STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555397	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of Los Angeles	340 South Alvarado Street Los Angeles, CA 90057

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36395 Based on observation, interview, and record review the facility failed to ensure residents are given their right to privacy for one of two sampled residents (Resident 1). Resident 1 who had an indwelling catheter (a hollow tube left implanted in the bladder [organ that stores urine] to promote urine drainage), the facility failed to provide a privacy cover for the indwelling catheter drainage bag. This deficient practice resulted in failing to provide Resident 1 the right for personal privacy and dignity. During a review of the Admission Record indicated the facility admitted Resident 1 on 8/29/18 and readmitted on [DATE] with diagnoses including chronic respiratory failure (not enough oxygen passes in the breathing organs to the blood), obstructive and reflux uropathy (hindrance of normal urine flow) and retention of urine (inability to empty all the urine from the bladder. During a review of the Minimum Data Set (MDS, standardized care and health screening tool) dated 6/16/24 indicated Resident 1 had severely impaired cognitive skills for daily decision making. Resident 1 was dependent (helper does all the effort) with oral hygiene, toileting hygiene, shower/bathe, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 1 had an indwelling catheter. During observation on 7/1/24 at 7:38 a.m., Resident 1 was observed lying in bed with the indwelling catheter drainage bag hanging on the side of the bed. The drainage bag had no privacy bag. During an interview on 7/1/24 at 8:31 a.m., licensed vocational nurse (LVN) 1 stated Resident 1 does not need the privacy bag for the indwelling catheter because Resident 1 does not leave her room. During an interview on 7/1/24 at 8:51 a.m., LVN 2 stated Resident 1 needed the privacy bag for the indwelling catheter to provide privacy and dignity to Resident 1. A review of the facility's policy titled Urinary Catheter Care reviewed on 2/21/24 indicated the urinary drainage bags should be placed in a privacy bag to preserve resident dignity. A review of the facility's Policy titled Dignity and Respect reviewed on 2/21/24 indicated the facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 36395 Based on observation, interview, and record review the facility failed to ensure the care plan was implemented and the effectiveness of the interventions were reviewed for one of two sampled residents (Resident 1). For Resident 1, the facility failed to: 1. Review the effectiveness of the care plan interventions and revise the care plan each time Resident 1's nephrostomy tube (thin plastic tube that is passed from the back through the skin into the kidney [pair of organs that take away waste matter from the blood] to help drain the urine) was dislodged. 2. Ensure the nephrostomy tube was anchored and secured to prevent from pulling or being dislodged. 3. Ensure nephrostomy drainage bag was kept below Resident 1's bladder. These deficient practices resulted in Resident 1's nephrostomy tube being dislodged on 1/31/24, 2/22/24, 5/7/24, 6/16/24 and 7/3/24. Resident 1 had to be sent to the general acute hospital (GACH) each time to have the nephrostomy tube re-inserted. Findings: During a review of the Admission Record indicated the facility admitted Resident 1 on 8/29/2018 and readmitted on [DATE] with diagnoses including chronic respiratory failure (not enough oxygen passes in the breathing organs to the blood), obstructive and reflux uropathy (hindrance of normal urine flow) and retention of urine (inability to empty all the urine from the bladder [organ that stores the urine in the body]. During a review of the Situation, Background, Assessment and Recommendation (SBAR, communication format used in healthcare to convey important information about the resident) Change of Condition (COC) dated 1/31/24 at 10:59 a.m., indicated Resident 1's nephrostomy tube was dislodged. The COC indicated the primary physician was notified and gave order to transfer Resident 1 to GACH 1 emergency department (ER) for nephrostomy tube replacement. During a review of the Care Plan initiated on 2/2/24 indicated Resident 1 has nephrostomy tube drainage bag for staghorn calculus (kidney stones) with right nephrostomy and at risk for urinary tract infection (UTI, infection of the urinary system [bladder, kidney, ureters [passage that carries the urine from kidney to bladder] and urethra [tube through which the urine leaves the body). The care plan goal indicated Resident 1 will have minimized risk for complications from nephrostomy tube with interventions by review date. Interventions included anchor nephrostomy tube to prevent tension, and to secure the catheter to facilitate urine flow. During a review of the Progress Note dated 2/22/24 at 2:20 p.m., indicated the nephrostomy tube was pulled out and there was no bleeding on nephrostomy site. Resident 1's primary physician was notified and gave order to transfer Resident 1 to GACH 1 for nephrostomy reinsertion. (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 review of the Physician Progress Record dated 2/28/24 at 11 p.m., indicated Resident 1's family member was concerned as to why the nephrostomy tube seems to come out frequently . The Record indicated this can occur if tube gets accidentally pulled when patient (Resident 1) is turned. Tube coming out is not a frequent occurrence . During a review of the SBAR COC dated 5/6/24 at 12:33 p.m., indicated Resident 1's nephrostomy tube was dislodged. Resident 1's primary physician was notified and gave order to transfer Resident 1 to GACH 1 for nephrostomy tube replacement. During a review of the Care Plan initiated on 5/9/24 indicated Resident 1 has nephrostomy tube drainage bag for staghorn calculus with right nephrostomy and at risk for UTI. The care plan goal indicated Resident 1 will have minimized risk for complications from nephrostomy tube with interventions by review date. Intervention included to secure the catheter with bordered foam dressing daily and as needed if soiled or dislodged to facilitate urine flow and prevent from pulling out nephrostomy tube. Intervention also included observe extra precautions when handling nephrostomy site during bed mobility, turning, repositioning, bathing, and transfers (initiated on 6/18/24). During a review of the COC dated 6/16/24 at 10 a.m., indicated Resident 1's nephrostomy was dislodged. The primary physician was notified and gave order to transfer Resident 1 to GACH 1 for nephrostomy tube replacement. During a review of the Minimum Data Set (MDS, standardized care and health screening tool) dated 6/16/24 indicated Resident 1 had severely impaired cognitive skills for daily decision making. Resident 1 was dependent (helper does all the effort) with oral hygiene, toileting hygiene, shower/bathe, upper and lower body dressing, and personal hygiene. During a review of the GACH 1 Document Report dated 6/16/24 at 11:12 p.m , indicated Resident 1 presented with dislodged right sided nephrostomy tube in the emergency department. The past medical surgical history indicated Resident 1 had multiple nephrostomy tube placements. During an observation and concurrent interview on 7/1/24 at 9:16 a.m., the LVN 1 changed Resident 1's nephrostomy site dressing. After LVN 1 completed the nephrostomy site dressing change, LVN 1 placed the nephrostomy tubing along Resident 1's right thigh area. LVN 1 also placed the nephrostomy bag on top of the bed at level with Resident 1's right thigh area. During observation and concurrent interview on 7/1/24 at 9:45 a.m., the registered nurse supervisor (RNS 1) stated the nephrostomy tube was not securely anchored. RNS 1 stated the nephrostomy tube should be taped securely to anchor the nephrostomy tube. RNS 1 further stated the nephrostomy drainage bag should be below Resident 1's bladder to keep the urine flow by gravity. During an interview on 7/1/24 at 10:50 a.m., the director of nursing (DON) stated Resident 1 does not move on her own. DON stated when Resident 1 gets turned by two staff, the nephrostomy tube suture becomes undone sometimes, or the nephrostomy tube will come out on its own. DON further stated sometimes the nephrostomy tube is just found dislodged. Stated she asked the physician what can be done to prevent the nephrostomy from becoming frequently dislodged, but the physician had no recommendation. DON stated the nephrostomy tube should be anchored to the skin to make the tube more secure and should be reinforced with gauze and tape daily and as needed . DON further stated the nephrostomy drainage bag should be placed below Resident 1's bladder. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/2/24 at 10:05 a.m., the nursing progress notes dated from 2/22/24 were reviewed with the DON. The DON stated the nephrostomy tube were documented as intact but there was no other documented evidence that the nephrostomy was kept secured to prevent from being dislodged. There was also no documentation found that the facility had investigated the reasons why the nephrostomy keeps being dislodged, update and implement new care plan interventions to prevent the nephrostomy from being dislodged. During a telephone interview 7/10/24 at 2:06 p.m., the complainant stated Resident 1's nephrostomy was again dislodged on 7/3/24. Resident 1 had to be sent to GACH 1 to have the nephrostomy tube replaced. A review of the facility's policy and procedures (P & P) titled Develop-Implement Comprehensive Care Plans, reviewed on 2/21/24 indicated the facility develops a person-centered comprehensive care plans that are culturally competent and trauma-informed, developed and implemented to meet his or her preferences and goals and address the resident's medical, physical, mental, and psychosocial needs. The interdisciplinary team develops the care plan with corresponding interventions for care that is in accordance with professional standards of practice and accounting for resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. The same Policy indicated the facility must establish, document, and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care plans shall describe the resident's needs and preferences and how the facility will assist in meeting these needs and preferences. A review of the facility's P & P titled Nephrostomy Care, reviewed on 2/21/24 indicated the Policy was to provide staff with guidelines to ensure the resident receives the necessary care and services for care of a nephrostomy tube. The same Policy indicated review the resident's care plan to assess any special needs of the resident. The general guidelines included to check placement of the tubing and integrity of the tape during assessments, drainage should be below the level of the kidney and to secure the tube with tape to prevent tension.

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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** 36395 Based on observation, interview, and record review the facility failed to protect the skin of residents from prolonged pressure caused by medical device for one of two sampled residents (Resident 1). For Resident 1, the facility failed to ensure the nephrostomy (thin plastic tube that is passed from the back through the skin into the kidney [pair of organs that take away waste matter from the blood] to help drain the urine) regulator did not cause prolonged pressure to Resident 1's abdomen. On 7/1/24 at 9:16 a.m., Resident 1 was observed with a mark caused by the nephrostomy regulator on right side of her abdomen. This deficient practice had the potential for Resident 1 to develop pressure ulcer related to the medical device. Findings: During a review of the Admission Record indicated the facility admitted Resident 1 on 8/29/2018 and readmitted on [DATE] with diagnoses including chronic respiratory failure (not enough oxygen passes in the breathing organs to the blood), obstructive and reflux uropathy (hindrance of normal urine flow) and retention of urine (inability to empty all the urine from the bladder [organ that stores the urine in the body]. During a review of Resident 1's Care Plan initiated on 5/9/24 indicated Resident 1 has higher risk for pressure ulcer development related to disease process with history of pressure ulcers, immobility, and incontinence. The care plan goal included Resident 1 will have intact skin, free of redness, blisters, or discoloration by review date. The care plan interventions included to monitor dressing every shift and to monitor/document/report to physician as needed that included skin status, appearance, and color. During a review of the Minimum Data Set (MDS, standardized care and health screening tool) dated 6/16/24 indicated Resident 1 had severely impaired cognitive skills for daily decision making. Resident 1 was dependent (helper does all the effort) with oral hygiene, toileting hygiene, shower/bathe, upper and lower body dressing, and personal hygiene. During an observation of Resident 1's nephrostomy site dressing change and concurrent interview on 7/1/24 at 9:16 a.m., the licensed vocational nurse (LVN) 1 removed the nephrostomy regulator that was taped against the right side of Resident 1's lower abdomen. When LVN 1 removed the tape on Resident 1's skin, Resident 1's right side of the abdomen had a mark that had the shape of the nephrostomy regulator. LVN 1 stated the mark was caused by the regulator and should not have been taped against Resident 1's skin. LVN 1 stated the mark can open and cause pressure ulcer. During an interview on 7/1/24 at 10:50 a.m., the director of nursing (DON) stated the nephrostomy regulator caused the mark on Resident 1's skin and can cause pressure injury. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures (P & P) titled Treatment Services to Prevent/Heal Pressure Ulcers, reviewed on 2/21/24 indicated the purpose of this guideline is to provide the facility with guidelines to provide care and services consistent with professional standards of practice to promote healing of existing pressure ulcers/injuries, including prevention of infection to the extent possible and prevent the development of additional pressure ulcer/injury. The same policy indicated the medical device related pressure injury result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The Policy further indicated the first step in the prevention of pressure ulcer/injury is the identification of the resident at risk of developing pressure ulcers. This is followed by implementation of appropriate individualized interventions and monitoring for the effectiveness of the intervention. Because a resident at risk can develop a pressure ulcer/injury within hours of the onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcer/injury.