STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555312	A. Building B. Wing	05/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Memorial Medical Ctr Dp	1720 Cesar E. Chavez Avenue Los Angeles, CA 90033

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on interview and record review, the facility failed to ensure three (3) of four (4) sampled Residents (Residents 4, 60, and 111) and/or the Residents' representatives were informed and provided written information regarding the right to formulate an advance directive (a written statement of a resident's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the resident be unable to communicate them to the doctor). This deficient practice had the potential for Residents 4, 60, and 111 and/or residents' representative to not know their rights and cause conflict in carrying out the Residents wishes for medical treatment and health care decisions. Findings: 1. A record review of Resident 4's Face Sheet (FS) indicated the resident was admitted to the facility on [DATE]. The FS indicated Family Member 1 was Resident 4's responsible party. A record review of Resident 4's History and Physical (H&P), dated 4/15/2024, indicated Resident 4 had diagnoses that included diabetes (elevated blood sugar), hypertension (elevated blood pressure) and osteomyelitis (inflammation of bone caused by infection). A record review of Resident 4's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 4/26/2024, indicated Resident 4's had an acute (severe sudden onset) change in mental status and was severely impaired with cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 4 needed maximal assistance (helper does more than half the effort) with oral and toilet hygiene, upper and lower body dressing, and sit to stand (ability to stand from sitting on a chair). A record review of Resident 4's Case Manager (CM)/Social Worker (SW) Screening Document, dated 4/16/024, completed by the Social Services Director (SSD), indicated Resident 4 did not have an Advance Directive (AD) and SW was unable to obtain a response if the resident wished to receive more AD information. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review of Resident 4's paper and electronic chart and interview with the Social Worker (SW) on 5/18/24 at 2:53 PM, the SW stated there was no documented evidence that Resident 4's representative was contacted and provided information on formulating an AD. SW stated if the resident was not able make decisions, then the facility should have inquired with the resident's representative. SW stated AD was important to know what the wishes of the Resident or their representatives were regarding care. During an interview with the Director of Nursing (DON) n 5/18/24 at 5:58 PM, the DON stated AD was a way to ensure resident's wishes were followed, in the event the resident becomes incapacitated (deprived of capacity or natural power, made incapable of or unfit for normal functioning) or in a emergency situation. A record review of the facility's Policy and Procedure, reviewed on 8/1/2009, indicated the facility will provide to each adult individual and emancipated minor (legal mechanism by which a minor before attaining the age of majority is freed from control by their parents or guardians), at the time of admission . written information describing: an individual's right under California statutes and court decisions to accept or refuse medical or surgical treatment even if the treatment is life-sustaining and to formulate and AD. The hospitals policies regarding these rights to make health care decisions and to formulate AD, and regarding the way such decisions and directives will be implemented in the hospital. A copy of the AD will be placed in the patients medical record. 40913 2. A review of Resident 60's Face Sheet, indicated the facility admitted the resident on 5/7/2024. A review of Resident 60's History and Physical (H&P) dated 5/6/2024, the H&P indicated Resident 60 had diagnoses that included sepsis (bloodstream infection) due to infected central venous catheter and end stage renal dialysis (ESRD, a medical condition in which a resident's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis [procedure to remove metabolic waste products or toxic substances from the bloodstream] or a kidney transplant to maintain life.) A review of Resident 60's MDS, dated [DATE], indicated the resident had an intact cognitive skills for daily decision making. The MDS indicated Resident 60 required moderate assistance (helper lifts, holds, supports trunk or limbs and provides less than half the effort) for bed mobility including rolling left and right, sit to lying, lying to sitting and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. During a concurrent record review and interview on 5/18/2024 at 2:14 PM, there was no advance directive in Resident 60's chart. The Director of Staff Development (DSD) stated there was no documentation that would indicate information was provided to the resident regarding formulating an advance directive or an inquiry was made if the resident had an advance directive. 3. A review of Resident 111's Face Sheet, indicated the facility admitted the resident on 5/11/2024. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 111's H&P dated 5/11/2024, the H&P indicated Resident 111 had diagnoses that included osteomyelitis (bone infection) of the right ankle, dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning.) The H&P indicated the resident was alert, demented, and bedbound. During a concurrent record review and interview on 5/18/2024 at 2:48 pm, DSD stated there was no documentation that would indicate information was provided to the resident regarding formulating an advance directive or an inquiry was made if the resident had an advance directive. The DSD stated it was important to provide information regarding formulating an advance directive or an inquiry was made if there was an advance directive in order to know the resident's wishes in the event of an emergency.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 40913 Based on observation, interview, and record review, the facility failed to prevent the development of a pressure ulcer (refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) for one of one sampled resident (Resident 60) by leaving the resident in chair without a pressure relieving device for five hours and 30 minutes in accordance with the facility policy. This deficient practice had the potential for Resident 60 to develop pressure ulcer. Findings: A review of Resident 60's Face sheet, indicated the facility admitted the resident on 5/7/2024. A review of Resident 60's History and Physical (H&P), dated 5/6/2024, indicated Resident 60 had diagnoses that included sepsis (bloodstream infection) due to infected central venous catheter and end stage renal dialysis (ESRD, a medical condition in which a resident's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis [procedure to remove metabolic waste products or toxic substances from the bloodstream] or a kidney transplant to maintain life.) A review of Resident 60's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/13/2024, indicated the resident had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 60 required moderate assistance (helper lifts, holds, supports trunk or limbs and provides less than half the effort) for bed mobility including rolling left and right, sit to lying, lying to sitting and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. The MDS indicated Resident 60 did not have pressure ulcer/injuries. The MDS indicated Resident 60 was at risk of developing pressure ulcer/injuries. During multiple observations on 5/19/2024, Resident 60 was sitting on a regular chair at the bedside. At 9:10 AM, Resident 60 was sitting on the chair. At 9:33 AM, Resident 60 was sitting on the chair. At 9:56 AM, Resident 60 was sitting on the chair. At 10:25 AM, Resident 60 was sitting on the chair. At 10:44 AM, Resident 60 was sitting on the chair. At 10:54 AM, Resident 60 was sitting on the chair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:23 AM, Resident 60 was sitting on the chair. At 12:00 PM, Resident 60 was sitting on the chair. At 12:25 PM, Resident 60 was sitting on the chair, eating lunch. At 1:15 PM, Resident 60 was sitting on the chair. At 2:40 PM, Resident 60 was sitting on the chair. During an interview on 5/19/2024 at 2:41 PM, Certified Nursing Assistant 1 (CNA 1) CNA 1 stated Resident 60 had been sitting on the chair since around 9 am. CNA 1 stated Resident 60 needed assistance to stand up from the chair. During a concurrent observation and interview on 5/19/2024 at 2:50 PM, Resident 60 was assisted by CNA 1 to stand up from the chair, after sitting on the chair for almost five hours and 30 minutes. Resident 60 was not steady when he got up and needed to be held by CNA 1, there was a towel under the chair where Resident 60 was sitting on. RN 1 stated there was brown discoloration on Resident 60's sacrococcyx (pertaining to both the triangular-shaped bone at the bottom of the spine and the tailbone) area. Registered Nurse 1 (RN 1) stated the assigned CNA did not inform RN 1 that Resident 60 was sitting on the chair all day. RN 1 stated there was no pressure relieving device on the chair and as prevention, they need to put pressure relieving device on the chair. During a concurrent review of Resident 60's Care Plan and interview on 5/19/2024 at 3:00 PM, the DSD stated there was no care plan developed regarding Resident 60's risk for pressure ulcer development due to Resident 60's preference to stay on the chair all day. A review of Resident 60's care plan on Activities of Daily Living (ADL)/Mobility dated 5/7/2024, indicated Resident 60 required extensive assistance with ADLs. The care plan indicated staff interventions included were to provide assistance as needed with ADLs and to provide assistance with transfers out of bed daily. A review of the facility's Policy and Procedure, Pressure Injury or Skin/Wound Conditions, Assessment, Prevention and Management, dated 11/15/2022, indicated pressure injury prevention involves identifying patients at risk, implementing prevention strategies for all patients identified as being at risk. If appropriate, offload bony prominence and utilize redistribution devices and protective dressings in high risk patients. Unless contraindicated, reposition the patient at least every 2 hours if they are unable to reposition themselves. This can be accomplished through but not limited to repositioning in the bed, bed to chair, chair to bed, sit to stand.

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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. 40913 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 111) was free from accident hazards in accordance with the facility policy when Resident 111's Family Member 1 (FM1), who was not provided training on how to assist resident with meals was observed giving the resident a drink through a straw while the resident's head of bed was flat. This deficient practice had the potential for Resident 111 to choke (have severe difficulty in breathing because of a constricted or obstructed throat or a lack of air) or aspirate (occurs when contents such as food, drink, saliva or vomit enters the lungs). Findings: A review of Resident 111's Face sheet, indicated the facility admitted the resident on 5/11/2024. A review of Resident 111's History and Physical (H&P), dated 5/11/2024, the H&P indicated Resident 111 had diagnoses that included osteomyelitis (bone infection) of the right ankle and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning.) During an observation on 5/19/2024 at 12:23 PM, Registered Nurse 1 (RN 1) left Resident 111's bed after checking Resident 111's blood sugar. Resident 111's Family Member 1 (FM 1) gave a drink to Resident 111 through a straw while the head of the bed was flat. During an interview on 5/19/2024 at 12:35 PM, FM 1 stated he assisted Resident 111 with lunch yesterday. During an interview on 5/19/2024 at 4:24 PM, the Director of Nursing (DON) stated the head of the bed needed to be up during meals. The DON stated the family needs to be provided education first prior to being allowed to assist resident with meals to ensure safety. During a concurrent record review and interview on 5/19/2024 at 4:31 PM, the Director of Staff Development stated there was no documentation that FM 1 had been provided education regarding assisting with meals. The DSD stated the family who would assist the resident with meals should be provided with education and supervision to keep the residents safe from aspiration. During a review of Resident 111's Care Plan titled Aspiration Risk initiated on 5/11/2024, indicated to assist keep resident's to elevate head of bed elevated during meal times or feeding times. A review of the facility's Policy and Procedure (P&P) titled, Feeding: Assistance with Meals, dated 4/21/2022, indicated it is the policy of the facility that each resident receives three meals each day and receives assistance per individual resident need. The P&P indicated to ensure that the resident is in upright, sitting position.

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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. 38108 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary conditions were maintained in the kitchen as indicated on the facility policy when: 1. Dietary Aid 1 (DA 1) and Dietary Aid 2 (DA 2), observed with a beard, did not have a beard cover, while in the kitchen food preparation area. 2. An opened bottle of browning and seasoning sauce and a 60 ounce (oz, unit of mass, weight or volume) container of crushed pepper was observed unlabeled and undated. These deficient practices had the potential to result in pathogen (germ) exposure to residents, which could place the residents at risk for developing foodborne illness (food poisoning with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever) which could lead to other serious medical complications and hospitalization . Findings: 1. During an observation in the facility kitchen, on 5/19/2024 at 11:44 AM, Dietary Cook 2 (DA 2), who had visible beard, was observed scooping rice from one tray to another. DA 2 did not have a beard cover on. During an observation in the facility kitchen of the food assembly train tray line that served food to the residents, on 5/19/2024 at 11:45 AM, Dietary Cook 1 was observed with a visible beard. DA 1 was did not have a beard cover on. During an observation and concurrent interview with the Director of Dietary Services (DDS), on 5/19/2024 at 11:46 AM, DDS stated kitchen staff needed to wear a beard net if they had a beard longer than a quarter of an inch long. DDS stated it was important to wear a beard net because food or debris can be entrapped in the beard and had the possibility to fall into the resident's food. A review of the facility's Policy and Procedure titled, Employee Handwashing and Infection Prevention, reviewed on 5/18/2021, indicated to provide guidelines for employee hygiene specific to food preparation and service. Clothing and Grooming: food employees shall wear hair constraints which cover and contain head and facial hair such as hats, hair covering or nets, beard restraints, and clothing that covers and contains body hair. Hair constraints will be designed and worn to effectively keep hair from containing exposed food . 2. During an initial tour of the kitchen, with the Dietary Supervisor (DS), on 5/17/2024 at 7:38 PM, with the Dietary Supervisor (DS), an opened bottle of browning and seasoning sauce and a 60 oz container of crushed pepper were observed unlabeled and undated. DS stated any seasoning should be labeled with an opened and used by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Facility Registered Dietician (RD), on 5/19/2024 at 2:58 PM, the RD stated it was critical to label all foods with the used by date and the type of food to ensure quality and safety for the residents. A record review of the facility's Policy and Procedure titled, Food Storage, reviewed on 10/18/2022, indicated the hospital stores food and nutrition products using proper sanitation, temperature, light, moisture, ventilation, and security. All stored foods must be properly labeled and dated with product name, date product opened or prepared date, and use by date.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on interview and record review, the facility failed to offer five (5) of 5 sampled residents (Residents 4, 60, 61, 62, and 110) the Covid-19 (a respiratory viral infection that affects primarily the lungs and result in cough and difficulty breathing) vaccine (substance used to stimulate immunity to particular infectious disease) and failed to provide a documented evidence that the resident or their the resident's responsible party (RP) were provided education regarding the benefits and potential risks associated with COVID-19 vaccine. This deficient practice had the potential to expose the residents of the facility to Covid-19 infection. Findings: 1. A record review of Resident 4's Face Sheet, indicated the resident was admitted to the facility on [DATE] with a diagnosis of right foot osteomyelitis (inflammation of bone caused by infection). A record review of Resident 4's History and Physical (H&P), dated 4/15/2024, indicated Resident 4 had diagnoses that included diabetes (elevated blood sugar), hypertension (elevated blood pressure) and osteomyelitis (inflammation of bone caused by infection). A record review of Resident 4's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 4/26/2024, indicated Resident 4's had an acute (severe sudden onset) change in mental status and was severely impaired with cognitive skills for daily decision making. The MDS indicated Resident 4 needed maximal assistance (helper does more than half the effort) with oral and toilet hygiene, upper and lower body dressing, and sit to stand (ability to stand from sitting on a chair). 2. A review of Resident 60's Face Sheet, indicated the resident was admitted on [DATE]. A review of Resident 60's H&P, dated 5/6/2024, indicated Resident 60 had diagnoses that included sepsis (bloodstream infection) due to infected central venous catheter and end stage renal dialysis (ESRD, a medical condition in which a resident's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis [procedure to remove metabolic waste products or toxic substances from the bloodstream] or a kidney transplant to maintain life). A review of Resident 60's MDS, dated [DATE], indicated Resident 60 had intact cognitive skills for daily decision making and needed moderate assistance (helper provided less than half the effort) for bed mobility, sit to lying, and lying to sitting. 3. A record review of Resident 61's Face Sheet, indicated the resident was admitted to the facility on [DATE] with a diagnosis of right-side weakness. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 61's H&P, dated 5/9/2024, indicated Resident 61 had diagnoses that included diabetes (elevated blood sugar), hypertension (elevated blood pressure), and stroke (a loss of blood flow to part of the brain, which damages brain tissue). 4. A record review of Resident 62's Face Sheet, indicated Resident 62 was admitted to the facility on [DATE] with the diagnosis of dislocated left shoulder arthroplasty (joint replacement). A record review of Resident 62 H&P, dated 5/2/2024, indicated Resident 62 had diagnoses that included atrial fibrillation (irregular heartbeats), hypertension (elevated blood pressure) and impaired mobility. A record review of Resident 62's MDS, dated [DATE], indicated Resident 62 had intact cognitive skills for daily decision making, had clear speech, and was able to understand and be understood. The MDS indicated Resident 62 needed partial to moderate assistance (helper does less than half the effort) with dressing, personal hygiene, laying to sitting position and transfers. 5. A record review of Resident 110's Physician's Face Sheet, indicated the resident was admitted to the facility on [DATE] with the diagnosis of complicated urinary tract infection (UTI, an infection in any part of the urinary system, the kidneys, bladder, or urethra). A record review of Resident 110's H&P, dated 4/21/2024, indicated Resident 110 had diagnoses that included diabetes (elevated blood sugar), cirrhosis (liver damage), and morbid obesity (severely overweight). A record review of Resident 110's MDS, dated [DATE], indicated Resident 110 had intact cognitive skills for daily decision making, had clear speech, and was able to understand and be understood. During a concurrent record review of Residents 4, 60, 61, 62, and 110 clinical record with the Infection Control Preventionist (ICP) on 5/19/24 at 10:10 AM, the IP stated was unable to locate any documentation to indicate that vaccine or the residents' boosters were offered. IP stated residents should have been offered Covid-19 vaccines and their boosters upon admission. IP stated it was important to offer vaccinations and their boosters for the resident's overall health. During an interview with the Director of Risk Management and Infection Control (DRMIC) on 5/19/24 at 12:40 PM, the DRMIC stated there were no documentation to indicate if the residents were offered, have agreed or declined to take the Covid-19 vaccine or booster shots. The DRMIC stated Residents 4, 60, 61, 62, and 110 did not have a COVID-19 Vaccination Acknowledgement Form or Vaccination Log. The DRMIC stated it was important to offer the Covid-19 vaccine to residents, and to provide education to keep them safe. The DRMIC stated the entire community needed to be informed to ensure safety. The DRMIC stated documentation of the COVID-19 vaccine in the resident's medical record was important to ensure acknowledgement, consent was obtained, and to ensure education and continuity of care. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the facility's Policy and Procedure titled, Procedural Guidelines for Administration of Pneumococcal, Influenza Vaccine and COVID-19- Skilled Nursing Facility (SNF), dated 4/19/2022, indicated to ensure a process for vaccination for influenza, pneumococcal pneumonia, and COVID-19 in the logn-term care setting. All residents will be provided with vaccination information upon admission. Residents will be vaccinated as appropriate. Vaccine administration will be recorded in the resident's medical record. COVID-19 vaccinations: upon admission the resident will be screened by licensed nursing staff for COVID-19 vaccination status and risk for acquiring highly contagious mild to severe COVID-19 infection and death. If the resident has not received the COVID-19 vaccination or if the resident meets the criteria for the second dose and booster dose of the COVID-19 vaccination, utilize the COVID-19 vaccination Scope of Practice to administer the vaccine. Document vaccine administration per facility process and standards - medical records, documentation, and vaccination logs.