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 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 (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:Ensure medications were administered as ordered for one of five sampled residents (Resident 40) when:Licensed Vocational Nurse (LVN) 4 administered hydralazine (a blood pressure medication) outside of the ordered parameters on 4/6/2026 and 5/12/2026.LVN 5 failed to administer insulin (a medication to control blood sugar) as ordered on 5/18/2026.Clarify medication orders with the physicians for two of five sampled residents (Resident 103 and 34), when the residents had advanced from intake via gastrostomy tube (G-tube, a flexible medical device inserted directly through the abdomen into the stomach) to being able to take medicine by mouth.Ensure two licensed nurses conducted and signed as witnesses in the destruction of non-controlled medications. Ensure discontinued controlled medications were accounted for and their disposition properly documented, for two of two sampled residents (Residents 109 and 120):Resident 109's 41 tablets of discontinued Norco (hydrocodone/acetaminophen, a narcotic, or controlled medication, pain medication) 5/325 milligrams (mg, unit to dose measurement) were not documented as destroyed, or accounted forResident 120's 2622 milliliters (mL, a unit of volume measurement) of discontinued phenobarbital 20 mg per (/) 5 mL solution (a controlled medication and a long-acting barbiturate that acts as a central nervous system depressant) was documented to have been destroyed as non-controlled medication.These deficient practices placed Resident 40 at risk for complications associated with low blood pressure, such as dizziness, falls, elevated heart rate, and at risk of untreated elevated blood sugar levels. These deficient practices also had the potential of medication errors, misuse of medications, and/or drug diversion.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 high blood pressure and type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). 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. a. During a review of Resident 40's physician order, dated 1/14/2026, the order indicated staff were to administer hydralazine 100 milligrams (mg, a unit of dose measurement) twice a day for high blood pressure. The order indicated staff were not to administer the medication if Resident 40's systolic blood pressure (SBP) reading was less than 110 millimeters of mercury (mm HG, a unit of measuring blood pressure). During a review of Resident 40's Electronic Medication Administration Record (EMAR), dated 4/1/2026 to 4/31/2026, the EMAR indicated staff were to hold Resident 40's hydralazine for SBP less than 110 mm HG. The EMAR indicated on 4/6/2026, LVN 4 documented Resident 40's SBP was 103 mm HG and administered Resident 40's hydralazine. During a review of Resident 40's EMAR, dated 5/1/2026 to 5/31/2026, the EMAR indicated staff were to hold Resident 40's hydralazine for SBP less than 110 mm HG. The EMAR indicated on 5/12/2026, LVN 4 documented Resident 40's SBP was 103 mm HG and administered Resident 40's hydralazine. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/20/2026 at 2:29 p.m., with LVN 4, LVN 4 stated that when administering blood pressure medication, she typically assessed the resident's blood pressure first because there were parameters for not administering the medication if the blood pressure was too low. LVN 4 stated if blood pressure medication was administered when the resident's blood pressure was low, the medication could cause the blood pressure to decrease further, resulting in lethargy and possibly death. During a concurrent interview and record review, on 5/20/2026 at 2:34 p.m., with LVN 4, Resident 40's EMARs dated 4/1/2026 to 4/31/2026, and 5/1/2026 to 5/31/2026, were reviewed. LVN 4 stated that she should not have administered Resident 40's hydralazine on 4/6/2026 or 5/12/2026. b. During a review of Resident 40's physician order, dated 1/14/2026, the order indicated staff were to administer two (2) units (a unit of measuring insulin) of insulin for blood glucose readings between 121 and 150 milligrams per deciliter (mg/dL, a unit of measuring blood glucose levels). During a review of Resident 40's EMAR, dated 5/1/2026 to 5/31/2026, the EMAR indicated LVN 5 documented Resident 40's blood glucose level was 123 mg/dL. The EMAR indicated LVN 5 did not administer two (2) units of insulin as ordered. During an interview on 5/20/2026 at 2:41 p.m. with LVN 5, LVN 5 stated she should have administered two (2) units of insulin for Resident 40's blood glucose level of 123 mg/dL. LVN 5 stated that if insulin was indicated but not administered, it could lead to a further rise in the resident's blood glucose levels. LVN 5 stated medications should be administered as ordered. 2. During a review of Resident 34's Face Sheet, the Face Sheet indicated Resident 34 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 34's diagnoses including chronic kidney disease (CKD, a long-term condition where the kidneys are damaged and lose their ability to filter blood properly) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 34's physician order, dated 6/28/2021, the physician order indicated to discontinue G-tube feeding and change medications to take by mouth. During a review of Resident 34's physician order, dated 5/28/2025, the physician order indicated to administer labetalol (a medication to treat high blood pressure) 200 mg, 1 tablet via G-tube two times a day. During a medication administration observation on 5/20/2026 at 10:25 a.m., Resident 34 took all medications by mouth. During an interview on 5/20/2026 at 2:37 PM with Registered Nurse 6 (RN 6), RN 6 stated the labetalol order was not updated when Resident 34's G-tube was removed. During a review of Resident 103's Face Sheet, the Face Sheet indicated Resident 103 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 103's diagnoses included peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs) and dysphagia (difficulty swallowing). During a review of Resident 103's dietary evaluation, dated 11/4/2022, the evaluation indicated to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discontinue the G-tube. During a review of Resident 103's physician order, dated 10/20/2025, the physician order indicated to administer amlodipine (a medication to treat high blood pressure) 1 tablet via G-tube daily. During a medication administration observation on 5/20/2026 at 9:45 a.m., Resident 103 took all the medications by mouth. During an interview on 5/20/2026 at 3:20 p.m. with the Director of Nursing (DON), the DON stated licensed nurses should check before administration and clarify with the physicians if there was a discrepancy. The DON stated the nurses that perform monthly order summary should have caught the discrepancies as well and clarify the orders. 3. During a concurrent interview and record review on 5/20/2026 at 4:15 p.m. with RN 4, the medication destruction logs, dated 5/11/2026, were reviewed. RN 4 stated the night shift nurse performed the non-controlled medication destructions. RN 4 stated the initials on the column named witness #1 were the night nurse, however, the witness #2 column was empty, which indicated there was no documented witness to the destruction. There was a total of twelve medications destroyed on 5/11/2026 without the signatures of a witness. During an interview on 5/20/2026 at 4:19 p.m. with the DON, the DON reviewed the log and stated the instruction on the destruction log indicated for one RN to destroy the medication and one other licensed nurse would witness the destruction. 4. a. During a review of Resident 109's Face Sheet, the Face Sheet indicated Resident 109 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 109's diagnoses included chronic respiratory failure (a long-term condition where the lungs cannot adequately get enough oxygen into the blood) and 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 109's physician order, dated 1/13/2026, the physician order indicated to administer Norco 5-325 mg 1 tablet via G-tube every four hours as needed for pain management for seven days. The physician order indicated the order was completed on 1/20/2026. b. During a review of Resident 120's Face Sheet, the Face Sheet indicated Resident 120 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 120's diagnoses included chronic respiratory failure and dysphagia. The Face Sheet indicated Resident 120 was discharged from the facility on 3/1/2026 to the hospital. During an interview on 5/21/2026 at 9:36 a.m. with the DON, the DON stated the assistant director of nursing (ADON) was the designated person for destroying controlled medications. During a concurrent interview and record review on 5/21/2026 at 9:36 a.m. with the DON and ADON, the controlled medications destruction logs, dated 5/11/2026, were reviewed. The logs indicated the process for destroying controlled medications consisted of an endorsement from the releasing nurse to the DON/designated RN and the destruction was conducted by the DON/designated nurse and a pharmacist. The log indicated there were nine discontinued controlled medications that were endorsed from the releasing nurse to the ADON, however, there was no signatures that indicated these 9 medications had been destroyed. The log indicated one of the nine controlled medications was (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 109's Norco 5/325 mg with a quantity of 41 tablets, endorsed on 2/16/2026. However, there was no releasing nurse's signature for the endorsement and there were no signatures for the destruction of the drug. The log indicated the remaining eight medications were eight bottles of Resident 120's phenobarbital 20mg/5 ml solutions, with a total volume of 2622 ml, endorsed to ADON on 2/11/2026, 2/28/2026, and 3/3/2026, and there were no signatures for the destruction. During an interview on 5/21/2026 at 9:50 a.m. with the DON and ADON, the DON stated Resident 109 was a current resident and the ADON stated Resident 109 did not have active Norco order. The DON stated Resident 120 was discharged to a hospital on 2/22/2026 and did not return to the facility. The ADON stated there was no documentation of what happened to the controlled medications. The ADON and the DON could not find the controlled medications in the locked cabinets that stored endorsed controlled medications to be destroyed. During an interview on 5/21/2026 at 10 a.m. with the DON, the DON stated the lack of documentation of the medications could have the potential of diversion or misuse that may affect the safety of the residents and staff.During a phone interview on 5/21/2026 at 10:28 a.m. with the facility consultant pharmacist (RPh), the RPh stated he remembered there were many bottles of phenobarbital. The RPh stated at the time of the destruction with ADON, the bottles were not destroyed because the facility ran out of space in the destruction bin (pharmaceutical waste bin) that could hold the volume. The RPh stated he and ADON secured the bottles in a locked cabinet in DON's office. During an interview on 5/21/2026 at 2:11 p.m. with the ADON, the ADON stated he had searched everywhere but could not locate Resident 120's 8 bottles of phenobarbital or Resident 109's 41 tablets of Norco. During an interview on 5/21/2026 at 2:53 p.m. with the ADON, the ADON stated he remembered he had moved the phenobarbital bottles to nursing station 2 medication rooms and destroyed them as non-controlled medications with another nurse. The ADON stated he knew phenobarbital was a controlled medication, however, he could not explain why he destroyed phenobarbital using the disposition process for non-controlled medications. During a concurrent interview and record review on 5/21/2026 at 3:22 p.m. with the ADON, the multipurpose drug disposition record, undated, was reviewed. The record indicated there were 8 bottles of Resident 120's phenobarbital destroyed on 4/29/2026 (1x 52 ml, 1x 220 ml, 3x of 400 ml, 1x 250 ml, and 2x 450 ml). The ADON stated he destroyed the medication with another RN. During an interview on 5/21/2026 at 3:45 p.m. with the DON, the DON stated controlled medications should not be destroyed as non-controlled meds. During an interview on 5/22/2026 at 5:25 p.m. with the ADON, the ADON stated Resident 120's medication was not correctly disposed of. The ADON stated the correct process was to dispose of the phenobarbital in the narcotic waste bin with a pharmacist. The ADON stated narcotics were potent. At the time of the survey exit, the facility did not find the missing 41 tablets of Resident 109's discontinued Norco or the records for Resident 109's Norco and Resident 120's Phenobarbital. During a review of the facility's policy and procedure (P&P) titled Administering Medications, dated 2001, the P&P indicated vital signs were to be checked/verified, if necessary, prior to administering medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Administering Medications, dated 2001, the P&P indicated medications were to be administered in accordance with prescriber's orders. During a review of the facility's P&P titled Medication Destruction, revised 01/2025, the policy indicated controlled substances are retained in a securely locked area with restricted access until destroyed by the facility director of nursing or a registered nurse employed by the facility, and a consultant pharmacist. During a review of the facility's P&P titled Physician orders and Telephone orders, dated 1/2004, the P&P indicated all orders would be reviewed for accuracy, completeness, and clarity. During a review of the facility's P&P titled Medication Destruction, dated 1/2025, the P&P indicated non-controlled medication destruction would occur in the presence of two licensed nurses.

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure:Resident 103's food at the bedside was dated and properly stored.One container of baking powder, one container of peanut butter, and one container of beef base in the dry storage area were labeled and dated.Two cabbages with discolored and black markings on edges were not kept in the walk-in refrigerator. These failures had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead to foodborne illness (an illness caused by food contaminated with bacteria, viruses, and other toxins) in all of the facility's residents. Findings: 1. During a review of Resident 103's Face Sheet, the Face Sheet indicated Resident 103 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 103's diagnosis included peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs), chronic kidney disease (a disease characterized by progressive damage and loss of function in the kidneys), and polyneuropathy (a diffuse, bilateral disorder where multiple peripheral nerves are simultaneously damaged). During a review of Resident 103's History and Physical (H&P), dated 10/22/2025, the H&P indicated Resident 103 had the capacity to understand and make decisions. During a review of Resident 103's Minimum Data Sheet (MDS, a resident assessment tool), dated 4/28/2026, the MDS indicated Resident 103's cognition (ability to think and reason) was intact. The MDS indicated Resident 103 was dependent (helper does all the effort) on staff for toileting hygiene, showering, and dressing. During an observation on 5/19/2026 at 11:04 a.m., in Resident 103's room, Resident 103 had opened hot dog buns, bread rolls, and salad dressing that was not dated and labeled on her bedside table. During a review of Resident 103's, Interdisciplinary Team (IDT), dated 4/28/2026, the IDT indicated Resident 103 was storing perishables (goods with a limited shelf life that spoils, decay, and is stored under specific conditions) in her room. During an interview on 5/20/2026 at 9:34 a.m., with Resident 103, Resident 103 stated she would allow the staff to mark the dates on her food items, but the staff had not marked her food items. During an observation and interview on 5/20/2026 at 11:51 a.m., with the Assistant Director of Nursing (ADON) in Resident 103's room, Resident 103 had opened hot dog buns, bread rolls, and salad dressing with no open date on her bedside table. The ADON stated the food items in Resident 103's room were open and were not dated. The ADON stated the food items were required to have an open date and were considered perishable in 72 hours. The ADON stated if the food items are not dated, Resident 103 would be at risk of getting an upset stomach. During an interview on 5/20/2026 at 1:10 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 103 wanted to keep her food items at the bedside. CNA 4 stated the food items were not (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated. CNA 4 stated Resident 103's food items were scattered around the room and was not sure when the food items were brought into the room. CNA 4 stated there was no system in place to keep track of her food items. CNA 4 stated the food items could spoil and put the resident at risk to become sick. 2. During a concurrent observation and interview on 5/19/2026 at 8:21 a.m., with Dietary Aide 1 (DA 1) in the dry food storage area, there were one unopened container of baking powder and one unopened container of peanut butter with no label and date and one open container of beef base with delivery date of 2/26/2026 with no best by date. DA 1 stated all food items in the dry storage should be labeled and dated with delivery date, open date, and best by date. DA 1 stated it was important to label and date all food items so the dietary staff would know the expiration date of the food items. 3. During a concurrent observation and interview on 5/19/2026 at 8:33 a.m., with DA 1 in the walk-in refrigerator, there were two discolored cabbages with black markings on the edges. DA 1 stated the cabbage should be good and kept in the refrigerator for only 3 days. DA 1 stated giving expired food items to residents could result in food poisoning that would jeopardize resident's health and safety. During a review of facility's policy and procedure (P&P) titled, Food from Outside Sources, unknown date, the P&P indicated facility staff will assist residents with food brought in to ensure safe and sanitary storage of outside food. The P&P indicated leftover food or unused portions of packaged foods should be discarded. The P&P indicated no food will be stored beyond 72 hours from received date. During a review of the facility's P&P, titled Dating and Labeling, undated, the P&P indicated all items should be properly covered, dated with delivery date, open date, thaw date, and labeled.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained for two of five sampled residents (Resident 86 and Resident 109).This deficient practice increased the potential for spread of infection among facility residents and staff. Findings: 1. During a review of Resident 86's Face Sheet, the Face Sheet indicated Resident 86 was admitted to the facility on [DATE]. Resident 86's diagnoses included need for assistance with personal care, generalized muscle weakness, and presence of a tracheostomy (a surgical procedure that creates an opening in the neck and directly into the windpipe) 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 86's Minimum Data Set (MDS, a resident assessment tool), dated 2/20/2026, the MDS indicated Resident 86's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 86 was dependent (helper does all 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 86's physician order, dated 3/3/2026, the order indicated staff were to implement contact isolation precautions (infection control measures used to prevent the spread of germs transmitted through direct or indirect contact) due to Carbapenem-Resistant Acinetobacter baumannii (CRAB, an aggressive, opportunistic bacterium, notorious for its resistance to multiple antibiotics) in Resident 86's sputum (a mixture of mucus and saliva that is coughed up from the lower respiratory tract).During a review of Resident 86's care plan titled Other contact isolation: CRAB Sputum, dated 3/3/2026, the care plan indicated goals of care included reducing the risk of complications and infections daily. The care plan indicated staff were to implement contact isolation precautions.During an observation on 5/19/2026 at 9:18 a.m., outside of Resident 86's room, signage was posted indicating staff and visitors were to implement contact isolation precautions. Signage was also posted with instructions for donning (put on) and doffing (take off) the required personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments). There were containers of hand sanitizer and required PPE (disposable gown and gloves) mounted on the wall next to the signage.During an observation on 05/19/2026 at 9:28 a.m., outside of Resident 86's room, Certified Nursing Assistant (CNA) 3 donned a disposable gown and mask prior to entering Resident 86's room. While in the room, CNA 3 placed a pile of clean linens on Resident 86's bed and pulled his privacy curtain closed. CNA 3 then exited the room while wearing the disposable gown and put on a pair of gloves taken from the wall-mounted container outside of the room. CNA 3 did not perform hand hygiene (the process of cleaning one's hands to prevent the spread of infectious diseases) prior to donning the gloves.During an observation on 5/19/2026 at 9:30 a.m., CNA 3 re-entered Resident 86's room. During an interview on 05/21/2026 at 4:35 p.m., with Registered Nurse (RN) 3, RN 3 stated it was not appropriate for CNA 3 to enter Resident 86's room without gloves on. RN 3 stated that after entering the room, if CNA 3 touched surfaces in the environment, she should stop right away, remove all PPE before exiting the room, perform hand hygiene upon exiting the room, and don the correct required PPE before re-entering the room. 2. During a review of Resident 109's Face Sheet, the Face Sheet indicated Resident 109 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Resident 109's diagnoses included carrying carbapenem-resistant enterobacterales (CRE, a family of highly drug-resistant bacteria [such as E. coli and Klebsiella pneumoniae] that are immune to carbapenem antibiotics.During a review of Resident 109's MDS, dated [DATE], the MDS indicated Resident 109's cognition was severely impaired and was dependent on staff for all attempted activities of daily living and mobility.During a review of Resident 109's physician order, dated 10/2/2025, the order indicated staff were to implement contact isolation precautions due to CRE.During a review of Resident 109's care plan titled Contact isolation: CRE, dated 2/14/2023 and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	last revised 7/3/2023, the care plan indicated goals of care included reducing the risk of complications and infections daily. The care plan indicated staff were to implement contact isolation precautions.During an observation on 5/19/2026 at 2:22 p.m., in Resident 109's room, Medical Doctor (MD) 1 was observed at Resident 109's bedside wearing a mask. MD 1 was not wearing a protective gown or gloves. MD 1 was observed pressing his stethoscope directly to Resident 109's chest and hanging the stethoscope around his neck after he was done. MD 1 was observed touching Resident 109 on various parts of her trunk and limbs without gloves on.During a concurrent observation and interview, on 5/19/2026 at 2:24 p.m., with MD 1, MD was observed exiting Resident 109's room. MD 1 did not perform hand hygiene or disinfect his stethoscope. MD 1 stated Resident 109's sputum culture (a laboratory test that analyzes secretions coughed up from the lungs to identify bacteria, fungi, or other germs causing a respiratory infection) was positive.During an observation on 5/19/2026 at 2:25 p.m., MD 1 was observed walking directly from Resident 109's room to Nurse's Station 2. MD 1 did not perform hand hygiene prior to removing a resident chart from the shelf.During an interview on 5/21/2026 at 4:36 p.m., with RN 3, RN 3 stated it was not appropriate for MD 1 to enter Resident 109's room and come into direct physical contact with Resident 109 without the required PPE. RN 3 stated no staff were exempt from implementing contact isolation precautions. RN 3 stated MD 1 should have also disinfected his stethoscope and performed hand hygiene before touching other surfaces in the facility. During an interview on 5/21/2026 at 4:32 p.m., with RN 3, RN 3 stated she was serving at the facility's infection preventionist. RN 3 stated the purpose of contact isolation precautions was to contain the applicable infectious organism and prevent spread between facility residents. RN 3 stated contact isolation precautions required staff to don a disposable gown, gloves, and a mask. RN 3 stated staff were to don all required PPE prior to entering the room and doff all PPE prior to exiting the room. RN 3 stated staff were to perform hand hygiene upon exiting the room.During a review of the facility's policy and procedure (P&P) titled Isolation - Categories of Transmission-Based Precautions, revised 9/2022, the P&P indicated contact isolation precautions were implemented for residents known (or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident, or indirect contact with environmental surfaces or resident-care items in the resident's environment. The P&P indicated staff were to wear gloves and a disposable gown upon entering the room. The P&P indicated hand hygiene was to be performed before leaving the room. The P&P indicated staff were to avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician obtained informed consent for restraint use for one of one sampled resident (Resident 40).This deficient practice had the potential for Resident 40's Responsible Party (RP 1), to not be fully informed of the risks and benefits associated with restraint use, or to have the opportunity to discuss alternatives to restraints. Findings: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 gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and encephalopathy (a broad term for any disease, damage, or malfunction that affects the brain's structure or function).During a review of Resident 40's History and Physical (H&P), dated 1/17/2026, the H&P indicated Resident 40 did not have the capacity to understand make decisions.During a review of Resident 40's Minimum Data Set (MDS, a resident assessment tool), dated 4/21/2026, the MDS indicated Resident 40 had severe cognitive impairment (a significant loss of intellectual and memory capacity that prevents independent living). The MDS indicated Resident 40 was dependent (helper does all of the effort) on staff for all activities of daily living (activities such as bathing, dressing and toileting a person performs daily) and mobility.During a review of Resident 40's physician order, dated 2/23/2026, the order indicated staff were to apply hand mitten restraints (a padded, glove-like medical device used to enclose a patient's hands) to both of Resident 40's hands. During a review of Resident 40's record titled Physical Restraint Informed Consent, dated 2/23/2026, the record indicated the Assistant Director of Nursing (ADON) verified informed consent for the use of hand mitten restraints was obtained. The record did not indicate the physician had confirmed they provided material information (any facts, risks, or details that a reasonable person would need to make an informed, voluntary decision about whether to) to Resident 40's RP, RP 1.During an interview on 5/21/2026 at 10:39 a.m., with the ADON, the ADON stated he contacted Resident 40's RP, RP 1, to obtain consent for the use of hand mitten restraints. The ADON stated that his name in the section of the record titled Verification of Informed Consent, indicated he called RP 1. The ADON stated the physician did not routinely obtain informed consent. The ADON stated he explained the risks and benefits of the restraints to RP 1 himself. The ADON stated the purpose of obtaining informed consent for restraints was to explain the treatment to verify that the RP knew the risks and benefits of the proposed treatment. The ADON stated there were risks associated with physical restraint use, including reduced mobility, skin breakdown, and circulation concerns.During an interview on 5/22/2026 at 11:25 a.m., with the Director of Nursing (DON), the DON stated the physician was responsible for obtaining informed consent. The DON stated the licensed nurse's responsibility was to verify that the physician spoke with the RP and obtained the consent. The DON stated it was not within the nurse's scope to obtain informed consent.During a review of the facility's policy and procedure (P&P) titled Use of Restraints, revised 3/2023, the P&P indicated restraints were only to be used after obtaining consent from the resident and/or Representative [RP].During a review of the facility's P&P titled Informed Consent, undated, the P&P indicated the attending physician was responsible for disclosing the risks of the proposed treatment or procedure. The P&P indicated an Informed Consent Form shall be prepared and acknowledged by the attending physician that indicates that the attending physician has disclosed the appropriate information prior to obtaining informed consent.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an interdisciplinary team ([IDT] - team members from different disciplines who come together to discuss resident care) or a Bioethics committee (multidisciplinary group designed to address, analyze, and advise on complex ethical challenges) meeting was conducted prior to initiation of a psychotropic drug (Any drug that affects brain activities associated with mental process and behavior) for one of one sampled resident (Resident 2) who had a diagnosis of Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities).This deficient practice placed Resident 2 at risk for sustaining adverse effects (undesired effect of a drug) from psychotropic medication.Findings:During a review of Resident 2's Face Sheet, the Face Sheet indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included Alzheimer's Disease, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and major depressive disorder (MDD, a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 2's History and Physical (H&P), dated 2/7/2026, the H&P indicated Resident 2 was unable to make decisions due to severe major neurocognitive disorder (a medical condition characterized by a significant, persistent decline in cognitive function).During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 2/11/2026, the MDS indicated Resident 2's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 2 was dependent (helper does all of the effort) from staff with toileting hygiene, upper and lower body dressing, personal hygiene, and mobility.During a review of Resident 2's physician's order, dated 2/5/2026, the physician order indicated to administer Lexapro (drug used to treat depression) 20 milligrams (mg, metric unit of measurement) by mouth in the evening (5:00 p.m.) for depression manifested by persistent feelings of hopelessness and helplessness. Resident 2's physician's order, dated 4/23/2026, indicated to administer Seroquel (drug used to treat bipolar disorder) 50 mg by mouth at bedtime (9:00 p.m.) for bipolar disorder manifested by recurrent behavior fluctuations from depressed behaviors to manic behaviors.During a concurrent interview and record review on 5/21/2026 at 11:39 a.m. with Registered Nurse 5 (RN 5), Resident 2's Psychotherapeutic Informed Consent forms, dated 2/5/2026 and 4/23/2026, were reviewed. The consent form, dated 2/5/2026, indicated Resident 2 was receiving Lexapro 20 mg at night. The consent form, dated 4/23/2026, indicated Resident 2 was receiving Seroquel 50 mg at bedtime. The consent forms indicated the licensed nurse confirmed the resident or resident representative gave their consent to treatment with the psychotherapeutic drug. RN 5 stated the Psychotherapeutic Informed Consent was obtained by the physician from Resident 2. RN 5 stated the Psychotherapeutic Informed Consents were not valid because Resident 2 was unable to make decisions. RN 5 stated there were no prior IDT meetings to address and discuss Resident 2's use of psychotropic medications. RN 5 stated psychotropic medications had serious adverse effects that would put Resident 2 at risk for fall.During an interview on 5/21/2026 at 12:35 p.m., with the Social Service Director (SSD), the SSD stated Resident 2 should have been placed under the care of the IDT or the bioethics committee when the physician determined Resident 2 did not have the capacity to make medical decisions. The SSD stated there were no IDT or bioethics committee meetings prior to Resident 2's initiation of psychotropic medications. The SSD stated it was important to have an IDT meeting to determine if the psychotropic medications were appropriate to Resident 2.During a review of the facility's policy and procedure (P&P) titled, Lack of Capacity when Medical Interventions Requires Informed Consent, undated, the P&P indicated an IDT review of prescribed medical interventions would be provided when the resident lacked capacity and there was no person with legal authority to make health care decisions on behalf of the resident. The P&P indicated when (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident lacked capacity for informed consent and a psychoactive medication was ordered by the physician, a bioethics meeting would be held and would include the resident's primary physician, another physician, and the facility interdisciplinary team member.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 73) call light was within reach.This deficient practice of not having the call light within reach had the potential for Resident 73 not to be able to call for assistance. Findings:During a review of Resident 73's Face Sheet, the Face Sheet indicated Resident 73 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 73's diagnosis included epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures), stage 4 pressure ulcer (full thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), and intracerebral hemorrhage (a life-threatening type of hemorrhagic stroke where blood ruptures directly into the brain tissue).During a review of Resident 73's Minimum Data Sheet (MDS, a resident assessment tool), dated 3/29/2026, the MDS indicated Resident 73 was rarely able to understand and be understood by others. The MDS indicated Resident 73's cognition (ability to think and process) was severely impaired. The MDS indicated Resident 73 was dependent (helper does all the effort) on staff for activities of daily living such as toileting hygiene and personal hygiene, and mobility. The MDS indicated Resident 73 was always incontinent.During a review of Resident 73's care plan titled, Alteration in Elimination Patterns related to Bowel Always Incontinent, dated 2/8/2024, the care plan intervention indicated to keep call light within reach and encourage to use for assistance.During a concurrent observation and interview on 5/20/2026 at 12:16 p.m., with the Assistant Director of Nursing (ADON), Resident 73's call light was on the floor to the left side of her bed and not within reach. The ADON stated the call light was not within reach and the call light was on the wrong side of the bed due to Resident 73's left hand contracture. The ADON stated the call light should be on the right side of the bed so Resident 73 could call in case of an emergency or for assistance so the staff could render care.During a review of the facility's policy and procedure (P&P) titled, Call System, Resident, dated 3/2023, the P&P indicated residents were provided with a means to call staff for assistance through a communication system that directly call a staff member or a centralized workstation.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the belongings for one of five sampled residents (Resident 103) were inventoried and documented.This deficient practice of not keeping track of Resident 103's belongings had the potential to increase the risk of Resident 103 losing her personal items.Findings:During a review of Resident 103's Face Sheet, the Face Sheet indicated Resident 103 was originally admitted to the facility on [DATE] and readmitted [DATE]. Resident 103's diagnoses included peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs), chronic kidney disease (a disease characterized by progressive damage and loss of function in the kidneys), and polyneuropathy (a diffuse, bilateral disorder where multiple peripheral nerves are simultaneously damaged).During a review of Patient 103's History and Physical (H&P), dated 10/22/2025, the H&P indicated Resident 103 had the capacity to understand and make decisions.During a review of Resident 103's Minimum Data Sheet (MDS, a resident assessment tool), dated 4/28/2026, the MDS indicated Resident 103's cognition (ability to think and process) was intact. The MDS indicated Resident 103 was dependent (helper does all the effort) on staff for toileting hygiene, showering, and dressing.During an observation on 5/19/2026 at 11:02 a.m. in Resident 103's room, Resident 103 had an abundance (a large, plentiful quantity or an overflowing fullness of something) of personal belongings in her room.During an interview on 5/20/2026 at 9:34 a.m., in Resident 103's room, Resident 103 stated she had a lot of personal items in her room. Resident 103 stated she did not recall the last time her items were inventoried.During an interview on 5/21/2026 at 11:57 a.m., with Social Service Director (SSD), the SSD stated Resident 103 had a large number of personal items in her room. The SSD stated inventory was to be done upon admission and during Resident 103's stay at the facility. The SSD stated an inventory log was to be done to keep track of Resident 103's items and know the location of her belongings. The SSD stated not keeping track of Resident 103's belongings made Resident 103's room disorderly.During an interview on 5/21/2026 at 2:06 p.m., with Director of Nursing (DON), the DON stated staff were to document Resident 103's belongings when Resident 103 received personal items or something was brought by the family. The DON stated there was no documentation or tracking of Resident 103's items. The DON stated not keeping track of Resident 103's items placed Resident 103 at risk for losing her belongings.During a review of facility's policy and procedure (P&P) titled, Personal Property, dated 8/2022, the P&P indicated residents are encouraged to use personal belongings to maintain homelike environment. The P&P indicated the residents' personal belongings and clothing were to be inventoried, documented upon admission, and updated as necessary.

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Western Convalescent Hospital	2190 W Adams Blvd Los Angeles, CA 90018

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement their policy and procedure (P&P) titled Use of Restraints, revised 3/2023, for one of one sampled resident (Resident 40) when:Staff placed pillows under Resident 40's fitted bed sheet, on both sides of his body, without an order or consent.Staff failed to document that Resident 40 was assessed for potential physical injury or discomfort while hand mitten restraints (a padded, glove-like medical device used to enclose a patient's hands) were used.This deficient practice restricted Resident 40's movement within his bed and increased the potential for late identification of potential skin breakdown or circulatory issues. Findings: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 gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and encephalopathy (a broad term for any disease, damage, or malfunction that affects the brain's structure or function).During a review of Resident 40's History and Physical (H&P), dated 1/17/2026, the H&P indicated Resident 40 did not have the capacity to understand make decisions.During a review of Resident 40's Minimum Data Set (MDS, a resident assessment tool), dated 4/21/2026, the MDS indicated Resident 40 had severe cognitive impairment (a significant loss of intellectual and memory capacity that prevents independent living). The MDS indicated Resident 40 was dependent (helper does all of the effort) on staff for all activities of daily living (activities such as bathing, dressing and toileting a person performs daily) and mobility. The MDS indicated Resident 40 used limb restraints daily.During a review of Resident 40's physician order, dated 2/23/2026, the order indicated staff were to apply hand mitten restraints (a padded, glove-like medical device used to enclose a patient's hands) to both of Resident 40's hands. 1. During an observation on 5/19/2026 at 11:00 a.m. at Resident 40's bedside, Resident 40 was observed lying in bed with hand mitten restraints to both hands. Resident 40 was lying in the center of his bed, and rolled pillows were observed under the fitted bed sheet on both sides of the resident.During an interview on 5/21/2026 at 10:54 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the facility used bolster restraints, which were cushions placed under the fitted bed sheet to prevent the resident from exiting the bed. The ADON stated the bolster restraints required informed consent and a physician order. The ADON stated that placement of pillows under the fitted bed sheet mimicked the action of bolster restraints and restricted the resident's movement. The ADON stated Resident 40 did not have orders for bolster restraints and stated there should not have been anything under the fitted sheet to restrict his movement.2. During an observation, on 5/19/2026 at 11:00 a.m., at Resident 40's bedside, Resident 40 was observed with hand mitten restraints on both hands. During an observation on 5/20/2026 at 2:55 p.m., at Resident 40's bedside, Resident 40 was observed with hand mitten restraints on both hands. During an observation on 5/21/2026 at 10:11 a.m., at Resident 40's bedside, Resident 40 was observed with hand mitten restraints on both hands.During an interview on 5/21/2026 at 10:47 a.m., with the ADON, the ADON stated the licensed nurse was to check Resident 40's skin and circulation every shift. The ADON stated ongoing monitoring of the resident's skin and circulation while restraints were used was important for timely identification of any complications and prompt intervention. The ADON stated he could not locate any documentation that these assessments were completed while Resident 40 has been in restraints. During an interview on 5/22/2026 at 11:03 a.m., with the Director of Nursing (DON), the DON stated interventions to remove the hand mitten restraints and assess Resident 40's skin and circulation was ordered on 5/21/2026. The DON stated Resident 40 had been in hand mitten restraints since 12/2025. The DON stated this intervention was important to identify skin breakdown and circulation issues. The DON could not locate any documentation that these (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessments were completed while Resident 40 has been in restraints. During a review of the facility's policy and procedure (P&P) titled Use of Restraints, revised 3/2023, the P&P defined physical restraints as any manual method., material or equipment.adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts access to one's body. The P&P indicated practices that inappropriately utilize equipment to prevent resident mobility are considered restraints. The P&P indicated restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. The P&P indicated restraints were to be used in such a way as to not cause physical injury to the resident, and to ensure the least possible discomfort to the resident.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a written Notice of Proposed Transfer and Discharge Form was sent to local ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) for one of five sampled residents (Resident 51).This deficient practice had the potential to compromise Resident 51's due process rights related to transfer.Findings:During a review of Resident 51's Face Sheet, the Face Sheet indicated Resident 51 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 51's diagnoses included Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), atherosclerosis (a buildup of fats, cholesterol and other substances in and on the artery walls), and hypertension (HTN, high blood pressure).During a review of Resident 51's History and Physical (H&P), dated 1/6/2026, the H&P indicated Resident 51 had fluctuating capacity to understand and make decisions.During a review of Resident 51's Minimum Data Set (MDS, a resident assessment tool), dated 3/18/2026, the MDS indicated Resident 51's cognition (ability to think and process) was intact. The MDS indicated Resident 51 required setup assistance (helper assists only prior to or following the activity) from staff with oral hygiene, toileting hygiene, and personal hygiene and was independent from staff with mobility.During a review of Resident 51's Situation, Background, Assessment, and Recommendation (SBAR, a communication tool used by healthcare workers when there is a change of condition among the residents), dated 12/28/2025, the SBAR indicated Resident 51 had a change of condition of headache, redness of the cheeks, and swelling of the nose. The SBAR indicated Resident 51 was transferred to General Acute Care Hospital (GACH) on 12/28/2025.During a concurrent interview and record review on 5/21/2026 at 9:43 a.m., with Registered Nurse 3 (RN 3), Resident 51's Notice of Proposed Transfer and Discharge, dated 12/28/2025, was reviewed. There was no evidence of the fax confirmation that the Notice was sent to the Ombudsman. RN 3 stated Resident 51's Notice of Proposed Transfer and Discharge form was not faxed to the local ombudsman. RN 3 stated the written Notice of Proposed Transfer and Discharge Form should be completed within 24 hours of resident's transfer or discharge date and a copy should be sent to the resident or his family representative and to the local ombudsman office. RN 3 stated it was important to notify and send a copy of the Notice of Proposed Transfer and Discharge Form to the local ombudsman for tracking purposes, transparency, and to identify if the transfer or discharge was appropriate.During a review of the facility's policy and procedure (P&P) titled, Transfer or Discharge Notice, dated 3/2021, the P&P indicated a copy of the notice would be sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.

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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 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 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. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a care plan was developed for one of 23 sampled residents (Resident 40) when Resident 40 did not have a care plan in place for his as needed use of melatonin (an over the counter or prescription pill used to improve sleep issues).This deficient practice prevented staff from having resident-specific non-drug interventions to aid Resident 40's sleep and monitor the effectiveness of his of melatonin.Findings: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 metabolic encephalopathy (a general term for altered brain function or structure caused by an underlying systemic condition).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 on staff for all activities of daily living (activities such as bathing, dressing and toileting a person performs daily) and mobility. During a review of Resident 40's physician order, dated 1/14/2026, the order indicated to administer melatonin five (5) milligrams (mg, a unit of dose measurement) at bedtime as needed for sleep aid.During an interview on 5/21/2026 at 12:51 p.m. with the Director of Nursing (DON), the DON stated staff administered melatonin to assist Resident 40 to sleep, but there were also non-pharmacological interventions that staff could have attempted to aid Resident 40's sleep. The DON stated these interventions would be documented in a care plan. The DON stated Resident 40 did not have a care plan for his sleeping difficulties or use of melatonin, but he should. The DON stated the care plan would ensure staff monitored the effectiveness of Resident 40's melatonin use. The DON stated the care plan would also encourage staff to attempt non-drug interventions to aid Resident 40's sleep. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, revised 3/2023, the P&P indicated a comprehensive, person-centered care plan that met the resident's physical, psychosocial and functional needs was to be developed and implemented for each resident.

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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 ensure a physician order for gastrointestinal referral (formal request by a physician to send a patient to a gastroenterologist [a medical doctor who specializes in diagnosing, treating, and preventing disease of the digestive system] for testing and work-up) was completed for one of one sampled resident (Resident 98).This deficient practice had the potential to put Resident 98 at risk for worsened gastrointestinal symptoms and delayed diagnosis of underlying medical condition.Findings:During a review of Resident 98's Face Sheet, the Face Sheet indicated Resident 98 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 98's diagnoses included gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube placement, anemia (a condition where the body does not have enough healthy red blood cells), and Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 98's Minimum Data Set (MDS, a resident assessment tool), dated 4/15/2026, the MDS indicated Resident 98's cognition (ability to think and process) was intact. The MDS indicated Resident 98 was dependent (helper does all of the effort) on staff with toileting hygiene, upper and lower body dressing, and personal hygiene.During a review of Resident 98's physician order, dated 4/29/2026, the physician order indicated to follow-up on a gastrointestinal referral for possible colonoscopy (a medical procedure where a doctor uses a flexible tube with a tiny camera to examine the inside of your rectum and colon) for rectal ulcer (an open sore, wound, or lesion that forms in the lining of the rectum).During a concurrent interview and record review on 5/20/2026 at 1:32 p.m. with Registered Nurse 4 (RN 4), Resident 98's physician order was reviewed. RN 4 stated Resident 98 had a physician order for gastrointestinal referral. RN 4 stated Resident 98's gastrointestinal referral had not been completed. RN 4 stated Resident 98 did not have a scheduled gastrointestinal appointment. RN 4 stated she communicated Resident 98's physician order for gastrointestinal referral to the social service department because they were responsible for following up with insurance and scheduling an appointment. RN 4 stated it was important for Resident 98 to be seen by a gastroenterologist and get a colonoscopy to find out the cause of the rectal ulcer and to rule out rectal cancer (a disease in which abnormal cells grow uncontrollably in the rectum). RN 4 stated Resident 98 was a high risk for bleeding and the risk for not having a gastrointestinal consult referral in a timely manner would result in delay of care and treatment.During a concurrent interview and record review on 5/20/2026 at 1:45 p.m. with the Social Service Director (SSD), Resident 98's Progress Notes, dated 4/29/2026 to 5/20/2026, were reviewed. The SSD stated there was no documentation indicating the social service staff requested an authorization from Resident 98's insurance for gastrointestinal referral. The SSD stated it was important to always follow the resident's physician's order.During a review of the facility's policy and procedure (P&P) titled, Quality of Care, dated 12/10/2022, the P&P indicated it was the policy of the facility to ensure that each resident received and the facility provided the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care, in accordance with State and Federal Regulations.Cross Reference F745

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of five sampled residents (Resident 104 and Resident 120) received care in accordance with professional standards of practice when:1. Resident 104 was not monitored for 72 hours after a change of condition ([COC] -any sudden, clinically significant deviation from a patient's normal baseline in their physical, cognitive, behavioral, or functional health status).2. Resident 120's abnormal heart rate was not reported to the physician in a timely manner.These deficient practices had the potential for Resident 104's skin rash (a noticeable change in the color, texture, or appearance of your skin) to worsen due to not being monitored and delayed physician intervention for Resident 120. Findings: 1. During a review of Resident 104's Face Sheet, the Face Sheet indicated Resident 104 was admitted to the facility on [DATE]. Resident 104's diagnosis included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Patient 104's History and Physical (H&P), dated 2/18/2026, the H&P indicated Resident 104 did not have the capacity to understand and make decisions. During a review of Resident 104's Minimum Data Sheet (MDS, a resident assessment tool), dated 2/18/2026, the MDS indicated Resident 104's cognition (ability to think and process) was intact. The MDS indicated Resident 104 required partial /moderate assistance (helper does less than half the effort) on staff for toileting hygiene, showering, and putting on footwear. The MDS indicated Resident 104 had skin treatment applications for ointment (a smooth, semisolid, oil-based preparation applied topically to the skin) medications. During an observation on 5/19/2026 at 10:45 a.m. in Resident 104 room, Resident 104 had a scattered itchy skin rash. During a review of Resident 104's COC, dated 5/14/2026, the COC indicated a sudden onset generalized rash throughout the body. The COC indicated Resident 104 reported itching and discomfort. During a concurrent interview and record review on 5/21/2026 at 4:20 p.m. with the Director of Nursing (DON), Resident 104's COC, dated 5/14/2026 was reviewed. The COC indicated a sudden onset generalized rash throughout the body. The COC indicated Resident 104 reported itching and discomfort. The DON stated the protocol was to do a COC by the licensed staff. The DON stated the licensed nurses were to do an assessment and monitor Resident 104 skin every shift for 72 hours. During a concurrent interview and record review on 5/21/2026 at 4:30 p.m. with the DON, Resident 104's Licensed Notes, dated 5/14/2026, was reviewed. The Licensed Notes indicated Resident 104 was being monitored for generalized rash. The DON stated there were no Licensed Notes assessments for the skin rash on 5/16/2026. The DON stated 72-hour monitoring was not completed after the COC. The DON stated when the 72-hour monitoring was not done, staff would not know if her skin was improving or worsening. 2. During a review of Resident 120's Face Sheet, the Face Sheet indicated Resident 120 was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypotension (low blood pressure), heart disease, and anemia. During a review of Resident 120's H&P dated 2/14/2026, the H&P indicated Resident 120 did not have the capacity to understand and make decisions. During a review of Resident 120's MDS dated [DATE], the MDS indicated Resident 120 was never able to understand or be understood by others. The MDS indicated Resident 120's cognition was severely impaired. The MDS indicated Resident 120 was dependent (helper does all of the effort) on staff for all activities of daily living and mobility. During a review of Resident 120's physician order, dated 2/12/2026, the physician order indicated to administer Metoprolol Tartrate (medication used to treat high blood pressure by slowing the heart rate), oral tablet via G-Tube (a device that allows feedings to be administered directly to the stomach, common for people with swallowing problems), two times a day for hypertension (HTN, high blood pressure) and to hold if the systolic blood pressure (SBP, top number of blood pressure measurement) was less than 110 or heart rate (HR) was greater than 60. During a record review of Resident 120's Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 2/1/2026 – 2/28/2026, the MAR indicated Resident 120's medication Metoprolol Tartrate, scheduled for 2/21/2026 at 5:00 pm was not given due to orders to hold if HR was less than 60. During a record review of Resident 120's Licensed Nurses Note, dated 2/21/2026 at 11:08 p.m., the note indicated Resident 120's Pulse (HR) was 38 on 2/21/2026 at 4:43 p.m. The note indicated Resident 120's vital signs were within normal range (normal limits for HR are 60-100.) During a record review of Resident 120's COC dated 2/22/2026 at 1:10 a.m., the COC indicated Resident 120's HR was 36. The COC indicated the physician was notified and ordered Resident 120 to be transferred to nearest hospital emergency room. During a concurrent record review and interview on 5/22/2026 at 3:35 pm with LVN 2, Resident 120's MAR dated 2/1/2026 – 2/28/2026 was reviewed. LVN 2 stated a HR under 60 should be reported to the Registered Nurse (RN) Supervisor and the resident's physician. LVN 2 stated she did not find documentation for reporting Resident 120's HR of 38 and did not remember which supervisor she told. During a review of facility's policy and procedure (P&P) titled, Acute Condition Changes-Clinical Protocol, dated 3/2024, the P&P indicated the staff would monitor and document the resident/patient's progress and responses to treatment. During a review of facility's P&P titled, Change in a Resident's Condition or Status, undated, the P&P indicated the facility would promptly notify the attending physician of changes in the resident's medical condition.

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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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure interventions were carried out to prevent malnutrition for one of seven sampled residents (Resident 40) when the facility failed to carry out Resident 40's physician orders for checking prealbumin levels (a specific protein level used to assess acute changes in nutritional status, particularly protein-calorie malnutrition) and a thyroid panel (a group of blood tests used to evaluate how well the thyroid gland is working and to diagnose disorders like hypothyroidism [slowed metabolism] or hyperthyroidism [excessive thyroid hormone that can result in unexplained weight loss]) following Resident 40's 39 pound (lb., a unit of weight measurement) weight loss.These deficient practices resulted in a delay in care, creating the potential for Resident 40's weight loss to worsen and for delayed identification of the reason for Resident 40's weight loss.Findings: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 gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 40's Minimum Data Set (MDS, a resident assessment tool), dated 4/21/2026, the MDS indicated Resident 40 had severe cognitive impairment (a significant loss of intellectual and memory capacity that prevents independent living). The MDS indicated Resident 40 was dependent on staff for all activities of daily living (activities such as bathing, dressing and toileting a person performs daily) and mobility. During a review of Resident 40's Change of Condition (COC) Assessment, dated 7/18/2025, the assessment indicated Resident 40 had a 39 lb. weight loss in one (1) month. The assessment indicated Resident 40's physician was notified and ordered for laboratory collection of prealbumin levels and a thyroid panel.During an interview on 5/21/2026 at 12:40 p.m. with the Director of Nursing (DON), the DON stated the purpose of the thyroid panel was to identify if there were any thyroid hormone issues causing Resident 40's weight loss and stated the prealbumin levels would identify any malnutrition or protein needs. The DON stated that prealbumin levels were never drawn, and a thyroid panel was not collected until 10/7/2025. The DON stated the labs should have been drawn sooner to initiate a plan of care to prevent Resident 40 from sustaining further weight loss.During a review of the facility's policy and procedure (P&P) titled Weight Assessment and Intervention, revised 8/2025, the P&P indicated care planning for significant weight changes was a multidisciplinary effort. The P&P indicated treatment options to address the weight changes included obtaining laboratory studies.

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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 provide respiratory care consistent with professional standards of practice for one of five sampled residents (Resident 40) when:Resident 40 received oxygen therapy at five (5) liters per minute (L/min, a unit of flow rate) without humidification (a method for moistening inhaled oxygen).Respiratory Therapist (RT) 1 did not clarify Resident 40's oxygen order with the ordering provider.These deficient practices placed Resident 40 at risk for discomfort related to irritation of the airways and placed Resident 40 at risk of not receiving oxygen as intended by the physician.Findings: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 had severe cognitive impairment (a significant loss of intellectual and memory capacity that prevents independent living). The MDS indicated Resident 40 was dependent 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 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 every six hours.1. During an observation on 5/19/2026 at 11:04 a.m., Resident 40 was receiving oxygen through a T-piece. The humidifier bottle was dated 5/17/2026 and was empty.During an interview on 5/20/2026 at 3:07 p.m., with Respiratory Therapist (RT) 1, RT 1 stated the purpose of humidifying oxygen was to make the administration of oxygen more comfortable for the resident. RT 1 stated humidification also kept the resident's secretions (fluids produced by the respiratory tract, including mucus, saliva, and phlegm) loose and easier to cough up and/or suction. RT 1 stated the humidifier bottle should not be left empty because it could lead to irritation of the resident's airway.2. During an interview on 5/21/2026 at 11:23 a.m., with RT 2, RT 2 stated respiratory therapy orders, including orders for oxygen administration, were written by the physician. RT 2 stated she reviewed the physician orders at the start of her shift. RT 2 stated that if something in the physician order was not clear, she would contact the physician for clarification.During a concurrent interview and record review, on 5/21/2026 at 11:30 a.m., with RT 2, Resident 40's physician order, dated 1/15/2026, was reviewed. RT 2 stated the order indicated Resident 40 was to receive oxygen at five (5) L/min every six hours. RT 2 stated the order should have been clarified because the way it was currently written could be misinterpreted.During a review of the facility's policy and procedure (P&P) titled Oxygen Administration, undated, the P&P indicated oxygen administered at 3 L/min or more required a humidifier. The P&P indicated the oxygen humidifier should be changed weekly and as needed. During a review of the facility's P&P titled Physician Orders and Telephone Orders, dated 1/2004, the P&P indicated all [physician] orders must be specific and complete, with all necessary details to carry out the prescribed order without questions.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow the physician orders for oxygen administration for one of five sampled residents (Resident 104).This deficient practice caused Resident 9 not to receive the correct oxygen administration.Findings:During a review of Resident 104's Face Sheet, the Face Sheet indicated Resident 104 was admitted to the facility on [DATE]. Resident 104's diagnosis included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and anemia (a condition where the body does not have enough healthy red blood cells).During a review of Patient 104's History and Physical (H&P), dated 2/18/2026, the H&P indicated Resident 104 did not have the capacity to understand and make decisions.During a review of Resident 104's Minimum Data Sheet (MDS, a resident assessment tool), dated 2/18/2026, the MDS indicated Resident 104's cognition (ability to think and process) was intact. The MDS indicated Resident 104 required partial /moderate assistance (helper does less than half the effort) from staff for toileting hygiene, showering, and putting on footwear. The MDS indicated Resident 104 received oxygen therapy (the administration of supplemental oxygen to treat or prevent low blood oxygen levels).During an observation on 5/19/2026 at 10:45 a.m. in Resident 104's room, Resident 104 had a nasal cannula (a flexible tube with two small prongs inserted into the nostrils to deliver supplemental oxygen) attached to the concentrator (a medical device that pulls in room air, purifies it, and delivers concentrated oxygen) was set at five liters (L, a metric unit of volume used to measure liquids and gases).During a review of Resident 104's physician orders, dated 3/11/2026, the physician orders indicated to set Resident 104's oxygen therapy at three (3) L.During a review of Resident 104's care plan titled, Oxygen Resident was Receiving Oxygen Therapy, dated 3/31/2026, the care plan intervention indicated to check the rate of oxygen flow every shift.During a concurrent interview and record review on 5/20/2026 at 11:19 a.m. with Registered Nurse (RN 6), Resident 104's physician orders were reviewed. The physician orders indicated to set Resident 104's oxygen therapy at 3L. RN 6 indicated Resident 104's oxygen therapy should be set at 3L per physician orders.During a concurrent observation and interview on 5/20/2026 at 11:36 a.m. with Registered Nurse (RN) 6 in Resident 104's room, Resident 104 had a nasal cannula attached to the concentrator and was set at 4.5L. RN 6 stated the oxygen was set at 4.5L. RN 6 stated the oxygen setting was incorrect and should be set at 3L. RN 6 stated the purpose of oxygen therapy was to improve Resident 104's health condition and prevent unnecessary hospitalization.During a review of facility's policy and procedure (P&P) titled, Physician Orders and Telephone Orders, dated 1/2024, the P&P indicated all orders must be specific and complete. The P&P indicated each month physician orders are to be compared with the previous month's orders. The P&P indicated to review orders for accuracy, completeness, and clarity.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was provided with medically related social services (services provided by the facility's staff to assist residents in attaining or maintaining their mental and psychosocial health) for an outside gastrointestinal (formal request by a physician to send a patient to a gastroenterologist [a medical doctor who specializes in diagnosing, treating, and preventing disease of the digestive system] for testing and work-up) referral for one of one sampled resident (Resident 98).This deficient practice had the potential to put Resident 98 at risk for delayed medical interventions that would affect her quality of lifeFindings:During a review of Resident 98's Face Sheet, the Face Sheet indicated Resident 98 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 98's diagnoses included gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube placement, anemia (a condition where the body does not have enough healthy red blood cells), and Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 98's Minimum Data Set (MDS, a resident assessment tool), dated 4/15/2026, the MDS indicated Resident 98's cognition (ability to think and process) was intact. The MDS indicated Resident 98 was dependent (helper does all of the effort) on staff with toileting hygiene, upper and lower body dressing, and personal hygiene.During a review of Resident 98's physician order, dated 4/29/2026, the physician order indicated to follow-up on a gastrointestinal referral for possible colonoscopy (a medical procedure where a doctor uses a flexible tube with a tiny camera to examine the inside of your rectum and colon) for rectal ulcer (an open sore, wound, or lesion that forms in the lining of the rectum).During a concurrent interview and record review on 5/20/2026 at 1:32 p.m. with Registered Nurse 4 (RN 4), Resident 98's physician order was reviewed. RN 4 stated Resident 98 had a physician order for gastrointestinal referral. RN 4 stated Resident 98's gastrointestinal referral had not been completed. RN 4 stated Resident 98 did not have a scheduled gastrointestinal appointment. RN 4 stated she communicated Resident 98's physician order for gastrointestinal referral to the social service department because they were responsible for following up with insurance and scheduling an appointment. RN 4 stated it was important for Resident 98 to be seen by a gastroenterologist and get a colonoscopy to find out the cause of the rectal ulcer and to rule out rectal cancer (a disease in which abnormal cells grow uncontrollably in the rectum).During a concurrent interview and record review on 5/20/2026 at 1:45 p.m. with the Social Service Director (SSD), Resident 98's Progress Notes, dated 4/29/2026 to 5/20/2026, were reviewed. The SSD stated there was no documentation indicating the social service staff requested an authorization from Resident 98's insurance for gastrointestinal referral. The SSD stated it was the responsibility of the social service staff to refer residents who needed outside referral services to maintain the standard of care and improve resident's quality of life.During a review of the facility's policy and procedure (P&P) titled Social Services, dated 9/2021, the P&P indicated the facility would provide medically related social services to assure that each resident could attain or maintain their highest practicable physical, mental, or psychosocial well-being. The P&P indicated the social worker/social services staff were responsible for making referrals and obtaining needed services from outside entities.During a review of the facility's P&P titled Social Services Referrals, dated 12/2008, the P&P indicated social services would collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician. The P&P indicated the social services will document the referral in the resident's medical records.Cross Reference F658

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Ensure hydrocortisone (a mild topical corticosteroid used to temporarily relieve itching, redness, and swelling) 1 percent ([%] - a drug percentage expresses the active ingredient in grams per milliliter) medication cream was properly stored for one of one sampled resident (Resident 104). 2. Clarify a pharmacy label with unclear instruction for 1 of 5 sampled residents (Resident 103) when Resident 103's amlodipine bubble pack had a label indicated to take 1 tablet by mouth via G-tube (gastrostomy tube, a flexible medical device inserted directly through the abdomen into the stomach). This deficient practice of not storing the medication after usage had the potential for Resident 104 to unsafely use the medication and had a potential for medication error for Resident 103. Findings: a. During a review of Resident 104's Face Sheet, the Face Sheet indicated Resident 104 was admitted to the facility on [DATE]. Resident 104's diagnoses included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 104's History and Physical (H&P), dated 2/18/2026, the H&P indicated Resident 104 did not have the capacity to understand and make decisions. During a review of Resident 104's Minimum Data Sheet (MDS, a resident assessment tool), dated 2/18/2026, the MDS indicated Resident 104's cognition (ability to think and process) was intact. The MDS indicated Resident 104 required partial /moderate assistance (helper does less than half the effort) from staff for toileting hygiene, showering, and putting on footwear. The MDS indicated Resident 104 had skin treatment applications for ointment medications. During a concurrent observation and interview on 5/19/2026 at 10:45 a.m., in Resident 104's room, Resident 104 had hydrocortisone 1% cream on her bedside table. Resident 104 stated her skin had been itching and the nurse gave it to her for the itching. During a review of Resident 104's record, titled Self-Administration of Medication, dated 2/15/2026, the record indicated Resident 104 could not administer topical (any drug that is applied directly to a specific are of the body's surface) medications. During a review of Resident 104's physician order, dated 5/18/2026, the physician order indicated to administer hydrocortisone 1% cream and to apply to affected area topically every shift for pruritus (an uncomfortable, irritating sensation on the skin that creates an urge to scratch). During an interview on 5/20/2026 at 12:15 p.m. with Treatment Nurse (TN) 1, TN 1 stated Resident 104 had hydrocortisone 1% cream ordered. TN 1 stated Resident 104's skin was itchy and hydrocortisone was prescribed by the physician. TN 1 stated the hydrocortisone cream should not be left on the bedside table. TN 1 stated the medication should have been stored in the medication cart. TN 1 stated Resident 104 should not have access to the medication to prevent her from overusing the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication. b. During a review of Resident 103's Face Sheet, the Face Sheet indicated Resident 103 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 103's diagnoses included peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs) and dysphagia (difficulty swallowing). During a review of Resident 103's dietary evaluation, dated 11/4/2022, the evaluation indicated to discontinue the G-tube. During a review of Resident 103's physician order, dated 10/20/2025, the physician order indicated to administer amlodipine (a medication to treat high blood pressure) 1 tablet via G-tube daily. During a review of Resident 103's amlodipine bubble pack (packaging for medication that organize pills into individual, sealed compartments), the pharmacy label on the bubble pack indicated to take by mouth via G-tube. During an interview on 5/20/2026 at 4:45 p.m. with the director of nursing (DON), the DON stated Resident 103 did not have G-tube in place and the label should be specific to by mouth or via G-Tube. The DON stated the nurse failed to check the label for accuracy. During a review of the facility's policy and procedure (P&P) titled Storage of Medications, dated 1/2025, the P&P indicated medications and biologicals are stored safely, securely, and properly. The P&P indicated only licensed nurses and pharmacy personnel are allowed access to medications. The P&P indicated medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart. During a review of the facility's P&P titled Administering Medications, dated 2001, the P&P indicated the individual administering the medication would check the label three times to verify the right method (route) of administration before giving the medication.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 9) intravenous peripheral line (IV, a short, flexible catheter inserted into a small vein) dressing was changed every 72 hours to correlate with the documentation on the Medication Administration Records (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to the resident.This deficient practice of not accurately documenting the IV dressing changes had the potential to place Resident 9 at risk for infection at the insertion site.Findings:During a review of Resident 9's Face Sheet, the Face Sheet indicated Resident 9 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 9's diagnoses included osteomyelitis (inflammation of the bone or bone marrow, usually due to infection), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and chronic kidney disease (is the progressive, irreversible loss of kidney function.During a review of Patient 9's History and Physical (H&P), dated 5/14/2026, the H&P indicated Resident 9 did not have the capacity to understand and make decisions.During a review of Resident 9's Minimum Data Sheet (MDS, a resident assessment tool), dated 4/9/2026, the MDS indicated Resident 9's cognition (ability to think and process) was moderately impaired. The MDS indicated Resident 9 was dependent (helper does all the effort) on staff for toileting hygiene, showering, and dressing.During an observation on 5/19/2026 at 11:35 a.m. in Resident 9's room, Resident 9 had a right upper arm peripheral IV with dressing dated 5/13/2026.During a review of Resident 9's physician orders, dated 5/14/2026, the physician orders indicated peripheral site care was to be done every 72 hours.During a review of Resident 9's MAR, dated 5/14/2026, the MAR indicated peripheral site care was to be done every 72 hours. The MAR indicated site care was done on 5/14/2026 and 5/17/2026.During a concurrent picture observation and interview on 5/21/2026 at 2:30 p.m., with the Director of Nursing (DON), the DON looked at a picture of Resident 9's right upper arm peripheral IV with dressing dated 5/13/2026. The DON stated Resident 9 dressing was dated and labeled 5/13/2026. The DON stated the IV dressing should have a date of 5/17/2026.During concurrent interview and record review on 5/21/2026 at 2:32 p.m. with the DON, Resident 9's MAR, dated 5/14/2026, was reviewed. The MAR indicated peripheral site care was to be done every 72 hours. The DON stated site care means that the IV dressing should be changed every 72 hours. The DON stated the MAR indicated the dressing was changed on 5/14/2026 and 5/17/2026. The DON stated the dressing was to be dated after site care every 72 hours. The DON stated the IV dressing was not changed and was dated 5/13/2026. The DON stated the IV dressing date was a way to inform the licensed nurses the dressing was changed. The DON stated the dressing not being changed placed Resident 9 at risk for infection or infiltration (fluid leakage into the surrounding tissue).During the facility policy and procedure (P&P) titled, Peripheral Catheter Dressing Change, dated 3/2023, the P&P indicated licensed nurse was to remove old dressing and dispose old dressing. The P&P indicated the peripheral site dressing was to be labelled with date, time and nurse's initials.

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

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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 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure two of two of the trash dumpsters were closed and not overfilled.This deficient practice has the potential to harbor and feed pests.Findings:During a concurrent observation and interview on 5/19/2026 at 8:42 a.m. with Dietary Aide 1 (DA 1) outside of the facility, two of the trash dumpster lids was opened and one trash dumpster was overfilled with trash. DA 1 stated the trash dumpsters should be closed all the time. DA 1 stated the risk of having opened and overfilled trash dumpsters are that they can attract rodents and insects and provide a place for them to harbor and go inside the facility.During a review of the 2022 U.S. Food and Drug Administration Food Code, code number 5-501.116 Cleaning Receptacles, the code indicated outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents.During a review of the facility's policy and procedure (P&P) titled, Waste Control and Disposal, undated, the P&P indicated outside garbage bin should be kept closed at all times and surrounding area must be kept clean.