensed Vocational Nurse ([LVN] unnamed) notified Registered Nurse (RN) 1, that Resident 1 had an episode (of ALOC) during the day shift and nursing staff called 911 however 911 was cancelled. The COC indicated nursing staff observed Resident 1 to be nonverbal when received during the shift and at 12:00 a.m. Resident 1 was less responsive with fixed gaze, unable to scan his environment, unable to raise his R arm and weak hand grip. The COC indicated Resident 1 ' s had a baseline of having a strong hand grip to R hand and was suspected to have a possible stroke. The COC also indicated at 1:00 a. m., 911 was called. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/25/2024 at 1:50 p.m., with LVN 2, the LVN 2 stated on 10/14/2024 he received report from the morning nurse that Resident 1 was lethargic and called 911 however woke up and 911 was cancelled. LVN 2 stated he observed Resident awake with impaired speech and the resident was gazing to the left side on 10/14/2024 at 3:30 p.m. LVN 2 stated around at 7:00 p.m. on the same day, Resident 1 ' s speech remained slurred, and he continued to have steady gaze. LVN 2 stated he did not call the physician that day because the resident still responded to him and did not know he needed to report the resident ' s condition to the physician. During an interview on 10/25/2024 at 5:00 p.m., with Registered Nurses (RN) 2, RN 2 stated Resident 1 had periods of confusion, but he could verbally communicate his needs without difficulty. RN 2 stated, when he began the shift on 10/14/2024 at 3:00 p.m., Resident 1, was quiet. RN 2 stated LVN 2 never informed him of Resident 1 having slurred speech. RN 2 stated licensed nurses should be capable to identify a COC. RN 2 stated It was a common nursing knowledge that slurred speech could be a sign of a stroke. During an interview on 10/25/2024 at 5:25 p.m., with the Director of Nursing (DON), the DON stated when Residents had a COC, nurses needed to assess the resident and notify the doctor as well as the family. The DON stated, if LVN 2 noticed something wrong with Resident 1, LVN 2 should have notified the Registered Nurse (RN 2) so the physician could be contacted for possible transfer to the hospital or treatment to be done. The DON stated if Resident 1 started having slurred speech it was considered a COC because that was not the resident ' s baseline. The DON stated, having slurred speech could be a sign of a stroke. The DON also stated, if nurses did not notify the physician at the COC, it placed Resident 1 at risk of worsening condition. During a review of facility ' s Policy and Procedures (P&P) titled, Licensed Vocational Nurses-Job Description dated 3/7/2024, the P&P indicated nursing care included monitoring of condition changes, properly documents, follows-up as necessary, reports labs and x-rays results, condition changes, and incidents, in a timely manner to physicians, gathers data and interventions related to change of patient condition: Acute changes in condition: LOC changes, confusion.