STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for one of three sampled residents (Resident 1), who had a gastrostomy tube (GT-a surgical opening fitted with a device to allow feedings to be administer directly to the stomach common for people with swallowing problems) and tracheotomy (a surgical opening in the neck fitted with a tube that helps a person breathe), by failing to ensure:1.Resident 1 was not provided with a breakfast tray and did not consume food by mouth without a physician's order. 2.Licensed nurses notified the physician and documented the incident regarding Resident 1 consuming food without a physician's order on 4/21/2026. These failures had the potential to result in Resident 1 aspirating (food or liquid entering the airway or lungs), having compromised respiratory status and death. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 1's diagnoses included respiratory failure (when the lungs cannot provide enough oxygen to the body), dysphagia (difficulty swallowing), gastrostomy and tracheostomy.During a review of Resident 1's Minimum Data Set MDS (a resident assessment tool), dated 3/10/2026, the MDS indicated the resident was rarely able to be understood and sometimes was able to understand others, responding to simple direct communication only. The MDS indicated Resident 1's cognitive (thought process) skill for daily decision making was severely impaired and functional abilities related to eating were not attempted due to medical condition or safety concerns. The MDS indicated Resident 1 was dependent on staff for activities of daily living such as oral care, toileting hygiene, showering/bathing, and dressing and personal hygiene. During a review of Resident 1's History and Physical (H&P) dated 3/24/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Order Summary Report dated 3/24/2026 through 4/21/2026, the Report indicated the physician ordered to place Resident 1 on aspiration precautions (safety measures for residents with dysphagia) and provide Glucerna (liquid feeding) enterally (through GT). The order did not indicate providing food by mouth to the resident. During a review of Resident 1's undated Baseline Care Plan titled, Nutritional/fluid impairment related to GT feeding, the Care Plan indicated to provide diet and fluids as ordered, head of bed elevated and provide GT feeding and care as ordered.During a review of Resident 1's Nutritional assessment dated [DATE], the Nutritional Assessment indicated Resident 1was NPO (no food by mouth) and received total nutrition via GT feeding.During an interview on 4/28/2026 at 3:00 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 4/21/2026, she observed Resident 1 eating food from a breakfast tray. LVN 1 stated Resident 1 should not have eaten any food by mouth because the resident was NPO (nothing by mouth) and did not have a physician's order to eat food by mouth. LVN 1 stated she did not notify the resident's physician of the incident nor document the incident in the resident's medical record.During an interview on 4/29/2026 at 12:00 p.m., with the Dietary Supervisor (DS), the DS stated (on 4/21/2026) Resident 1 received another resident's breakfast meal and stated Resident 1 consumed the meal that included bacon, toast, dry cereal, scrambled eggs, and thickened liquids. The DS stated Resident 1 had no physician's order for a meal tray and Resident 1's dietary status (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

Printed: 06/25/2026
Form Approved OMB
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was NPO (nothing by mouth).During an interview on 4/29/2026 at 12:25 p.m., with Registered Nurse (RN) 1, RN 1 stated she was notified that Resident 1 was eating breakfast when he was NPO. RN 1 stated she should have notified the physician and documented the incident in the medical records, however she did not because the resident had no ill effects from eating breakfast. During an interview on 4/29/2026 12:35 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated he gave Resident 1 a breakfast tray to eat on 4/21/2026 by mistake. Resident 1 should not have received a food tray. During an interview on 4/29/2026 at 3:00 p.m., with the Director of Nursing (DON) the DON stated the incident (Resident 1 eating food by mouth) was not documented in the medical records until 4/29/2026 (8 days later) and the physician was notified on 4/28/2026 (7 days later). The DON stated the incident placed Resident 1 at risk for choking and aspiration. During a review of the facility's Policy and Procedure (P&P) titled, Charting and Documentation dated 7/2017, the P&P indicated the medical record should facilitate communication between the interdisciplinary team (a group of healthcare professionals from different disciplines who work together to manage the resident's care) regarding the resident's condition and response to care. The P&P indicated the following information is to be documented in the resident medical record: objective observations, changes in the resident's condition and events, incidents or accidents involving the residents. Documentation in the medical record will be objective, complete and accurate. During a review of the facility's undated P&P titled, Diet orders, the P&P indicated, a written order must appear on the medical record before the resident may be served.