STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555255	A. Building B. Wing	11/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Los Angeles Doctors Hosp	4060 E. Whittier Blvd. Los Angeles, CA 90023

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on interview and records review the facility's staff failed to: 1. Ensure one out of two sampled residents (Resident 13) rights were not violated by not explaining medications that were given. This deficient practice had the potential of the resident lower the resident self-esteem. Findings: During a review of Resident 13's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 13 was admitted to the facility on [DATE]. Resident 13's diagnosed was dysfunctional uterine bleeding (a condition heavy or prolonged vaginal bleeding from the uterus). During a review of Resident 13's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 8/19/2024 the MDS indicated, Resident 13's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired. The MDS indicated Resident 13's had a gastronomy (a surgical procedure that creates an opening in the stomach to help with feeding and administering medication) for nutrition. The MDS indicated Resident 13's active diagnoses were respiratory failure (a condition when the lungs are unable to provide enough oxygen to the blood or remove carbon dioxide from the body) and anoxic brain injury (occurs when the brain is deprived of oxygen). During an observation on 11/9/2024 at 9:43 a.m. in Resident 13's room, Resident 13 was wiping her mouth with a towel to wipe away secretions (fluids produced by the glands that line the nose, mouth, and throat) after coughing. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/9/2024 at 9:55 a.m. in Resident 13's room, Licensed Vocational Nurse (LVN) 1, LVN 1 gave Resident 13's medications via gastrotomy tube and did not explain the medications to the resident. Resident 13 was alert and awake looking in the direction of LVN 2 while medications were being administered. During an interview on 11/10/2024 at 12:09 p.m. with Registered Nurse (RN) 2, RN 2 stated when giving medications the process is to introduce ourselves to the resident and explain to the resident what medications they are receiving. RN 2 state it was important to explain the medications so the resident will know the risk and benefits of the medication. RN 2 stated the medications were to be explained before giving to maintain dignity. RN 2 stated if the medications are not explained it takes away the residents right to refuse and it could make the resident feel uninformed. During an interview on 11/10/2024 at 1:04 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated during the mediation pass she had missed that step to explain the mediations to Resident 13 before administering. LVN 1 stated was important to explain the medications, so the resident knows what's going into their bodies. LVN 1 stated Resident 13 was alert and had the right to refuse the medications. LVN 1 stated not explaining the medications to the resident would take away her rights as a resident. During a review of the facility's policy and procedure (P&P) titled, Residents and Family Education, dated 2/2021, the P&P indicated the resident and family members will be given sufficient information to make decision. The P&P indicated to educate to improve outcomes by promoting healthy behavior and appropriately involving residents in their care, treatment, and service decision. The P&P indicated to educate on how to use medications safely and effectively. During a review of the facility's policy and procedure (P&P) titled, Residents Rights, dated 2/2021, the P&P indicated to ensure that the subacute will provide the necessary care and treatment of the residents within the boundaries of their rights. The P&P indicated residents will be treated with consideration, respect and full recognition of dignity and individuality, treatment, and care of personal needs. The P&P indicated the right of the resident to refuse treatment to the extent permitted by law.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on interview and record review the facility failed to: 1. Ensure one out of two sampled residents (Resident 12) had a revised care plan for outside food. This deficient practice of not revising the care plan for outside food had the potential to place Resident 12 at risk for aspiration (the act of breathing in a foreign object). Findings: During a review of Resident 12's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 12 was admitted to the facility on [DATE]. Resident 12's diagnosed was respiratory failure (a condition when the lungs are unable to get enough oxygen into the blood or remove carbon dioxide from the body). During a review of Resident 12's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 10/26/2024 the MDS indicated, Resident 12's cognition (ability to learn, reason, remember, understand, and make decisions) was moderate impairment. The MDS indicated Resident 12's nutritional approaches were to be mechanical altered diet (a diet that consist of food that are easy to swallow and chew). had a gastronomy (a surgical procedure that creates an opening in the stomach to help with feeding and administering medication) for nutrition. During an interview on 11/10/2024 at 9:17 a.m. with Resident 12, Resident 12 stated my family brings me food from home. Resident 12 stated his family has been bringing him food for the last few weeks. During a review of Resident12's Nutrition Care Plan, dated 10/26/2024, the Nutrition Care Plan Indicated Resident 12's problem had the potential for altered nutrition related to weight loss/gain and mechanically altered/therapeutic diet. The Nutrition Care Plan goals indicated Resident 12 would be free from signs and symptoms of aspiration. The Nutrition Care Plan indicated the approaches were to provide the diet as ordered. During a concurrent interview and record review on 11/10/2024 at 10:42 a.m. with Registered Nurse (RN) 1, Resident 12's Nutrition Care Plan, dated 10/26/2024 was reviewed. The Nutrition Care Plan Indicated Resident 12's problem had the potential for altered nutrition related to weight loss/gain and mechanically altered/therapeutic diet. The Nutrition Care Plan goals indicated Resident 12 will be free from signs and symptoms of aspiration. The Nutrition Care Plan indicated the approaches were to provide diet as ordered. RN 1 stated Resident 12 is on a regular diet with small size bites. RN 1 stated the care plan needed to be revised so the staff will know the resident is receiving food from home. RN 1 stated the process was to update the care plan after there was a change such as family bringing in food from home. RN 1 stated if the care plan is not revised it would increase the risk of the resident aspirating. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/10/2024 at 12:55 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 12's Nutrition Care Plan, dated 10/26/2024 was reviewed. The Nutrition Care Plan Indicated Resident 12's problem had the potential for altered nutrition related to weight loss/gain and mechanically altered/therapeutic diet. The Nutrition Care Plan goals indicated Resident 12 will be free from signs and symptoms of aspiration. LVN 2 stated the care plan is revised by the charge nurse. LVN 2 stated the revised care plan needed to be revised to adapt (to create a balance between a person and their environment) to the patient needs. During a review of the facility's policy and procedure (P&P) titled, Care Plan, Multidisciplinary, dated 8/2014, the P&P indicated to communicate information for continuity of care, to develop long and short-term goals for the patient, and to identify the problem needs, concerns of the patient. The P&P indicated care needs shall be prioritized when planning the patient's care including necessary to assure the patient's care that is left unaddressed are likely to become emergent or necessary to assure the safety of the patient. During a review of the facility's policy and procedure (P&P) titled, Interdisciplinary Team Conference (IDT), dated 2/2021, the P&P indicated the IDT will collaborate in developing the plan of care and assessment on an ongoing basis in response to resident's condition. The P&P indicated to develop, review, and update the resident's care plan of care. During a review of the facility's policy and procedure

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on observation, interview and record review, the facility failed to: 1. Ensure RNA services were performed daily for five out of six sampled residents (Resident 5, Resident 8, Resident 21, Resident 22 and Resident 23). This deficient practice had the potential to decline in functional mobility and contractures. Findings: a. During a review of Resident 5's face sheet, the face sheet indicated Resident 5 was admitted to the facility on [DATE]. The face sheet indicated Resident 5 had diagnoses that included chronic respiratory failure (a long-term condition that prevents the body from exchanging oxygen and carbon dioxide properly), hypocapnia (a decrease of carbon dioxide in the blood) and hypercapnia (a increase of carbon dioxide in the blood). During a review of the Resident's 5 Minimum Date Set (MDS- a federally mandated resident assessment tool), the MDS indicated Resident 5's cognitive skills were severely impaired. The MDS also indicated Resident 5 was dependent on staff member with toileting hygiene, showering and upper/lower body dressing. b. During a review of Resident 8's face sheet, the face sheet indicated Resident 8 was admitted to the facility on [DATE]. The face sheet indicated Resident 8 had diagnoses that included cellulitis (a bacterial infection that affects the deep layers of the skin and underlying tissues), multi-compartment hemorrhage (an intracranial hemorrhage that affects multiple compartments of the brain) and acute respiratory failure (results from inadequate gas exchange by the respiratory system). During a review of the Resident 8's Minimum Date Set (MDS- a federally mandated resident assessment tool), the MDS indicated Resident 8's cognitive skills were severely impaired. The MDS also indicated Resident 8 was dependent on staff member with toileting hygiene, showering and upper/lower body dressing. c. During a review of Resident 21's face sheet, the face sheet indicated Resident 21 was admitted to the facility on [DATE]. The face sheet indicated Resident 21 had diagnoses that included acute hypoxic respiratory failure (the lungs are not adequately exchanging oxygen into the bloodstream). During a review of the Resident 21's Minimum Date Set (MDS-?), the MDS indicated Resident 21's cognitive skills were severely impaired. The MDS also indicated Resident 21 was dependent on staff member with toileting hygiene, showering and upper/lower body dressing. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. During a review of Resident 22's face sheet, the face sheet indicated Resident 22 was admitted to the facility on [DATE]. The face sheet indicated Resident 22 had diagnoses that included pneumonia (an infection that inflames the air sacs in one or both lungs), seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), respiratory distress (a condition in which fluid collects in the lungs' air sacs, depriving organs of oxygen), and congestive heart failure (a serious condition that occurs when the heart can't pump enough blood to meet the body's needs). During a review of the Resident's 22 Minimum Date Set (MDS-?), the MDS indicated Resident 22's cognitive skills were severely impaired. The MDS also indicated Resident 22 was dependent on staff member with toileting hygiene, showering and upper/lower body dressing. e. During a review of Resident 23's face sheet, the face sheet indicated Resident 23 was admitted to the facility on [DATE] The face sheet indicated Resident 2 had diagnoses that included acute chronic respiratory failure (results from inadequate gas exchange by the respiratory system). During a review of the Resident's 23 Minimum Date Set (MDS-?), the MDS indicated Resident 23's cognitive skills were severely impaired. The MDS also indicated Resident 23 was dependent on staff member with toileting hygiene, showering and upper/lower body dressing. During a review of Resident 5's Restorative Nurse Assistant (RNA- assists the patient in performing tasks that restore or maintain physical function as directed by the established care plan) treatment record, dated October 2024, Resident 5's treatment record indicated to Apply bilateral hand rolls, right elbow and bilateral knee splints, 2 hours on, 2 hours off daily. The treatment record indicated treatment was completed 5 times a week instead of daily. During a review of Resident 8 and 21's RNA treatment record, dated October 2024, Resident 8's treatment record indicated to Apply bilateral PRAFOS, 2 hours on, 2 hours off daily. and Apply bilateral resting and splints 2 hours on, 2 hours off daily. The treatment record indicated treatment was completed 5 times a week instead of daily. During a review of Resident 22's RNA physician order, the physician order indicated, RNA to do PROM exercises to bilateral upper and lower extremities and AROM right upper extremities daily. There was no treatment record of RNA services for Resident 22. During a review of Resident 23's RNA treatment record, dated November 2024, indicated, Apply bilateral hand rolls, 2 hours on, 2 hours off daily and apply bilateral knee splints and bilateral PRAFO, 2 hours on, 2 hours off daily. During a concurrent interview and record review, on 11/10/2024 at 11:30 a.m., with the Director of Nursing (DON), the DON stated residents received RNA services five days a week. The DON stated all RNA services were to be followed per physician orders. The DON stated there were no RNA services on the weekends. The DON acknowledged Resident 5, Resident 8, Resident 21, Resident 22 and Resident 23's RNA physician order and stated all orders indicated RNA services were to be performed daily. The DON stated the risk of not providing RNA services per physician orders could result in wrist/foot drop and further contractures. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedures, titled Restorative Nursing Program (RNA), revised 8/2024, indicated, The RNA will carry out the treatment programs according to the written plan of care and documents daily in the Restorative Nursing Documentation record.

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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** 46144 Based on observation, interview, and record review the facility failed to: 1. Ensure one out of two sampled residents (Resident 12) had physician orders that were not updated for the diet plan. This deficient practice of not updating physician orders for Resident 12's diet had the potential to cause a delay in care. Findings: During a review of Resident 12's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 12 was admitted to the facility on [DATE]. Resident 12's diagnosed was respiratory failure (a condition when the lungs are unable to get enough oxygen into the blood or remove carbon dioxide from the body). During a review of Resident 12's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 10/26/2024 the MDS indicated, Resident 12's cognition (ability to learn, reason, remember, understand, and make decisions) was moderate impairment. The MDS indicated Resident 12's nutritional approaches were to be mechanical altered diet (a diet that consist of food that are easy to swallow and chew). had a gastronomy (a surgical procedure that creates an opening in the stomach to help with feeding and administering medication) for nutrition. During an observation on 11/9/2024 at 5:45 p.m. a regular soft and bite size diet with thin liquid from the kitchen was brought to Resident 12's room. During a review of Resident 12's Physician Orders, dated 11/6/2024, the Physician Orders indicated Resident 12 was to have enteral feeding (a method of delivering nutrition to the body through the digestive system) During a concurrent interview and record review on 11/10/2024 at 10:42 a.m. with Registered Nurse (RN) 1, Resident 12's Physician Orders, dated 11/6/2024, was reviewed. The Physician Orders indicated Resident 12 was to have enteral feeding (a method of delivering nutrition to the body through the digestive system) Jevity 1.5 (a liquid nutritional supplement that is used for tube feeding in patients) at 55 milliliters (a unit measuring length in the metric system) per hour via gastronomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). RN 1 stated the physician orders should have been changed to the regular diet with small bite size. RN 1 stated it was important to know what type of diet the resident is on to prevent the risk of choking and aspiration (the act of breathing in a foreign object). (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/10/2024 at 11:57 a.m. with Registered Nurse (RN) 2, Resident 12's Physician Orders, dated 11/6/2024, was reviewed. The Physician Orders indicated Resident 12 was to have enteral feeding (a method of delivering nutrition to the body through the digestive system) Jevity 1.5 at 55 milliliters per hour via gastronomy. RN 2 stated Resident 12 is on a regular soft with small bite size diet. RN 2 stated the night shift nurses were to reconciliate (a process of comparing a patient's current medications to their medical records and medication orders to identify and resolve discrepancies) the orders once a month. RN 2 stated the orders should have been transcribed and updated to reflect the regular soft diet. RN 2 stated it was important to have the correct physician orders, so the staff members know what diet Resident 12 is on. RN 2 stated not having the correct diet order could cause a delay in care. During a review of the facility's policy and procedure (P&P) titled, Order Clarification, dated 7/2023, the P&P indicated to describe standard procedure for clarification of orders that are incomplete, illegible, or unclear. The P&P indicated a clarification message will be placed in the patient profile documenting what type of clarification in the external comments section of the order. The P&P indicated clarification message will be discontinued when the order is clarified. During a review of the facility's policy and procedure (P&P) titled, Medication Reconciliation, dated 4/2023, the P&P indicated patients are at risk during transition of care (hand-offs) across settings, providers, or levels of care. The P&P indicated accurate and complete reconciliation of orders across the continuum of care is essential in the reduction of errors.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to: 1. Ensure laboratory test (a medical procedure that involves testing a sample of blood, urine, or other substance from the body) of phenobarbital level (a test that measures the amount of phenobarbital-a medicine used to treat seizure, in the blood) for the month of October 2024, was completed for one of one sampled resident (Resident 20). This deficient practice had the potential for Resident 20's to have abnormal values or drug toxicity (accumulation of an excessive amount of any medication in the bloodstream) that would result in delay of treatment and services. Findings: During a review of Resident 20's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 20 was admitted to the facility on [DATE]. The Face Sheet indicated Resident 20's diagnoses included chronic respiratory failure (a serious condition that makes it difficult to breathe on your own) with tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe to help a person breathe) and gastrostomy tube (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 20's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 7/7/2024, the MDS indicated, Resident 20's cognitive (ability to think and reason) skills for daily decision making was severely impaired. The MDS indicated, Resident 20 was dependent (helper does all of the effort) on staff with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 20's Physician Orders (a document containing active physician order), dated 11/10/2024, indicated Resident 20 had an active order of phenobarbital 97.2 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) in the morning and 129.6 mg at night for seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) prophylaxis (to prevent disease or the spread of illness). The Physician Orders also indicated, Resident 20 had an active order to monitor phenobarbital level every month. During a review of Resident 20's care plan titled, Potential for injury related to seizure disorder, dated 10/5/2024, the care plan indicated the goal will be free from falls and injury daily in the next 3 months. The care plan intervention included laboratory as ordered and medical doctor for abnormal results. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/10/2024 at 9:24 a.m., with the Director of Nursing (DON), Resident 20's clinical records were reviewed. The DON stated the laboratory test result of phenobarbital level for the month of October 2024 for Resident 20 as ordered by the physician was not available and completed. The DON stated there was no documentation indicating the facility staff communicated with the physician of Resident 20 that phenobarbital level for the month of October 2024 was reported and there was no documented evidence of follow-up of what happened with the phenobarbital level that should had been drawn. The DON stated the phenobarbital level blood test was important to manage Resident 20's seizure making sure he is getting the right dose and to avoid drug toxicity. During a review of the facility's policy and procedure (P&P) titled, Drug Therapy Monitoring, dated 4/2023, the P&P indicated, Drug therapy monitoring shall be an ongoing, prospective or concurrent process to assure effective, appropriate, and safe drug therapy and shall be a collaborative assessment by physicians, nurses, pharmacists, and other practitioners responsible for the patient. During a review of the facility's P&P titled, Physician's Orders, Acceptance and Implementation, dated 3/2018, the P&P indicated, Orders shall be processed in accordance with applicable local, state and federal law, hospital policies and other medical staff documents. During a review of the facility's P&P titled, Monitoring Medication Administration, dated 4/2023, the P&P indicated, Each patient's medication shall be monitored on an ongoing basis for the effectiveness and actual or potential adverse effects of toxicity.

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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** 46144 Based on observation, interview, and record review the facility failed to: 1. Ensure one out of two sampled residents (Resident 12) had accurate documentation to have food from home. This deficient practice of not accurately documenting food brought in by Resident 12's family and friends which had the potential for Resident 12 to aspirate (the act of inhaling food, liquids, or other material into the lungs). Findings: During an observation on 11/9/2024 at 5:45 p.m., Resident 12 refused to eat his meal. During a review of Resident 12's Admission Record ([Face Sheet] front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 12 was admitted to the facility on [DATE]. Resident 12's diagnosed was respiratory failure (a condition when the lungs are unable to get enough oxygen into the blood or remove carbon dioxide from the body). During a review of Resident 12's Minimum Data Set ([MDS] a federally mandated assessment tool), dated 10/26/2024 the MDS indicated, Resident 12's cognition (ability to learn, reason, remember, understand, and make decisions) was moderate impairment. The MDS indicated Resident 12's nutritional approaches were to be mechanical altered diet (a diet that consist of food that are easy to swallow and chew). had a gastronomy (a surgical procedure that creates an opening in the stomach to help with feeding and administering medication) for nutrition. During an interview on 11/10/2024 at 9:17 a.m. with Resident 12, Resident 12 stated my family brings me food from home. Resident 12 stated his family has been bringing him food for the last few weeks. During a concurrent interview and record review on 11/10/2024 at 9:25 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated the family for Resident 12 brought food from home. LVN 2 stated she had told the Charge Nurse about the family bringing in food. LVN 2 reviewed the progress notes (a crucial part of a patient's medical record and are used to document a patient's care and recovery) there were no documentation addressing family bringing food to Resident 12. LVN 2 stated there should have been a note written in the progress notes about the food brought in by family. LVN 2 stated it was important to document and keep track of what the resident is doing just in case Resident 12 had an allergic reaction and in case he was to choke. During an interview on 11/10/2024 at 11:14 a.m. with Registered Nurse (RN) 1, RN 1 stated the progress notes should have been updated when the family had brought food from home. RN 1 stated the progress notes should have explained to the family type of diet and education to the resident to prevent choking. RN 1 stated it was important to communicate to the next shift through the progress notes to make sure the staff is aware of the choking risk that outside food would pose. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555255	A. Building B. Wing	11/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Los Angeles Doctors Hosp	4060 E. Whittier Blvd. Los Angeles, CA 90023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P), Charting, Guidelines, dated 2/2021, the P&P indicated to provide for appropriate documentation in the health record. The P&P indicated all documentation will be completed as required for each shift. The P&P indicated all charting should be done as soon as possible after a given event. The P&P indicated document normal findings as well as abnormal findings as this shows that the resident was being assessed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555255	A. Building B. Wing	11/10/2024

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to: 1. Complete the Revised McGeer Criteria (minimum set of signs and symptoms which when met, indicate that a resident likely has an infection and that an antibiotic (a drug used to treat infections caused by bacteria) might be needed) for Infection Surveillance Checklist for two out of two sampled residents (Resident 17 and 20). This deficient practice had the potential to result in the development of multi-drug resistant organisms ([MDRO] - microorganisms, predominantly bacteria that are resistant to one or more classes of antimicrobial agents) from inappropriate antibiotic use. Findings: During a review of Resident 17's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 17 was admitted to the facility on [DATE]. Resident 17's diagnoses included pneumonia (an infection/inflammation in the lungs) and respiratory failure (a serious condition that makes it difficult to breathe on your own). During a review of Resident 17's Minimum Data Set ([MDS] - a federally mandated resident assessment tool), dated 10/30/2024, the MDS indicated, Resident 17's cognitive (ability to think and reason) skills for daily decision making was severely impaired. The MDS indicated, Resident 17 was dependent (helper does all of the effort) on staff with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 17's Physician Order, dated 10/9/2024, the Physician Order indicated, Resident 17 had an order to give erythromycin ethyl succinate (an antibiotic used to treat many different types of infection caused by bacteria) every 12 hours for 14 days for treatment of high gastric residual (the volume of fluid remaining in the stomach at a point in time during enteral nutrition feeding). During a review of Resident 20's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 20 was admitted to the facility on [DATE]. The Face Sheet indicated Resident 20's diagnoses included chronic respiratory failure (a serious condition that makes it difficult to breathe on your own) with tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe to help a person breathe) and gastrostomy tube (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 20's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 7/7/2024, the MDS indicated, Resident 20's cognitive (ability to think and reason) skills for daily decision making was severely impaired. The MDS indicated, Resident 20 was dependent (helper does all of the effort) on staff with oral hygiene, toileting hygiene, and personal hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555255	A. Building B. Wing	11/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Los Angeles Doctors Hosp	4060 E. Whittier Blvd. Los Angeles, CA 90023

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 20's Physician Orders (a document containing active physician order), dated 11/10/2024, indicated Resident 20 had an active order of Zosyn (a combination of two antibiotics used to treat many different infections caused by bacteria) 3.375 grams ([gm] - metric unit of measurement, used for medication dosage and/or amount) intravenously ([IV] into or within a vein) every 6 hours and vancomycin 1 gm IV every 8 hours for treatment of leukocytosis (a condition where there is an abnormally high number of white blood cells in the body). During a concurrent interview and record review on 11/9/2024 at 5:30 p.m., with the Infection Preventionist Nurse (IPN), Resident 17 and Resident 20's clinical records were reviewed. The IPN stated she did not complete and fill out Resident 17 and Resident 20's Revised McGeer Criteria for Infection Surveillance Checklist form within 3 days after the antibiotic was ordered. The IPN stated the Revised McGeer Criteria for Infection Surveillance Checklist form was a guide to determine if the resident meets the criteria for the use of antibiotic as prescribed by a physician. The IPN stated she could not validate Resident 17 and Resident 20's antibiotics were appropriate since she did not complete the Revised McGeer Criteria for Infection Surveillance Checklist form. The IPN stated one of her functions being in charge of the antibiotic stewardship (a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse event s associated with antibiotic use) was to review the antibiotic order, the duration and the laboratory results. During an interview on 11/9/2024 at 5:42 p.m., with the Director of Pharmacy (DOP), the DOP stated it was a standard of practice for all licensed nurses to complete the Revised Mcgeer Criteria for Infection Surveillance Checklist Form when the physician prescribed antibiotic for residents. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 9/2024, the P&P indicated, Facility wide surveillance will be performed to identify opportunities to prevent and/or reduce the rate in infection in our residents, employees and visitors. During a review of the facility's P&P titled, Antimicrobial Stewardship, dated 6/2023, the P&P indicated, To optimize safe and appropriate use of antibiotics, enhance clinical outcomes while minimizing unintended consequences of antimicrobial and reduce healthcare costs without adversely affecting quality of care. The P&P also indicated the antibiotic stewardship program implements at least two evidence-based guidelines to improve antibiotic use for the most common indications.