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	10/29/2024

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on interview and record review, the facility failed to report an allegation of abuse, for one of 8 sampled residents, (Resident 1), to the California Department of Public Health (CDPH) within two (2) hours, as indicated in the facility ' s policy and procedure (P&P), titled Abuse and Mistreatment of Residents. This failure resulted in the delayed investigation by CDPH and placed Resident 1 at risk for further abuse. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparalysis (a condition that causes weakness or paralysis on one side of the body), dysphagia (difficulty swallowing) and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 1 ' s Minimum Data Set ([MDS] a federally mandated resident assessment tool), the MDS indicated Resident 1 ' s cognitive skills (thinking skills) was severely impaired (a physical or mental condition that significantly limits a person's ability to function in their daily life). The MDS indicated Resident 1 was dependent on staff with toileting hygiene, showering, and upper/lower body dressing. During a review of Resident 1 ' s progress notes dated 8/2/2024, the progress notes did not indicate documentation regarding Family Member 2 ' s (FM2) report of Resident 1 ' s left wrist skin discoloration. During a review of Resident 1 ' s Change of Condition (COC) assessment for 8/2/2024, there was no COC created for 8/2/2024 regarding Resident 1 ' s left wrist skin discoloration. During a review of Resident 1 ' s Change of Condition (COC) assessment, dated 8/3/2024, the change of condition assessment indicated Resident 1 had yellowish-green skin discoloration on his left wrist. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s fax transmission report dated 8/3/2024 at 1:57 p.m., the report indicated the facility faxed the Report of Suspected Dependent Adult/Elder Abuse ([SOC 341] documentation of information given by the reporting party on the suspected incident of abuse or neglect of an elder or dependent adult), dated 8/3/2024 (no time indicated) indicating an allegation of abuse by FM 1, to the CDPH. During an interview on 8/7/2024 at 8:37 a.m. with FM 2, FM 2 stated FM 1 saw Resident 1 on 7/30/2024 (time not specified) and noticed Resident 1 had yellow bruise (skin discoloration) on the left wrist. FM2 stated, on 8/2/2024 when she (FM2) visited Resident 1, Resident 1 ' s left wrist had purplish and yellowish discoloration, like someone held the wrist tight. During an interview on 8/7/2024 at 11:25 a.m., with LVN 4, LVN 4 stated she heard FM reported a skin discoloration on 8/2/2024 on the left wrist. LVN 4 stated, on 8/3/2024, Resident 1 ' s left thumb to the wrist, had a reddish purplish skin discoloration. During an interview, on 10/24/24, at 3:08 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 ' s wife called on 8/2/2024 (time unspecified) and reported that Resident 1 had left wrist skin discoloration. LVN 1 stated, if a resident was observed with bruise (skin discoloration), the abuse coordinator should be notified within 2 hours. LVN 1 stated the resident will be assessed for pain, notify the physician, and do a COC as soon as bruises are observed. LVN 1 stated bruise is an unusual occurrence and should be reported to the CDPH. LVN 1 stated, if the bruise was not reported to CDPH, it placed the resident for further abuse. During an interview, on 10/29/24 at 12:00 pm., with the Director of Nursing (DON), the DON stated licensed staff informed her on 8/3/2024 (time unspecified) that Resident 1 ' s wife called the facility on 8/2/2024 (time unspecified) reporting Resident 1 had a left wrist skin discoloration. The DON stated Resident 1 ' s left wrist skin discoloration was reported to the Administrator on 8/3/2024. The DON stated the risk of not reporting abuse allegations in a timely manner could result in a potential for further abuse. During a review of the facility ' s undated P&P, titled Abuse and Mistreatment of Residents, the P&P indicated the facility should report allegations of abuse to the CDPH within 2 hours.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on interview and record review, the facility failed to ensure one of 8 sampled residents (Resident 1), received toileting hygiene in a timely manner. This failure had the potential to cause resident discomfort and skin breakdown. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparalysis (a condition that causes weakness or paralysis on one side of the body), dysphagia (difficulty swallowing) and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 1 ' s Minimum Data Set ([MDS] a federally mandated resident assessment tool), the MDS indicated Resident 1 ' s cognitive skills (thinking skills) was severely impaired (a physical or mental condition that significantly limits a person's ability to function in their daily life). The MDS indicated Resident 1 was dependent on staff with toileting hygiene, showering, and upper/lower body dressing. During an interview on 10/29/2024 at 11:36 a.m., with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated Resident 1 was combative when toileting hygiene was provided on 8/2/2024at 4:00 p.m. CNA 1 stated, she stopped and attempted to change Resident 1 and Resident 1 continued to be combative. CNA 1 stated Resident 1 was not changed for at least 30 minutes. CNA 1 stated Resident 1 ' s family member (FM1) came at around 4:30 p.m. and assisted in changing Resident 1. CNA 1 stated the risk of leaving a resident wet could result in skin breakdown. During an interview on 10/29/2024 at 12:00 p.m., with the Director of Nursing (DON), the DON stated there was no documentation indicating Resident 1refused to be changed on 8/2/2024. The DON stated CNA1 should not wait for the wife to assist in changing Resident 1. The DON stated Resident 1 should not have to wait for 30 minutes to be changed until the wife came. The DON stated the risk of not changing Resident 1 timely could result in skin breakdown. During a review of the facility ' s policy and procedures (P&P), titled Perineal Care, dated 3/2023, the purpose of the P&P indicated was to provide cleanliness and comfort, to prevent infections and skin irritation and to observe the resident ' s skin condition. The P&P indicated, if a resident refuses the perineal care, the charge nurse should be notified.

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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** 46832 Based on observation, interview and record review, the facility failed to implement infection control practices, by failing to ensure: 1. Oxygen nasal cannulas (a small plastic tube, which fits into the person ' s nostrils for providing supplemental oxygen) were properly stored when not used, for two of eight sampled residents, (Resident 1 and Resident 2). 2. The gastrostomy tube ([GT] a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) site was maintained clean, for two of 8 sampled residents, (Resident 7 and Resident 8). This deficiency had the potential to cause infections to the affected residents. Findings: a. During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparalysis (a condition that causes weakness or paralysis on one side of the body), dysphagia (difficulty swallowing) and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 1 ' s Minimum Data Set ([MDS] a federally mandated resident assessment tool), the MDS indicated Resident 1 ' s cognitive skills was severely impaired. The MDS also indicated Resident 1 was dependent on staff with toileting hygiene, showering, and upper/lower body dressing. b. During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE]. with diagnoses included epilepsy (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), encephalopathy (any brain disorder or damage that affects the brain's structure or function), hydrocephalus (a condition in which fluid accumulates in the brain, enlarging the head and sometimes causing brain damage) and dysphagia (difficulty swallowing). During a review of Resident 2 ' s MDS, the MDS indicated Resident 2 ' s cognitive skills was severely impaired. The MDS also indicated Resident 2 was dependent on staff with toileting hygiene, showering, and upper/lower body dressing. During an observation on 10/25/2024 at 9:32 am., in Resident 1 and Resident 2 ' s room (roommate), Resident 1 and Resident 2 ' s oxygen concentrators (a medical device that provides a continuous supply of oxygen-enriched air to help residents breathe easier) were turned on. Resident 1 and Resident 2 were observed lying in bed without nasal annual oxygen tubing connected to the residents ' nostrils. Residents 1 and 2 ' s nasal cannulas were observed hanging, uncovered on the GT feeding poles (a pole to hang tube feeding formula). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/25/2024 at 10:14 a.m., in Resident 1 and Resident 2 ' s room, the Certified Nurse Assistant 1 (CNA 1) who just finished providing hygiene care to Resident 1 was observed. CNA 1 placed Resident 1 ' s blankets on him and took Resident 1 ' s nasal cannula from the GT pole and placed the nasal cannula on Resident 1 ' s nostrils to administer the oxygen. During an interview on 10/25/2024 at 1:20 p.m. with CNA 1, CNA 1 stated the oxygen tubing should have been placed in a plastic bag with a resident ' s name and room number when not in use. CNA 1 stated. the nasal cannula should not be hanged on the GT pole, uncovered due to the risk of contamination. During an interview on 10/25/2024, at 3:08 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Residents 1 and 2 ' s nasal cannula oxygen tubings should not be hanged on the GT pole. LVN stated, the oxygen tubings should have been placed in a bag and should not be touching any surface. LVN 1 stated if tubing was in contact with a surface, the tubings were contaminated, and should not be reapplied to the residents. LVN 1 stated the risk of applying contaminated oxygen tubing to a resident, could result in infection and possible respiratory illnesses. During an interview on 10/29/2024, at 12:00 p.m., with the Director of Nursing (DON), the DON stated if oxygen tubings were not used, it should have been placed in a bag near the concentrator with the resident ' s name and room number. The DON stated the risk of applying dirty oxygen tubing on a resident could result in an infection due to the tubing being contaminated and dirty. During a review of the undated facility ' s policy and procedures (P&P), titled Oxygen Administration, the P&P indicated, when oxygen tubings are not in use, they should be stored in a clean bag, for example, a zip lock bag . c). During a review of Resident 7 ' s Admission Record, the Admission Record indicated Resident 7 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), epilepsy, type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and parkinson ' s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 7 ' s MDS, the MDS indicated Resident 7 ' s cognitive skills was severely impaired. The MDS indicated Resident 7 was dependent on staff with toileting hygiene, showering, and upper/lower body dressing. During an observation on 10/24/2024 at 10:00 a.m., in Resident 7 ' s room, Resident 7 ' s GT site was observed with no dressing and had dried serous sanguineous (a fluid that contains both blood and serum, the liquid part of blood) spots and slight redness around the GT site. d). During a review of Resident 8 ' s Admission Record, the Admission Record indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including anoxic brain damage (occurs when the brain is deprived of oxygen), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and type 2 DM. (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 8 ' s MDS, the MDS indicated Resident 8 ' s cognitive skills was severely impaired. The MDS also indicated Resident 8 was dependent on staff with toileting hygiene, showering, and upper/lower body dressing. During an observation on 10/24/2024 at 10:30 a.m., in Resident 8 ' s room, Resident 8 ' s GT dressing was observed with dried brownish spots on the top, around the tubing and on the bottom of dressing. During an interview and concurrent record review on 10/24/2024, at 3:08 p.m., with Licensed vocational Nurse 1 (LVN 1), Residents 7 and 8 ' s GT site photographs were reviewed. LVN 1 stated Resident 7 and Resident 8 ' s GT sites were dirty and should have been cleaned. LVN 1 stated the risk of not having the GT site and dressings cleaned could result in GT site infections and skin breakdown. LVN 1 stated the treatment nurse was responsible for changing and cleaning the GT sites of the residents. During an interview on 10/29/2024, at 12:00 p.m., with the Director of Nursing (DON), the DON stated GT dressings should have been changed once a day or as needed when dirty. The DON stated licensed staff could also change the GT site dressings when they make rounds and medication pass. The DON stated, the risk of not changing or cleaning the GT site could cause GT site infection. During a review of the facility ' s P&P titled, Gastrostomy/Jejunostomy Tube Site Care, dated 3/2023, the P&P indicated the purpose was to promote cleanliness and to protect the gastrostomy site from irritation, breakdown, and infection. The P&P indicated to clean the area immediately surrounding the tube and to clean under the bolster (button). The P&P indicated to assess the stoma site for signs of redness, pain, or soreness, swelling, or drainage and to report the signs of infection immediately the resident's physician.