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	09/18/2025

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. (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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report one of three resident's (Resident 7) right thumb fracture (broken bone) to the California Department of Public Health (CDPH) within two hours, as indicated in the Federal regulations. This failure resulted in the delayed investigation by CDPH, placing the affected resident and other residents at risk for potential abuse and injuries.Findings:During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 7 had a history tracheostomy (a surgical opening in the neck, fitted with a device to allow air and oxygen to be administered directly to the airway), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), ventilator (a medical device to help support or replace breathing) dependence, and dementia (a progressive state of decline in mental abilities).During a review of Resident 7's Situation, Background, Assessment, and Recommendations Form (SBAR, situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 6/24/2025, the SBAR indicated Registered Nurse (RN 7) identified redness and swelling on Resident 7's right thumb. The SBAR indicated Resident 7's Medical Doctor (MD 7) was notified and ordered an x-ray (a diagnostic medical imaging technique that uses a small amount of radiation to create detailed images of the inside of the body).During a review of Resident 7's Radiology Report, dated 6/24/2025, the Radiology Report indicated Resident 7 had an acute (short-term) nondisplaced fracture (a break in a bone where the fractured pieces remain in their original, proper alignment) inter-articular (in or near the joint) of the first proximal phalanx (the bone closest to the palm at the beginning of the thumb).During a review of Resident 7's Interdisciplinary Team (IDT) Note, dated 6/25/2025, the IDT Note indicated Resident 7 had a diagnosis of muscle wasting and atrophy.During a review of Resident 7's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 7/3/25, the MDS indicated Resident 7 had no speech, was rarely or never able to understand others, and was rarely or never able to express ideas and wants. The MDS indicated Resident 7 was dependent (helper does all of the effort, the assistance of 2 or more helpers is required to complete the activity) to roll left and right and maintain personal hygiene (combing hair, shaving, washing/drying face and hands).During a review of Resident 7's History and Physical (H&P), dated 9/1/2025, the H&P indicated Resident 7 did not have the capacity to understand and make decisions.During a concurrent interview and record review with the Administrator on 9/9/2025 at 11:30 a.m., the Administrator stated she was the abuse coordinator and did not report Resident 7's right thumb fracture because Resident 7 did not require hospitalization or surgical intervention. The Administrator stated she did not send the results of the abuse investigation to the State Survey Agency.During a concurrent interview and record review on 9/9/2025 at 1:45 p.m. with RN 7, Resident 7's SBAR dated 6/24/2025, and the facility's undated P&P titled Abuse & Mistreatment of Residents were reviewed. RN 7 stated she wrote Resident 7's SBAR and Radiology Report indicating a right thumb bone fracture while residing in the facility. RN 7 stated that the P&P indicated an unusual occurrence like Resident 7's right thumb bone fracture could be a result of alleged abuse and must be reported to the California Department of Public Health (CDPH) immediately by the facility's nursing staff because there was a possibility of abuse. RN 7 stated the right thumb fracture could have occurred as a result of abuse because it was not witnessed by staff, not explained by the resident, and was a severe injury. During an interview on 9/22/2025 at 2:57 p.m. with MD 7, MD 7 stated Resident 7's fracture could be a result of accidents, mishandling, and abuse. MD 7 stated staff should consider mishandling and abuse any time a resident develops a bone fracture in the facility. During a review of the facility's undated P&P titled Abuse & Mistreatment of Residents, the P&P indicated the facility shall ensure all alleged violations of abuse were reported to the state agency. The P&P indicated any mandated reporter (an individual who holds a professional position that is required by law to report suspected or known instances of abuse to state agencies and local law enforcement) should report suspected instances of abuse to the CDPH by telephone immediately, as soon as practically possible, and within two hours of the knowledge of the incident. The P&P indicated a written report sent to the CDPH within two working days.

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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 - Some	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. (continued on next page)

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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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:1). Implement occupational therapy (OT- a form of therapy for those recuperating from physical or mental illness that encourages rehabilitation through the performance of activities required in daily life) recommendations of hand splints and obtain physician orders for 2 of 5 sampled residents (Resident 2 and Resident 3) to prevent contractures (a medical condition where muscles, tendons, or other tissues become permanently shortened or tightened, limiting movement and causing deformity) of hands and fingers to improve joint mobility. 2). Implement the facility's policy and procedure (P&P) titled Screening, when the Physical Therapist (PT 1) did not reassess one of five residents (Resident 8), after readmission to the facility and after Resident 8 could no longer tolerate his physician-ordered services.These failures had the potential to increase the risk of joint disability and had the potential to cause or worsen the pain.Findings: 1). During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including urinary tract infection (UTI-an infection of the urinary tract, which includes the kidneys, ureters, bladder, and urethra), dysphagia following cerebral infarction (difficulty swallowing that occurs after a stroke), and type 2 diabetes mellitus (abnormal blood sugar levels). During a review of Resident 2's Occupational Therapy Evaluation and Plan of Treatment dated 5/17/2025, the Occupational Therapy Evaluation indicated recommendations for Resident 2 to wear a hand roll on right and on left hand for 2 hours on and 2 hours off in order to reduce pain caused by muscle tightening, maintain joint integrity and maintain joint mobility. During a review of Resident 2's Joint Mobility Screen Occupational Therapy (OT), dated 5/19/2025, the Joint Mobility Screening indicated Resident 2's right and left hand/fingers had severe loss (greater than 50%) of passive range of motion. During a review of Resident 2's Minimum Data Set (MDS-an assessment and care planning tool) dated 5/22/2025, the MDS indicated Resident 2 had no speech, was rarely/never understood and rarely/never understands. The MDS indicated Resident 2 was dependent on staff for toileting hygiene, personal hygiene, and shower/bathe of self.During a review of Resident 2's Interdisciplinary Team (IDT, a group of diverse professionals with different areas of expertise who collaborate to address complex problems and achieve shared goals) Mad words form, dated 8/21/2025, the IDT form indicated Resident 2 was non-ambulatory and required total assistance with activities of daily living (ADL) and restorative nursing assistance (RNA) program (a structured nursing intervention, often implemented after formal rehabilitation, that uses specially trained staff and individualized care plans to help residents in long-term care facilities achieve and maintain their highest possible level of physical, mental, and psychosocial functioning and independence). The IDT form indicated that staff would monitor Resident 2 for any significant functional changes and refer to the medical doctor if any is noted. During a concurrent observation and interview on 9/8/2025 at 11:15 a.m., with the Assistant Director of Nursing (ADON) at Resident 2's bedside, Resident 2 was observed in bed with her hands contracted in a fist position. The ADON stated Resident 2 did not have orders for hand splints (a device that help maintain the hand and fingers in a specific, functional position to prevent or treat contractures). During a concurrent observation and interview on 9/8/2025 at 12:40 p.m. with the Lead Occupational Therapist (OT 1), at Resident 2's bedside, Resident 2's contracted both hands was observed balled fist (hand becoming tightly clenched in a fist that the person cannot voluntarily open). OT 1 stated the OT was providing passive range of motion exercises (moving a joint through its full range of motion without the patient's muscle contraction) to her hands and to both upper and lower extremities, but Resident 2 was not assessed for the use of hand splints and was not provided hand splints. OT 1 stated Resident 2's hand contractures could get worse without the hand splints. During a review of Resident 2's Order Summary Report dated 9/2/2025 to 9/30/2025, the Order Summary Report indicated a physician's order dated 9/9/2025 (after the surveyor's visit) to apply hand rolls (a padded device used to prevent or treat the tightening [contracture] of muscles, tendons, ligaments, or skin in the hand), or contracture prevention and management. During a review of Resident 2's untitled care plan, with a target date of 9/14/2025, the care plan indicated Resident 2 had limitations in range of motion related to contractures. The care plan goal indicated complications will be minimized related to decrease mobility or contractures through appropriate interventions through the next assessment. The care plan nursing interventions included calling the medical doctor for any change of condition, RNA to apply and remove bilateral hand rolls with skin checks to maintain skin every day 5 times a week for up to 5 hours as tolerated

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for 1of 5 sample residents, Resident 2, the facility failed to:1). Ensure the intravenous (IV- administration of the medications via a catheter inserted into a vein) medication was administered completely, consistent with professional standards of practice and physician's order.2). Ensure the IV site was securely placed and did not dislodge (pulled out).This failure had the potential for the infection will not be resolved due to an incomplete dose of antibiotic medication administered.This failure had the potential to cause infection on the IV site and the potential for a missed antibiotic dose.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including urinary tract infection (UTI-an infection of the urinary tract, which includes the kidneys, ureters, bladder, and urethra), dysphagia following cerebral infarction (difficulty swallowing that occurs after a stroke), and type 2 diabetes mellitus (abnormal blood sugar levels). During a review of Resident 2's Minimum Data Set (MDS-an assessment and care planning tool) dated 5/22/2025, the MDS indicated Resident 2 had no speech, was rarely/never understood and rarely/never understands. The MDS indicated Resident 2 was dependent on staff for toileting hygiene, personal hygiene, and shower/bathe of self. During a review of Resident 2's physician order dated 9/2/2025, the physician's order indicated to give Ertapenem Sodium (an antibiotic medication)1 gram IV every 24 hours for UTI until 9/10/2025. During a review of Resident 2's untitled care plan, dated 9/2/2025, the care plan indicated Resident 2 required IV therapy of Ertapenem 1 gram every 24 hours for UTI. The care plan goal indicated Resident 2's IV access will be maintained and be free of complications for successful completion of therapy until the next assessment. The care plan goals indicated the Registered Nurse (RN) to infuse the fluids and/or medications as ordered, observe the IV site frequently for signs and symptoms of complications such as redness, swelling, pain, drainage and leakage. During a concurrent observation and interview on 9/8/2025 at 11:15 a.m. with the Assistant Director of Nursing (ADON), at Resident 2's bedside, the IV antibiotic medication, Ertapenem 1 gram bag of 100 cubic centimeters (cc- a unit of measurement) was not infusing. The IV Ertapenem antibiotic bag indicated it was hung on 9/8/2025 at 5:30 a.m. and had 40 cc's left to infuse. The ADON stated the medication (IV Ertapenem antibiotic) should have been completely infused by 6:30 a.m. The ADON stated failure to monitor the IV Ertapenem was completely infused and ensure the complete dose was administered will not treat the infection. During a second concurrent observation and interview on 9/9/2025 at 11:05 a.m., with the RN 1, Resident 2's saline lock (a thin, flexible tube placed into a vein) needle tip was observed dislodged out of Resident 2's vein and was lying on the skin of the right back side of hand. RN 1 stated Resident 2 received the IV antibiotic (Ertapenem) last night and there was no report of any problem. RN 1 stated a patent (open and unobstructed) saline lock should be in the vein to administer IV medications.During a review of the facility's policy and procedure (P&P) titled, Continuous Infusion of Medications and Solutions, dated 3/2023, the P&P indicated the RN and IV Certified Licensed Vocational Nurse must perform IV infusions according to state law and facility policy. The P&P indicated the nurse should monitor the venous access site frequently for signs and symptoms of complications, and report if appropriate.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of 5 sampled residents (Resident 2) was administered the correct amount of oxygen (a gas considered as medication essential for life to supplement the body's oxygen supply in conditions), ordered by the physician.This failure had the potential to cause oxygen toxicity (lung damage from breathing in excessive supplemental oxygen [also called oxygen poisoning] causing the resident to cough and trouble breathing and in severe cases, can cause death) to the affected resident.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including urinary tract infection (UTI-an infection of the urinary tract, which includes the kidneys, ureters, bladder, and urethra), dysphagia following cerebral infarction (difficulty swallowing that occurs after a stroke), and type 2 diabetes mellitus (abnormal blood sugar levels). During a review of Resident 2's untitled care plan, dated 2/28/2025, the care plan indicated Resident 2 was receiving oxygen (O2) therapy due to chronic obstructive pulmonary disease (COPD- a group of lung diseases that cause long-term breathing problems) and Respiratory Failure. The care plan goal indicated Resident 2 will be free from adverse effects related to the use of oxygen daily until the next assessment. The care plan interventions indicated to provide oxygen as ordered, monitor O2 saturation (amount of oxygen level in the resident's system [normal range is 90-100%) and check the rate of oxygen flow every shift. During a review of Resident 2's Minimum Data Set (MDS-an assessment and care planning tool) dated 5/22/2025, the MDS indicated Resident 2 had no speech, was rarely/never understood and rarely/never understands. The MDS indicated Resident 2 was dependent on staff for toileting hygiene, personal hygiene, and shower/bathe of self. During a review of Resident 2's Order Summary Report dated 9/2/2025 through 9/30/2025, the Order Summary Report indicated a physician order dated 9/9/2025, to administer oxygen at 2 Liters per minute ([L]/min) via nasal cannula (NC- supplemental oxygen delivered to a patient through a flexible tube with two prongs that are placed into the nostrils), as needed. The Order Summary Report indicated to titrate (adjust) oxygen up to 3 L/min if oxygen saturation was less than 92% every shift. During an observation on 9/8/2025 at 11:15 a.m. and 12:40 p.m., Resident 2 was observed lying in bed, with oxygen at 3L/min via NC. During a concurrent observation and interview on 9/9/2025 at 11:05 a.m., with Registered Nurse 1 (RN 1), Resident 2 was observed lying in bed, with O2 at 3L/NC. RN 1 stated when Resident 2 returned from the general acute care hospital, the physician order was for Resident to receive O2 at 2L/min via NC. RN 1 stated Resident 2 could be over oxygenated (excessive amount of oxygen which can lead to oxygen toxicity). During a review of the facility's policy and procedure (P&P) titled, Reconciliation of Medications on Admission, dated 7/2017, the P&P indicated the purpose of Reconciliation of Medications on admission was to ensure medication safety by accurately accounting for the resident's medications dosages upon admission or readmission to the facility to reduce medication errors and enhance resident safety by ensuring medications the resident need be continued without interruption, in the correct dose during the admission/transfer process.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three residents' (Resident 8) clinical record contained complete and accurate documentation of the services resident did not receive as indicated in its policy and procedure (P&P) titled Charting and Documentation.This failure had the potential for miscommunication and had the potential that the residents would not receive the quality of care and services the resident need. Findings:During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was admitted to the facility on [DATE]. The admission Record indicated Resident 8 had a history of traumatic brain injury (TBI-a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head), tracheostomy (a surgical opening in the neck, fitted with a device to allow air and oxygen to be administered directly to the airway), ventilator (a medical device to help support or replace breathing) dependence, and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems).During a review of Resident 8's Physician Orders, dated 5/19/2025, the Physician Orders indicated Resident 8 to receive Restorative Nursing Assistant (RNA) program (a structured nursing intervention, often implemented after formal rehabilitation, that uses specially trained staff and individualized care plans to help residents in long-term care facilities achieve and maintain their highest possible level of physical, mental, and psychosocial functioning and independence), for application of bilateral resting hand splint (an orthopedic device that supports the hand, wrist, and fingers in a neutral, open resting position to prevent or reduce abnormal shortening of soft tissues [contractures]) and bilateral knees extension splint (a device that holds the knee in a straight (extended) position to prevent or treat knee flexion contractures) for four hours or as tolerated, seven times per week.During a review of Resident 8's Documentation Survey Report, dated 5/2025, the Documentation Survey Report indicated Resident 8 received 15 minutes of bilateral resting hand and bilateral knee extension splint assistance and tolerated the splint for four hours on 5/19/2025-5/23/2025 and 5/25/2025-5/29/2025.During a review of the facility's RNA Meeting Minutes, dated 5/22/2025, the RNA Meeting Minutes indicated a recommendation to place a pillow instead of splint for bilateral knees. During a concurrent interview and record review on 9/10/2025 at 12:30 p.m. with RNA 1, Resident 8's Physician Orders dated 5/2025, Documentation Survey Report dated 5/2025 and RNA Meeting Minutes dated 5/22/2025 were reviewed. RNA 1 stated Resident 8's physician's order indicated for Resident 8 to receive bilateral hand and knee splints seven days per week. RNA 1 stated Resident 8 was unable to tolerate any of the hand or knee splints since 5/9/2025 to 5/18/2025. RNA 1 stated the Documentation Survey Report indicated Resident 8 had tolerated the bilateral resting hand and bilateral knee extension splints for four hours on 5/19/2025-5/23/2025 and 5/25/2025-5/29/2025. RNA 1 stated there were no other splint progress notes written because Resident 8 did not receive the splint services. RNA 1 stated she should have written splint progress notes to document Resident 8's inability to tolerate the bilateral hand and knee splints but did not. RNA 1 stated she notified the Director of Rehabilitative Services (DOR) about Resident 8's inability to wear bilateral extension knee splints during the RNA Meeting on 5/22/2025. RNA 1 stated the Documentation Survey Report was inaccurate because it did not reflect Resident 8's tolerance to the splint services provided.During an interview on 9/10/2025 at 1:40 p.m. with the DOR, the DOR stated Resident 8 was unable to tolerate his bilateral resting hand splints and bilateral knee extension splints since he was readmitted on [DATE]. The DOR stated the documentation should have been done accurately reflecting the services provided to Resident 8 and what treatment or services Resident 8 did not tolerate. The DOR stated the DOR was responsible for overseeing RNA services, splint care, and accuracy of documentation.During a concurrent interview and record review on 9/10/2025 at 4:15 p.m. with the Director of Nursing (DON), the facility's P&P titled Charting and Documentation was reviewed. The DON stated the P&P indicated documentation should be objective and should have accurate documentation of the treatment and services provided to the resident. During a concurrent interview and record review on 9/18/2025 at 2:00 p.m. with the DOR, the facility's Job Description - RNA, dated 8/23/2011, was reviewed. The DOR stated RNAs were responsible for documenting daily for residents in the RNA program, and document the significant changes, as per policy and procedure (P&P). During a review of the facility's P&P titled, Charting and Documentation, dated 2001, the P&P indicated treatments and services performed and a resident's tolerance to the treatment must be documented objectively, completely, and accurately in the resident's medical record