

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555255	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER East Los Angeles Doctors Hosp		STREET ADDRESS, CITY, STATE, ZIP CODE 4060 E. Whittier Blvd. Los Angeles, CA 90023	
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 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. Based on observation, interview, and record review, the facility failed to ensure the can opener was maintained in a sanitary manner in the kitchen. This deficient practice had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in two of two residents who received food from the kitchen. Findings: During the initial kitchen tour observation on 1/5/2026 at 8:30 a.m., a can opener attached to the food preparation table was observed to be blackened, covered with black stains and dried residue. The area surrounding the can opener blade and gear were heavily stained with dark, hardened food debris. During a concurrent observation and interview on 1/5/2026 at 8:40 a.m. in the kitchen, with the Dietary Supervisor (DS), the DS stated the can opener was dirty and had food stains attached to the can opener blade. The DS stated the can opener should be cleaned and kept in sanitary condition to prevent contamination and the growth of harmful bacteria. The DS stated failure to maintain the cleanliness of the can opener had the potential to cause foodborne illness, placing residents at risk of harm. During a review of the Food and Drug Administration (FDA) Food Code 2017, section 4-601.11 of the FDA Food Code indicated: (A) Equipment Food Contact Surfaces and utensils shall be clean to sight and touch. (B) Nonfood-Contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. During a review of the facility's policy and procedure (P&P) titled Infection Control- Equipment, revised 11/2019, the P&P indicated kitchen equipment would be cleaned after each use. During a review of the FDA Food Code 2022 titled, Can Openers section 4-202.15, the Food Code indicated, Once can openers become pitted or the surface in any way becomes uncleanable, they must be replaced because they can no longer be adequately cleaned and sanitized.		

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 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 prescribing provider obtained informed consent for the administration of psychotropic medication (drugs that alter brain chemistry to affect mood, thoughts, perceptions, and behavior) for three of three sampled residents (Residents 4, 14, and 5), and failed to renew the psychotropic informed consents every six months for one of three sampled residents (Resident 5). These deficient practices removed Residents 4, 14, and 5's responsible parties right to make an informed decision to consent to, or continue, administration of psychotropic medications. Findings: 1a. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on 3/11/ 2024. Resident 4's diagnoses included anoxic brain injury (when the brain is completely deprived of oxygen, causing brain cells to die) and convulsions (sudden, violent, irregular movement of a limb or of the body, caused by involuntary contraction of muscles and associated especially with brain disorders). During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 11/29/2025, the MDS indicated Resident 4 had severe cognitive impairment (ability to think and reason). The MDS indicated Resident 4 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and mobility while in and out of bed. During a review of Resident 4's physician order, dated 5/10/2025, the order indicated Resident 4 was to receive Zoloft (a medication used to treat depression) 50 milligrams (a unit of dose measurement) daily from 5/10/2025 to 5/26/2025. During a review of Resident 4's record titled Facility Verification of Informed Consent, dated 5/9/2025, the record indicated informed consent was obtained by Resident 4's family member (FM 1). The record indicated two nurses verified that informed consent was obtained. During a review of Resident 4's physician order, dated 5/26/2025, the order indicated Resident 4 was to receive Zoloft 100 milligrams from 5/10/2025 to 8/26/2025. During a review of Resident 4's record titled Facility Verification of Informed Consent, dated 5/25/2025, the record indicated informed consent was obtained by FM 1. The record indicated two nurses verified that informed consent was obtained. During a review of Resident 4's physician order, dated 8/27/2025, the order indicated Resident 4 was receiving Zoloft 100 milligrams starting 8/27/2025 through 2/5/2026. 1b. During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was admitted to the facility on [DATE]. Resident 14's diagnoses included encephalopathy (a broad term for any widespread brain disease or dysfunction, altering brain function) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 14 had severe cognitive impairment. The MDS indicated Resident 14 was dependent on staff for all ADLs and mobility while in and out of bed. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 14's physician order, dated 5/14/2025, the order indicated Resident 14 was to receive Zyprexa (an antipsychotic medication) 2.5 milligrams twice daily from 5/14/2025 to 6/21/2025. During a review of Resident 14's record titled Facility Verification of Informed Consent, dated 5/14/2025, the record indicated informed consent was obtained by Resident 14's family member (FM 2). The record indicated two nurses verified that informed consent was obtained. During a review of Resident 14's physician order, dated 6/21/2025, the order indicated Resident 14 was to receive Zyprexa (an antipsychotic medication) 5 milligrams twice daily from 6/21/2025 to 6/23/2025. During a review of Resident 14's record titled Facility Verification of Informed Consent, dated 6/21/2025, the record indicated informed consent was obtained by FM 2. The record indicated two nurses verified that informed consent was obtained. 1c. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE]. Resident 5's diagnoses included schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 had severe cognitive impairment. The MDS indicated Resident 5 was dependent on staff for all ADLs. During a review of Resident 5's physician order, dated 11/24/2024, the order indicated Resident 5 was to receive Zyprexa 10 milligrams daily from 11/24/2024 to 12/3/2024. During a review of Resident 5's record titled Facility Verification of Informed Consent, dated 11/23/2024, the record indicated informed consent was obtained by Resident 5's sister. The record indicated two nurses verified that informed consent was obtained. During a review of Resident 5's physician order, dated 1/19/2025, the order indicated Resident 5 was to receive Ativan (a medication to treat anxiety) 1 milligram every six hours as needed. During a review of Resident 5's record titled Facility Verification of Informed Consent, dated 1/19/2025, the record indicated informed consent was obtained by Resident 5's family member (FM 3). The record indicated two nurses verified that informed consent was obtained. During an interview on 1/6/2026 at 12:39 p.m., with Registered Nurse (RN) 2, RN 2 stated that licensed nursing staff were responsible for obtaining informed consent for psychotropic medications. RN 2 stated that once a new psychotropic medication order was received from the physician, the licensed nurse contacted the family or responsible party to obtain consent. RN 2 stated the licensed nurse stated the prescribing provider only spoke with the families or responsible parties if they had further questions about the medication after speaking to the licensed nurse. During an interview on 1/7/2026 at 8:10 a.m., with the Chief Nursing Office (CNO), the CNO stated the facility did not have a current policy for obtaining informed consent for psychotropic medications. The CNO stated the facility was currently using the All Facilities Letters (AFLs, letter issued by the California Department of Public Health (CDPH) to health facilities to inform them about important updates, requirements, and guidance). (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/2026 at 9:43 a.m., with the CNO, the CNO stated AFL 25-27 was the AFL the facility was to follow for obtaining informed consent for psychotropic medication. The CNO stated the facility's current process for obtaining informed consent was not in alignment with the current guidance. The CNO stated residents (or their responsible parties) had the right to refuse treatment and to be informed of the care received. The CNO stated it was not within the licensed nurse's scope of practice to obtain informed consent. 2. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE], with diagnoses included schizophrenia. During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognition was severely impaired. The MDS indicated Resident 5 received antipsychotic and antianxiety medication. During a review of Resident 5's Order, dated 1/19/2025, the Order indicated to give Ativan (an anti-anxiety medication) one (1) milligrams via feeding tube, every six hours, for agitation. During a review of Resident 5's Electronic Health Record (EHR) titled Order Inquiry, undated, the EHR indicated on 11/24/2024, Resident 5's attending physician prescribed Olanzapine (an antipsychotic medication [a medication that affects the mind, emotions, and behavior]) 10 milligrams, twice a day, for schizophrenia. During a concurrent interview and record review on 1/6/2026 at 3:08 p.m., with Registered Nurse (RN) 1, Resident 5's informed consents for the use of psychotropic medication, were reviewed. RN 1 stated Resident 5's informed consent for Ativan 1 milligram was obtained on 1/19/2025, one year prior. RN 1 stated Resident 5's informed consent for the use of Olanzapine 10 milligrams was obtained on 11/23/2024, 14 months prior. RN 1 stated the facility had not obtained updated informed consent within six months, as required. RN 1 stated resident's condition and goals of care may change over time, and that renewing informed consent for Ativan and Olanzapine was essential to ensure the resident and/or their responsible party (RP) continues to agree with the medication plan and understands the risks and benefits. RN 1 stated Resident 5 and their RP should have been given the opportunity to make an informed decision regarding the continuation of psychotropic medication treatment, as it was their right. During a review of the Health and Human Services Agency California Department of Public Health All Facilities Letter (AFL), dated 2/28/2024, the AFL indicated facilities were to obtain a resident's written informed consent for treatment using psychotherapeutic drugs, and consent renewal every six months.		

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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 observation, interview, and record review, the facility failed to elevate the head of bed (HOB) during the administration of enteral feeding (tube feeding, liquid nutrition delivered directly into the gastrointestinal tract via a soft tube), and perform daily behavioral monitoring for residents receiving psychotropic medications (drugs that alter brain chemistry to affect mood, thoughts, perceptions, and behavior), as indicated in the care plan, for five of 12 sampled residents (Residents 9, 13, 16, 4, and 14). These deficient practices placed Residents 9, 13, and 16 at risk for aspiration (the accidental inhalation of foreign material into the airways/lungs, causing issues like pneumonia [an infection/inflammation in the lungs]) and death. These deficient practices also placed Residents 4 and 14 at risk of not receiving adjustments to their psychotropic medication dosages if needed. Findings: During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was admitted to the facility on [DATE]. Resident 9's diagnoses included respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body), pneumonia (infection of the lungs), and presence of a gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food). During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool), dated 11/3/2025, the MDS indicated Resident 9 did not have cognitive impairments (ability to think and reason). The MDS indicated Resident 9 was fully dependent on staff for activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and mobility while in and out of bed. The MDS indicated Resident 9 required enteral feeding. During a review of Resident 9's physician orders, dated 1/22/2024, the orders indicated Resident 9 was to receive enteral feeding 22 hours a day. The orders indicated staff were to maintain Resident 9's HOB in a semi-Fowler's position (a nursing posture where a patient lies on their back with the head of the bed raised to a 30-45-degree angle) while the enteral feeding was being administered. During a review of Resident 9's care plan titled Tube Feeding, dated 11/3/2025, the care plan indicated Resident 9 received enteral feeding and was at risk for aspiration. The interventions indicated to elevate Resident 9's HOB to at least 30 to 45 degrees during enteral feeding administration. During an observation on 1/5/2026 at 9:48 a.m., at Resident 9's bedside, Resident 9 was observed receiving enteral feeding at a rate of 55 milliliters per hour. Resident 9's HOB was maintained at less than 30 degrees of elevation. During an observation on 1/6/2026 10:02 a.m., at Resident 9's bedside, Resident 9 was observed receiving enteral feeding at a rate of 55 milliliters per hour. Resident 9's HOB was maintained at less than 30 degrees of elevation. During an observation on 1/7/2026 at 10:50 a.m., at Resident 9's bedside, Resident 9 was observed receiving enteral feeding at a rate of 55 milliliters per hour. Resident 9's HOB was maintained at less than 30 degrees of elevation. 2. During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE]. Resident 13's diagnoses included respiratory failure, pneumonitis (inflammation of the lung tissue (alveoli) caused by inhaling irritants), and presence of a gastrostomy. During a review of Resident 13's MDS, dated [DATE], the MDS indicated Resident 13 was comatose. The MDS indicated Resident 13 was fully dependent on staff for ADLs and mobility while in and out of bed. The MDS indicated Resident 13 required enteral feeding. During a review of Resident 13's physician orders, dated 11/19/2025, the orders indicated Resident 13 was to receive enteral feeding 22 hours a day. The orders indicated staff were to maintain Resident 13's HOB in a semi-Fowler's position while enteral feeding was being administered. During a review of Resident 13's care plan titled Tube Feeding, dated 12/1/2025, the care plan indicated Resident 13 received enteral feeding and was at risk for aspiration. The interventions indicated to elevate Resident 13's HOB to at least 30 to 45 degrees during enteral feeding administration. During an observation on 1/5/2026 at 10:03 a.m., at Resident 13's bedside, Resident 13 was observed receiving enteral feeding (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at a rate of 65 milliliters per hour. Resident 13's HOB was maintained at less than 30 degrees of elevation. 3. During a review of Resident 16's admission Record, the admission Record indicated Resident 16 was admitted to the facility on [DATE]. Resident 16's diagnoses included respiratory failure, pneumonitis, and presence of a gastrostomy. During a review of Resident 16's MDS, dated [DATE], the MDS indicated Resident 16 was comatose. The MDS indicated Resident 16 was fully dependent on staff for ADLs and mobility while in and out of bed. The MDS indicated Resident 16 required enteral feeding. During a review of Resident 16's physician orders, dated 3/8/2024, the orders indicated Resident 16 was to receive enteral feeding 22 hours a day. The orders indicated staff were to maintain Resident 16's HOB in a semi-Fowler's position while enteral feeding was being administered. During a review of Resident 16's care plan titled Tube Feeding, dated 11/20/2025, the care plan indicated Resident 16 received enteral feeding and was at risk for aspiration. The interventions indicated to elevate Resident 16's HOB to at least 30 to 45 degrees during enteral feeding administration. During an observation on 1/5/2026 at 9:13 a.m., at Resident 16's bedside, Resident 16 was observed receiving enteral feeding at a rate of 55 milliliters per hour. Resident 16's HOB was maintained at less than 30 degrees of elevation. During an interview on 1/7/2026 at 11:04 a.m., with Registered Nurse (RN) 2, RN 2 stated the HOB should be maintained at a minimum elevation of 30 degrees to prevent aspiration. RN 2 stated aspiration prevented enteral feeding from accidentally entering the lungs and placing them at risk for lung infections. 4. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on 3/11/ 2024. Resident 4's diagnoses included anoxic brain injury (when the brain is completely deprived of oxygen, causing brain cells to die) and convulsions (sudden, violent, irregular movement of a limb or of the body, caused by involuntary contraction of muscles and associated especially with brain disorders). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had severe cognitive impairment. The MDS indicated Resident 4 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and mobility while in and out of bed. During a review of Resident 4's physician order, dated 5/26/2025, the order indicated Resident 4 was to receive Zoloft (an antidepressant) 100 milligrams (a unit of dose measurement) from 5/10/2025 to 8/26/2025. During a review of Resident 4's physician order, dated 8/27/2025, the order indicated Resident 4 was to receive Zoloft 100 milligrams starting 8/27/2025 through 2/5/2026. During a review of Resident 4's care plan titled Antidepressant, dated 11/28/2025, the care plan indicated Resident 4 was to receive Zoloft due to sad facial expressions and episodes of continuous crying. The interventions indicated to monitor Resident 4's behaviors and document the frequency every shift. During a review of Resident 4's record titled Psychotropic Medication Sheet and Notes, dated 4/2025, the record did not indicate Resident 4's behaviors were monitored during the night shift on 4/25/2025. During a review of Resident 4's record titled Psychotropic Medication Sheet and Notes, dated 7/2025, the record did not indicate Resident 4's behaviors were monitored during the night shifts on 7/20/2025 and 7/21/2025. During a review of Resident 4's record titled Psychotropic Medication Sheet and Notes, dated 8/2025, the record did not indicate Resident 4's behaviors were monitored during the night shifts on 8/21/2025 and 8/22/2025. During a review of Resident 4's record titled Psychotropic Medication Sheet and Notes, dated 11/2025, the record did not indicate Resident 4's behaviors were monitored during the night shift on 11/24/2025. 5. During a review of Resident 14's admission Record, the admission Record indicated Resident 14 was admitted to the facility on [DATE]. Resident 14's diagnoses included encephalopathy (a broad term for any widespread brain disease or dysfunction, altering brain function) and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 14 had severe cognitive impairment. The MDS indicated Resident 14 was dependent on staff for all ADLs and mobility while in and out of bed. During a review of Resident 14's physician order, dated 6/23/2025, the order indicated Resident 14 was to receive Zyprexa five (5) milligrams twice a day. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 14's physician order dated 10/14/2025, the order indicated Resident 14 was to receive Ativan (a medication used to treat anxiety) one (1) milligram every eight hours as needed for restlessness and agitation. During a review of Resident 14's care plan titled Antipsychotic Drug, dated 6/3/2025, the care plan indicated Resident 14 was receiving olanzapine (brand name Zyprexa, a medication used to treat schizoaffective disorder) due to agitation and aggressive behavior. The interventions indicated to monitor Resident 14's behaviors and document the frequency every shift. During a review of Resident 14's care plan titled Antianxiety, dated 12/3/2025, the care plan indicated Resident 14 was receiving Ativan due to restlessness and aggressive behavior. The interventions indicated to monitor those behaviors and document the frequency every shift. During a review of Resident 14's records titled Psychotropic Medication Sheet and Notes, dated 7/2025, the records did not indicate Resident 14's behaviors were monitored for the administration of olanzapine or Ativan administration during the morning shift on 7/29/2025. During a review of Resident 14's records titled Psychotropic Medication Sheet and Notes, dated 8/2025, the records did not indicate Resident 14's behaviors were monitored for the administration of olanzapine or Ativan during the night shift on 8/21/2025. During a review of Resident 14's records titled Psychotropic Medication Sheet and Notes, dated 10/2025, the records did not indicate Resident 14's behaviors were monitored for the administration of olanzapine or Ativan administration during the day shift on 10/28/2025. During an interview on 1/8/2026 at 9:55 a.m., with the Chief Nursing Officer (CNO), the CNO that care plan interventions indicating staff were to monitor behaviors every shift were to ensure the treatment was effective, including the dose of the medication. The CNO stated the care plan was to be followed. During a review of the facility's Registered Nurse job description, dated 1/2024, the job description indicated the registered nurses were to collect current symptoms and implement resident care plans.		

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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 the head of bed (HOB) was elevated for three of seven sampled residents (Residents 9, 13, and 16) during the administration of enteral feeding (liquid nutrition delivered directly into the gastrointestinal tract via a soft tube). This deficient practice placed Residents 9, 13, and 16 at risk for aspiration (the accidental inhalation of foreign material into the airways/lungs, causing issues like pneumonia [an infection/inflammation in the lungs]) and death. Findings: During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was admitted to the facility on [DATE]. Resident 9's diagnoses included respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body), pneumonia (infection of the lungs), and presence of a gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food). During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool), dated 11/3/2025, the MDS indicated Resident 9 did not have cognitive impairments (ability to think and reason). The MDS indicated Resident 9 was fully dependent on staff for activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and mobility while in and out of bed. The MDS indicated Resident 9 required enteral feeding. During a review of Resident 9's physician orders, dated 1/22/2024, the orders indicated Resident 9 was to receive enteral feeding 22 hours a day. The orders indicated staff were to maintain Resident 9's HOB in a semi-Fowler's position (a nursing posture where a patient lies on their back with the head of the bed raised to a 30-45-degree angle) while enteral feeding was being administered. During an observation on 1/5/2026 at 9:48 a.m., at Resident 9's bedside, Resident 9 was observed receiving enteral feeding at a rate of 55 milliliters per hour. Resident 9's HOB was maintained at less than 30 degrees of elevation. During an observation on 1/6/2026 10:02 a.m., at Resident 9's bedside, Resident 9 was observed receiving enteral feeding at a rate of 55 milliliters per hour. Resident 9's HOB was maintained at less than 30 degrees of elevation. During an observation on 1/7/2026 at 10:50 a.m., at Resident 9's bedside, Resident 9 was observed receiving enteral feeding at a rate of 55 milliliters per hour. Resident 9's HOB was maintained at less than 30 degrees of elevation. 2. During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE]. Resident 13's diagnoses included respiratory failure, pneumonitis (inflammation of the lung tissue [alveoli] caused by inhaling irritants), and presence of a gastrostomy. During a review of Resident 13's MDS, dated [DATE], the MDS indicated Resident 13 was comatose (in a state of deep and usually prolonged unconsciousness; unable to respond to external stimuli). The MDS indicated Resident 13 was fully dependent on staff for ADLs and mobility while in and out of bed. The MDS indicated Resident 13 required enteral feeding. During a review of Resident 13's physician orders, dated 11/19/2025, the orders indicated Resident 13 was to receive enteral feeding 22 hours a day. The orders indicated staff were to maintain Resident 13's HOB in a semi-Fowler's position while enteral feeding was being administered. During an observation on 1/5/2026 at 10:03 a.m., at Resident 13's bedside, Resident 13 was observed receiving enteral feeding at a rate of 65 milliliters per hour. Resident 13's HOB was maintained at less than 30 degrees of elevation. 3. During a review of Resident 16's admission Record, the admission Record indicated Resident 16 was admitted to the facility on [DATE]. Resident 16's diagnoses included respiratory failure, pneumonitis, and presence of a gastrostomy. During a review of Resident 16's MDS, dated [DATE], the MDS indicated Resident 16 was comatose. The MDS indicated Resident 16 was fully dependent on staff for ADLs and mobility while in and out of bed. The MDS indicated Resident 16 required enteral feeding. During a review of Resident 16's physician orders, dated 3/8/2024, the orders indicated Resident 16 was to receive enteral feeding 22 hours a day. The orders indicated staff were to maintain Resident 16's HOB in a semi-Fowler's position while enteral feeding was being administered. During an observation on 1/5/2026 at 9:13 a.m., at Resident 16's bedside, (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555255	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER East Los Angeles Doctors Hosp		STREET ADDRESS, CITY, STATE, ZIP CODE 4060 E. Whittier Blvd. Los Angeles, CA 90023	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 16 was observed receiving enteral feeding at a rate of 55 milliliters per hour. Resident 16's HOB was maintained at less than 30 degrees of elevation. During an interview on 1/7/2026 at 11:04 a.m., with Registered Nurse (RN) 2, RN 2 stated the HOB should be maintained at a minimum elevation of 30 degrees to prevent aspiration. RN 2 stated aspiration prevented enteral feeding from accidentally entering the lungs and placing them at risk for lung infections. During a review of the facility's policy and procedure (P&P) titled Feeding by Nasoenteric, Gastrostomy, or Jejunostomy Tube, dated 7/2024, the P&P indicated that for administration of enteral feeding the HOB must be elevated at least 30 degrees. The P&P further indicated that if the feeding was continuous, the HOB was to remain elevated for the duration of administration.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 maintain infection control measures by not ensuring the phlebotomist (health worker trained in drawing venous blood) donned (to put on) personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) prior to performing blood collection, and by not ensuring the phlebotomist did not place phlebotomy supplies on another resident's bedside dresser and disinfect after use for two of 12 sampled residents (Residents 4 and 6). These deficient practices placed Residents 4 and 6 at risk for cross contamination and increased the risk for spread of infection. Findings: 1. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was admitted to the facility on [DATE]. Resident 6's diagnoses included pneumonia (an infection/inflammation in the lungs), respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in your body) with tracheostomy (a hole your surgeon makes through your neck and into your windpipe to allow breathing), gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food), and gastrostomy infection. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 11/28/2025, the MDS indicated Resident 6 was comatose (in a state of deep and usually prolonged unconsciousness; unable to respond to external stimuli). The MDS indicated Resident 6 was dependent on staff for all mobility and movement. During an observation on 1/5/2026 at 10:37 a.m., at Resident 6's bedside, a phlebotomist was observed standing at Resident 6's bedside wearing a white lab coat and a pair of gloves. The phlebotomist's white lab coat was observed touching Resident 6's bed and bed linens. The phlebotomist used her gloved hands to move and reposition Resident 6's arm prior to opening the phlebotomy supplies. The empty wrappers were moved from Resident 6's bed and placed on Resident 6's roommate's (Resident 4) dresser. During an observation on 1/5/2026 at 10:40 a.m., at Resident 6's bedside, the phlebotomist completed Resident 6's blood sample collection. While wearing the same gloves, the phlebotomist collected the empty wrappers from Resident 4's bedside dresser and discarded them into the trash. The phlebotomist did not disinfect the surface of Resident 4's bedside dresser. During an observation on 1/5/2026 at 10:41 a.m., the phlebotomist exited Resident 6's room. During an interview on 1/6/2026 at 3:03 p.m., with the Infection Preventionist (IP), the IP stated enhanced barrier precautions (EBP, infection control measures that use gowns and gloves during direct, high-contact care) applied to all residents with indwelling medical devices, including Residents 4 and 6. The IP stated that the purpose of EBP was to prevent the spread of infections caused by multi-drug resistant organisms (MDROs, bacteria or other microbes that resist multiple antibiotics). The IP stated EBP required staff to wear gloves and single-use gowns when providing high contact resident care and stated the phlebotomist should have been wearing the required PPE. The IP also stated any supplies or materials that were in contact with one resident should be immediately discarded into the trash and should not touch anything belonging to another resident. The IP stated that Resident 4's bedside dresser should have been disinfected immediately to prevent cross-contamination and prevent infection. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on 3/11/ 2024. Resident 4's diagnoses included respiratory failure, and presence of a tracheostomy and gastrostomy. During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had severe cognitive impairment. The MDS indicated Resident 4 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and mobility while in and out of bed. During a review of the facility's policy and procedure (P&P) titled Infection Prevention and Control Program, revised 9/2025, the P&P indicated all employees were to support resident safety by adhering to all policies and procedures related to infection prevention. During a review of the facility's P&P titled Enhanced Barrier Precautions, dated 12/2025, the P&P indicated the purpose of (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the policy was to provide a safe environment and to prevent the spread of MDROs among the residents. The P&P indicated residents at high risk for acquiring MDROs included fully dependent residents and those with indwelling medical devices.		