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	05/22/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Minimum Data Sets (MDS, a resident assessment tool) were coded accurately for two of 23 sampled residents (Resident 40 and Resident 65).Resident 40's MDS, dated [DATE], did not reflect his use of continuous oxygen therapy, and receipt of intermittent suctioning and tracheostomy care (the routine cleaning and maintenance of a surgically created opening in the neck (stoma) and the inserted breathing tube).Resident 65's MDS, dated [DATE], did not reflect his venous ulcer (slow healing open sore that typically develop on lower leg that is caused by poor blood circulation).These deficient practices resulted in the transmission of inaccurate data to the Centers for Medicare and Medicaid Services (CMS) regarding Resident 40's and 65's health status and increased the potential for these residents to not receive the care and services they needed. Findings: 1. During a review of Resident 40's Face Sheet, the Face Sheet indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 40's diagnoses included presence of a tracheostomy (a surgical procedure that creates an opening in the neck and directly into the windpipe) and chronic respiratory failure (a long-term condition where the respiratory system cannot properly oxygenate the blood or remove excess carbon dioxide) with hypoxia (low oxygen levels in the blood). During a review of Resident 40's Minimum Data Set (MDS, a resident assessment tool), dated 4/21/2026, the MDS indicated Resident 40's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 40 was dependent (helper does all effort) on staff for all attempted activities of daily living (activities such as bathing, dressing and toileting a person performs daily) and mobility. The MDS indicated Resident 40 was not receiving continuous oxygen, tracheostomy care, or intermittent suctioning. During a review of Resident 40's physician order, dated 1/15/2026, the order indicated staff were to administer oxygen by T-piece (a T-shaped tubular connector primarily used in medicine to deliver oxygen or humidity to patients with breathing tubes) at five (5) L/min. During an observation on 5/19/2026 at 11:04 a.m., Resident 40 was receiving continuous oxygen through a T-piece. During an observation on 5/20/2026 at 2:56 p.m., Resident 40 was receiving continuous oxygen through a T-piece. During an interview on 5/21/2026 at 11:34 a.m., with Respiratory Therapist (RT) 2, RT 2 stated (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 40 was receiving continuous oxygen at five (5) L/min and received suctioning of his respiratory secretions (fluids produced by the respiratory tract, including mucus, saliva, and phlegm) as needed. RT 2 stated Resident 40 received tracheostomy care every shift and as needed. During an interview on 5/21/2026 at 12:18 p.m., with Minimum Data Set Nurse (MDSN) 2, MDSN 2 stated Resident 40 had physician orders for continuous oxygen and was receiving tracheostomy care and intermittent suction of his respiratory secretions. During a concurrent interview and record review on 5/21/2026 at 12:20 p.m. with MDSN 2, Resident 40's MDS, dated [DATE], was reviewed. MDSN 2 stated Resident 40's MDS did not accurately reflect his use of continuous oxygen, intermittent suctioning, and receipt of tracheostomy care. MDSN 2 stated the purpose of the MDS was to assess the residents and to guide their plans of care. 2. During a review of Resident 65's Face Sheet, the Face Sheet indicated Resident 65 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 65's diagnoses included left leg above knee amputation (AKA, surgical removal of the leg above the knee joint), peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs), cerebral infarction (a type of ischemic stroke – occurs when a blood clot or fatty plaque blocks a blood vessel in the brain), and sepsis (a life-threatening blood infection). During a review of Resident 65's Wound Care Notes, dated 12/31/2025, the Wound Care Notes indicated Resident 65 had one vascular wound (kind of wound that occurs due to poor blood flow in the arteries and veins) on left anterior (toward the front) foot extending to the left great toe (big toe) to second toe gangrene (death of body tissue due to a lack of blood flow or a serious bacterial infection). During a review of Resident 65's History and Physical (H&P), dated 4/21/2026, the H&P indicated Resident 65 did not have the capacity to understand and make decisions but was able to make decisions for activities of daily living. During a concurrent interview and record review on 5/21/2026 at 7:57 a.m. with MDSN 1, Resident 65's MDS Significant Change in Status Assessment (SCSA, a comprehensive assessment that must be completed when the Interdisciplinary Team [IDT, team members from different disciplines who come together to discuss resident care] has determined that a resident meets the significant change guidelines for either improvement or decline), dated 1/6/2026, was reviewed. MDSN 1 stated Resident 65's MDS SCSA, Section M1030 (Number of Venous and Arterial Ulcers), was completed inaccurately. MDSN 1 stated there should be number 1 (one) not 0 (zero) on Resident 65's MDS SCSA, Section M1030, because Resident 65 had 1 vascular wound on left foot classified by wound specialist on 12/31/2025. MDSN 1 stated MDS accuracy of assessment was very important in order to reflect the actual condition of the resident and the interventions provided by facility staff. MDSN 1 stated there was a possibility that resident's plan of care would be affected by not completing the MDS accurately. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Assessments, revised 3/2023, the P&P indicated comprehensive assessments were conducted to assist in developing person-centered care plans. During a review of the facility's P&P titled, Certifying Accuracy of the Resident Assessment, dated 11/2019, the P&P indicated any person completing a portion of the Minimum Data Set/MDS must sign and certify the accuracy of that portion of the assessment.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide interventions for the prevention of pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence) for four of eight sampled residents (Residents 40, 108, 10, and 65) when:Resident 40's and 108's low air loss mattresses (LALM, therapeutic support surfaces designed to prevent and treat pressure ulcers) were not functioning according to manufacturer's guidance.Resident 10's LALM did not have the correct setting.The facility failed to follow its policy and procedure (P&P) titled Wound Care to document Resident 65's wound assessment when doing wound care.These deficient practices placed Residents 40,108, 10, and 65 at risk of developing new pressure ulcers, or developing a worsening condition of their existing pressure ulcers. Findings: 1. During a review of Resident 40's Face Sheet, the Face Sheet indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 40's diagnoses included chronic respiratory failure (a long-term condition where the respiratory system cannot properly oxygenate the blood or remove excess carbon dioxide) with hypoxia (low oxygen levels in the blood), encephalopathy (a group of conditions that cause brain dysfunction), and sepsis (a serious condition in which the body responds improperly to an infection). During a review of Resident 40's Minimum Data Set (MDS, a resident assessment tool), dated 4/21/2026, the MDS indicated Resident 40's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 40 was dependent (helper does all of the effort) on staff for all attempted activities of daily living (activities such as bathing, dressing and toileting a person performs daily) and mobility. The MDS indicated Resident 40 was at risk for developing pressure ulcers (PUs) and used a pressure-reducing device in his bed. During a review of Resident 40's physician order, dated 1/16/2026, the order indicated staff were to provide Resident 40 with a LALM for wound care and management. During a review of Resident 40's care plan titled Risk for further developing pressure sore, and other types of skin breakdown., dated 2/20/2025, the care plan indicated goals of care were minimization of the risk of skin breakdown and pressure sore development daily. The care plan indicated staff were to provide Resident 40 with a pressure relieving device. During a review of Resident 40's record titled, Braden Assessment, dated 4/15/2026, the assessment indicated Resident 40 was at very high risk for developing a PU. During an observation on 5/19/2026 at 10:57 a.m. at Resident 40's bedside, Resident 40 was lying in bed on a LALM. The pump attached to the LALM at the foot of Resident 40's bed had an orange flashing light with an audible beeping alarm. The pump indicated the alarm and flashing light was a low-pressure alarm. An unidentified Licensed Vocational Nurse was at the bedside and stated the maintenance department was notified of the malfunctioning LALM. During an observation on 5/20/2026 at 9:36 a.m., 2:25 p.m., and 3:00 p.m., at Resident 40's bedside, Resident 40 was lying in bed on a LALM. The pump attached to the LALM at the foot of Resident 40's bed had an orange flashing light indicating a low-pressure alarm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/20/2026 at 2:26 p.m., with Certified Nursing Assistant (CNA) 5, CNA 5 stated she was Resident 40's one-to-one sitter (a dedicated caregiver or staff member assigned to constantly monitor a single individual) since 7:00 a.m. that morning. CNA 5 stated no staff from the maintenance department had come to check on Resident 40's LALM. During an observation on 5/21/2026 at 10:12 a.m. and 11:42 a.m., at Resident 40's bedside, Resident 40 was lying in bed on a LALM. The pump attached to the LALM at the foot of Resident 40's bed had an orange flashing light and audible beeping, indicating a low-pressure alarm. b. During a review of Resident 108's Face Sheet, the Face Sheet indicated Resident 108 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 108's diagnoses included chronic respiratory failure with hypoxia and dependence on a ventilator (a medical machine that completely takes over or assists breathing for a patient who cannot do so independently). During a review of Resident 108's MDS, dated [DATE], the MDS indicated Resident 108's cognition was severely impaired and was dependent on staff for all attempted activities of daily living and mobility. The MDS indicated Resident 40 was at risk for developing pressure ulcers (PUs) and used a pressure-reducing device in his bed. During a review of Resident 108's record titled Braden Scale for Predicting Pressure Sore Risk, dated 5/9/2026, the record indicated Resident 108 was at high risk for developing a PU. During a review of Resident 108's physician order, dated 5/10/2026, the order indicated staff were to provide Resident 108 with a LALM for wound care and management. During an observation on 5/20/2026 at 2:26 p.m. and 3:00 p.m., at Resident 108's bedside, Resident 108 was lying in bed on a LALM. The pump attached to the LALM at the foot of Resident 108's bed had an orange flashing light and audible beeping, indicating a low-pressure alarm. During an observation on 5/21/2026 at 10:12 a.m. and 11:42 a.m., at Resident 108's bedside, Resident 108 was lying in bed on a LALM. The pump attached to the LALM at the foot of Resident 108's bed had an orange flashing light and audible beeping, indicating a low-pressure alarm. During an interview on 5/21/2026 at 3:05 p.m., with the Maintenance Assistant (MA), the MA stated he had not received any report from nursing staff regarding malfunctioning LALMs. The MA stated that when the low pressure alarm was flashing and audible, it indicated there was an air leak somewhere in the system. The MA stated that the presence of an air leak prevented the mattress from working effectively. During an interview on 5/21/2026 at 3:37 p.m., with Treatment Nurse (TN) 1, TN 1 stated a low-pressure alarm meant there was an air leak somewhere in the LALM system, and the alarm alerts staff that something needed to be addressed. TN 1 stated a PU could develop as soon as two hours. TN 1 stated it was not appropriate for a LALM alarm to go unaddressed for multiple days because it increased the risk for development of PUs. 2. During a review of Resident 10's Face Sheet, the Face Sheet indicated Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10's diagnoses included dementia (a progressive state of decline in mental abilities), and pressure ulcer of the sacral region, left buttock, and other site, stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ligament, cartilage, or bone). During a review of Resident 10's H&P, dated 10/23/2025, the H&P indicated Resident 10 had fluctuating capacity to understand and make decisions. During a review of Resident 10's MDS, the MDS indicated Resident 10's cognition was severely impaired. The MDS indicated Resident 10 was dependent on staff for all activities of daily living and mobility. During a review of Resident 10's physician order, dated 10/22/2025, the physician order indicated Resident 10 was to receive a LALM for wound care and management. During a review of Resident 10's care plan titled, Multiple Stage Four Pressure Ulcers, dated 10/22/2025, the care plan intervention indicated to utilize pressure relieving devices including specialty mattress. During a review of Resident 10's Weight Summary dated 5/5/2026, the weight summary indicated Resident 10 weighed 107 pounds ([lbs.]- a unit of weight). During an observation on 5/19/2026 at 10:24 a.m. in Resident 10's room, Resident 10 was lying on a LALM with the setting at 200 lbs. During a concurrent observation and interview on 5/20/206 at 11:27 a.m. with the Assistant Director of Nursing (ADON) in Resident 10's room, the LALM was set at 160lbs. The ADON stated the LALM was set at 160 lbs. and the resident weighed (107 lbs.) less than 160 lbs. The ADON stated the LALM should be set at 120 lbs. The ADON stated the LALM should be at the correct setting to prevent injury. During a concurrent observation and interview on 5/20/2026 at 12:40 p.m., with Treatment Nurse (TN) 1), the LALM was set at 160 lbs., the TN 1 stated Resident 10 weighed less than 160 lbs. The TN 1stated the LALM protocol was to match the weight of the resident to the low air loss pressure of the mattress. TN 1 stated the LALM was to promote wound healing and skin management (frequent and thorough assessment, basic hygiene, and protecting skin areas at risk from harmful friction and shear). During a review of manufacture operational manual titled, Proactive Medical Products, unknown date, the operational manual indicated LAL mattress was for the prevention and treatment of all stage pressure ulcers. The operational manual indicated determining the patient's weight and set the control knob to that weight setting on the control unit. 3. During a review of Resident 65's Face Sheet, the Face Sheet indicated Resident 65 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 65's diagnoses included left leg above knee amputation (AKA, surgical removal of the leg above the knee joint), peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs), cerebral infarction (a type of ischemic stroke – occurs when a blood clot or fatty plaque blocks a blood vessel in the brain), and sepsis (a life-threatening blood infection). During a review of Resident 65's MDS, dated [DATE], the MDS indicated Resident 65's cognition was severely impaired. The MDS indicated Resident 65 was dependent (helper does all of the effort) from (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff with oral hygiene, toileting hygiene, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 65 was at risk of developing pressure ulcers. During a review of Resident 65's H&P, dated 4/21/2026, the H&P indicated Resident 65 did not have the capacity to understand and make decisions but was able to make decisions for activities of daily living. During a review of Resident 65's Treatment Administration Record (TAR, a daily documentation record used by a licensed nurse to document treatment given to a resident) dated 12/24/2025 to 3/23/2026, the TAR indicated Resident 65's wound care treatment on left foot gangrene was done daily and had the initials of the individual performing the wound care. During a concurrent phone interview and record review on 5/26/2026 at 9:48 a.m., with Registered Nurse 3 (RN 3), the facility's policy and procedure (P&P) titled, Wound Care, revised 3/2023, was reviewed. The P&P indicated the date and time the wound care was given, the position in which the resident was placed, the name and title of the individual performing the wound care, if there were any changes in the resident's condition, all assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound, how the resident tolerated the procedure, if there were any problem or complaints made by the resident related to the procedure, if the resident refused the treatment and the reason(s) why, and the signature and title of the person recording the data should be documented in the resident's medical record. RN 3 stated the facility's practice when doing wound care was to check and provide the wound care treatment as ordered by the physician to the residents and put the initials of the licensed nurse performing the wound care on the TAR. RN 3 stated the licensed nurse would document resident's wound assessment which includes the type, location, and size of the wound, and the wound description on a weekly basis. RN 3 stated the facility did not follow its P&P by not assessing the wound while doing wound care treatment. RN 3 stated it was important to assess and document the wound condition daily so the facility could identify any changes of the wound and notify and address by the physician promptly.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe and hazard-free environment for three of three sampled residents (Residents 76, 110, and 37) when:1. Staff did not provide padded side rails as indicated in Resident 76's and 110's respective care plans.2. Staff failed to provide fall mats, as ordered by the physician, for Resident 37.These deficient practices increased the potential for Residents 76 and 110 to sustain avoidable injuries and complications related to missing siderail padding in the event of a seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) and increased the potential for Resident 37 to sustain fall-related injuries. Findings: 1. During a review of Resident 76's Face Sheet, the Face Sheet indicated Resident 76 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 76's diagnoses included seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 76's Minimum Data Set (MDS, a resident assessment tool), dated 3/31/2026, the MDS indicated Resident 76's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 76 was dependent (helper does all of the effort) on staff for all attempted activities of daily living (activities such as bathing, dressing and toileting a person performs daily) and mobility. During a review of Resident 76's physician order, dated 7/30/2024, the order indicated staff were to keep Resident 76's upper half side rails up while he was in bed. During a review of Resident 76's care plan titled History of Myoclonus (sudden, brief, involuntary jerking or twitching of a muscle or group of muscles), dated 10/31/2023, the care plan indicated Resident 76 was at risk for injury, and goals of care included Resident 76 sustaining no injuries. The care plan indicated staff were to provide Resident 76 with padded side rails. During an observation on 5/20/2026 at 9:26 a.m. and 2:54 p.m., and 5/21/2026 at 11:13 a.m., Resident 76 was observed lying in bed with side rails on both sides of his bed. The side rails were not padded. During a concurrent interview and record review, on 5/21/2026 at 11:37 a.m., with Licensed Vocational Nurse (LVN) 3, Resident 76's care plan titled History of Myoclonus, dated 10/31/2023, was reviewed. LVN 3 stated the care plan indicated Resident 76 was to have padded side rails. During a concurrent observation and interview, on 5/21/2026 at 11:38 a.m., LVN 3 stated Resident 76 did not have padding on his side rails. LVN 3 stated the purpose of the padding was to prevent Resident 76 from sustaining injuries if he hit his head during a seizure. During a review of Resident 110's Face Sheet, the Face Sheet indicated Resident 110 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 110's diagnoses included anoxic brain damage (when the brain is completely deprived of oxygen, leading to widespread brain cell death), encephalopathy (a group of conditions that cause brain dysfunction), and seizures. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 110's MDS, dated [DATE], the MDS indicated Resident 110's cognition was severely impaired and was dependent on staff for all attempted activities of daily living and mobility. During a review of Resident 110's physician order, dated 5/18/2026, the order indicated staff were to keep Resident 110's upper half side rails up while she was in bed. During a review of Resident 110's care plan titled Seizure Disorder, dated 10/31/2023, the care plan indicated Resident 110 was at risk for injury, and goals of care included Resident 110 sustaining no injuries. The care plan indicated staff were to provide Resident 110 with padded side rails. During an observation on 5/19/2026 at 3:47 p.m., 5/20/2026 at 2:55 p.m., and 5/21/2026 at 11:13 a.m., Resident 110 was observed lying in bed with side rails on both sides of her bed. The side rails were not padded. During a concurrent interview and record review, on 5/21/2026 at 11:16 a.m., with LVN 4, Resident 110's care plan titled Seizure Disorder, dated 10/31/2023, was reviewed. LVN 4 stated the care plan indicated Resident 110 was to have padded side rails. During a concurrent observation and interview, on 5/21/2026 at 11:19 a.m., with LVN 4, LVN 4 stated Resident 110 did not have padding to any of her side rails. LVN 4 stated Resident 110 needed padding on the side rails to protect her from injury. 2. During a review of Resident 37's Face Sheet, the Face Sheet indicated Resident 37 was admitted to the facility on [DATE] with diagnoses including seizures and contracture (A stiffening/shortening at any joint that reduces range of motion) of left and right shoulders. During a review of Resident 37's MDS, dated [DATE], the MDS indicated Resident 37 was rarely able to understand and be understood by others. The MDS indicated Resident 37's cognition was severely impaired. The MDS indicated Resident 37 was dependent on a staff to do all of the effort for toileting, showering/bathing, dressing upper and lower body dressing, and for oral and personal hygiene. During a review of Resident 37's Change of Condition (COC)/Interact Assessment Form, dated 5/17/2026, the form indicated Resident 37 fell from her bed. During a review of Resident 37's physician order dated 5/17/2026, the order indicated staff were to add floor mats to decrease potential injury. During a concurrent observation and interview on 5/21/2026 at 4:30 p.m. in Resident 37's room with the Assistant Director of Nursing (ADON), Resident 37 was lying in bed but did not have floor mats on either side. The ADON stated the floor mats should be there as ordered in case she falls so she won't land on the hard floor. During a review of the facility's policy and procedure (P&P) titled Accident/Incident Prevention, undated, the P&P indicated it was the facility's policy to strive to prevent accidents and provide adequate care plans with procedures to prevent accidents. During a review of the facility's P&P titled, Safety and Supervision of Residents, Revised July 2017, the P&P indicated staff will ensure that interventions are implemented correctly and consistently.

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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 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the physician's order for arterial and venous ultrasounds (painless, non-invasive imaging tests that use sound waves to evaluate blood flow throughout your body) in a timely manner for one of one sampled resident (Resident 65).This deficient practice had the potential to result in the delay of the identification of medical concerns, delaying the care and services necessary for Resident 65.Findings:During a review of Resident 65's Face Sheet, the Face Sheet indicated Resident 65 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 65's diagnoses included left leg above knee amputation (AKA, surgical removal of the leg above the knee joint), peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs), cerebral infarction (a type of ischemic stroke - occurs when a blood clot or fatty plaque blocks a blood vessel in the brain), and sepsis (a life-threatening blood infection).During a review of Resident 65's physician order, dated 12/16/2025, the physician order indicated Resident 65 would have an arterial and venous ultrasounds done on 12/17/2025.During a review of Resident 65's Minimum Data Set (MDS, a resident assessment tool), dated 4/15/2026, the MDS indicated, Resident 65's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 65 was dependent (helper does all of the effort) on staff for oral hygiene, toileting hygiene, upper and lower body dressing, and personal hygiene.During a review of Resident 65's History and Physical (H&P), dated 4/21/2026, the H&P indicated Resident 65 did not have the capacity to understand and make decisions but was able to make decisions for activities of daily living.During an interview on 5/21/2026 at 4:40 p.m., with Registered Nurse 3 (RN3), RN 3 stated Resident 65's arterial and venous ultrasounds were not done on 12/17/2025. RN 3 stated Resident 65's arterial and venous ultrasounds were completed on 12/18/2025. RN 3 stated the licensed nurse staff should have communicated to Resident 65's physician that the arterial and venous ultrasounds were not done on 12/17/2025.During an interview on 5/22/2026 at 8:52 a.m., with the Director of Nursing (DON), the DON stated all physician orders including ultrasound should be completed in a timely manner. The DON stated there was no documentation in Resident 65's Progress Notes that the facility staff made a follow-up call with the ultrasound provider and asked what happened why Resident 65's order for arterial and venous ultrasound to be done on 12/17/2025 was not completed. The DON stated it was important to implement the physician's order in a timely manner so the physician could decide and evaluate the next action plan for the resident.During a review of the facility's policy and procedure (P&P) titled, Lab and Diagnostic Test Results - Clinical Protocol, dated 3/2023, the P&P indicated, the physician would identify and order diagnostic lab testing based on the resident's diagnostic and monitoring needs. The P&P indicated the facility staff should document information about when, how, and to whom the information was provided and the response.