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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555397 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/08/2025 |
| NAME OF PROVIDER OR SUPPLIER The Rehabilitation Center of Los Angeles | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49571</p> <p>Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) received the necessary care and nursing services to prevent recurrent dislodgement of a nephrostomy tube (a tube that is placed directly into the kidney to drain urine from the kidney).</p> <p>This deficient practice resulted in Resident 1 ' s recurrent transfers to General Acute Care Hospital (GACH) on 1/9/2025, 3/23/2025, and 4/6/2025 due to a dislodged nephrostomy tube, requiring repeated invasive procedures (medical procedure where the body is entered or invaded through an incision, percutaneous [through the skin] puncture, or insertion of an instrument). Placing the resident at risk for sepsis (a life-threatening condition that arises when the body's response to an infection damages its own tissues and organs, potentially leading to organ failure and death) and death.</p> <p>Findings:</p> <p>A review of Resident 1 ' s admission record indicated the facility initially admitted the resident to the facility on [DATE] and readmitted on [DATE] with a diagnosis that included Chronic respiratory failure (a condition in which your blood doesn't have enough oxygen causing shortness of breath and difficulty breathing, often caused by a disease or injury), Anoxic brain damage (a condition when oxygen is cut off from the brain), cardiac arrest (a condition when heart suddenly stops beating, causing blood flow to the brain and other organs to stop), quadriplegia (paralysis below the neck that affects all of a person's limbs).</p> <p>A review of Resident Minimum Data Set (MDS, standardized assessment) dated 1/29/2025 indicated, cognitive (ability to acquire and understand knowledge severely impaired), dependent on facility staff for rolling left and right (helper does all of the effort. Resident does none of the effort to complete the activity, or the assistance of 2 or more helper is required for the resident to complete the activity), extensive assistance required for all Activities of Daily Living (ADL), had a diagnosis of Obstructive uropathy (a condition in which the flow of urine is blocked).</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During a review of Resident 1 ' s Care Plan (a document outlining a detailed approach to care customized to an individual resident ' s need) for Nephrostomy date initiated on 2/21/2025, indicated Resident 1 had a right nephrostomy tube to drainage bag for staghorn calculus (a large, branched kidney stone that occupies the kidney collecting system). The goal was for Resident 1 to have minimized risk for complications from nephrostomy [NAME]. The approached interventions were, call medical doctor if right nephrostomy tube was dislodged or pulled out, empty nephrostomy bag every four hours and as needed. The care plan did not indicate interventions to prevent dislodgement.</p> <p>During a review of Resident 1 ' s Situation Background Assessment and Recommendations (SBAR) for Change of Condition (COC) dated 3/31/2025, indicated blood draining on left nephrostomy tube started on 3/31/2025 and stayed the same. Vital signs indicated the following: Blood pressure 107/47, heart rate 107, respiration 19, temperature 97.9, oxygen saturation 97% on ventilator.</p> <p>A review of Resident 1 ' s physician ' s order dated 1/9/2025 indicated, transfer to GACH emergency room due to clogged nephrostomy tube.</p> <p>A Review of Resident 1 ' s GACH admission report dated 1/13/2025 indicated Resident 1 had a recent right nephrostomy tube exchange and malfunction on 11/21/2024. The admission report indicated the resident was to have a nephrostomy tube replacement consultation with interventional radiology (IR).</p> <p>A review of Resident 1 ' s physician ' s order dated 3/23/2025 indicated, transfer patient GACH emergency room for further evaluation of no urine output noted from the right nephrostomy stat (immediately).</p> <p>During a review of Resident 1 ' s GACH Physician Progress Note dated 3/23/2025 indicated, plan right nephrostomy tube removal and placement of left nephrostomy tube on 3/25/2025. Afebrile (without fever and no [NAME] Blood Count (WBC).</p> <p>During a review of Resident 1 ' s Care Plan for Nephrostomy date initiated on 4/4/2025, indicated Resident 1 has nephrostomy tube drainage bag for staghorn calculus (a large, branched kidney stone that occupies the kidney collecting system) at risk for urinary tract infection (UTI). The goal was for Resident 1 will have minimized risk for complications from nephrostomy tube. The approached interventions were, monitor every shift, empty nephrostomy bag every four hours and as needed, monitor temperature and vital signs as ordered or as needed. The care plan did not indicate interventions to prevent dislodgement.</p> <p>A review of resident 1 ' s GACH record titled Physician History and Physical dated 3/29/2025 indicated, indicated Resident 1 was sent from Skilled Nursing Facility (SNF) with report of dislodged nephrostomy tube and fever.</p> <p>A review of Resident 1 ' s H&P dated 3/29/2025 indicated, Resident 1 returned to the facility ' s sub-acute unit after hospitalization to GACH for misplaced nephrostomy tube.</p> <p>A review of Resident 1 ' s GACH Physician H&P dated 3/31/2025 indicated, Skilled Nursing Facility (SNF) found blood in nephrostomy tube, the resident was sent to GACH for further evaluation. Resident 1 was just recently admitted to GACH on 3/23/2025 for sepsis, and dislodged nephrostomy tube.</p> <p>(continued on next page)</p> | | |

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| <p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>A review of Resident 1 ' s physician ' s order dated 4/6/2025 indicated, transfer to GACH emergency room due to dislodged nephrostomy tube.</p> <p>A review of Resident 1 ' s Care Plan for Nephrostomy Tube Drainage Bag, initiated 4/4/2025 indicated the following: Goal for the care plan, minimized risk for complications from nephrostomy tube with interventions by review date. Interventions indicated, observe extra precautions when handling nephrostomy site during bed mobility, turning, repositioning, bathing and transfers. The care plan did not indicate interventions to prevent dislodgement.</p> <p>A review of Resident 1 ' s Care Plan Resident Nephrostomy Dislodged initiated 4/6/2025 indicated the following: Goal for the care plan, Resident 1 will be free from complications related to nephrostomy dislodgement. Interventions indicated, notify physician/responsible party regarding status changes, transfer to acute. The care plan did not indicate interventions to prevent dislodgement.</p> <p>During an interview on 4/8/2025 at 10:10 AM, Certified Nursing Assistant 1(CNA1) stated on Sunday 4/6/25 around 9 AM in the morning, while I was trying to change her, I saw the nephrostomy tube dislodged, CNA1 did not witness drainage or bleeding from the site. CNA1 was working with a treatment nurse when the nephrostomy tube was found to be dislodged. CNA1 reported the incident to the charge nurse and the resident was transferred to GACH. CNA1 stated a dislodged nephrostomy tube could potentially be harmful to the resident causing infection at the insertion site and the resident not being able to use the nephrostomy tube.</p> <p>During an interview on 4/8/2025 at 10:25 AM, Licensed Vocational Nurse 1(LVN1) stated Resident 1 was totally dependent on staff for activities of daily living (ADL), required at least two persons assist to provide ADL and wound care. It is very unlikely for the resident to remove the nephrostomy tube on her own because she is not mobile.</p> <p>During an interview on 4/8/2025 at 10:38 AM, the Treatment Nurse 1(TN1) stated Resident 1 had a nephrostomy tube on her right side. TN1 stated Resident 1 was in and out of the facility in the last six months to replace the nephrostomy tube and other medical conditions. TN1 was unaware of how the nephrostomy tube was being dislodged. TN1 stated Resident 1 does not have voluntary or involuntary movement, does not even jerk, it is unlikely and impossible for Resident 1 to pull out the nephrostomy tube. TN1 stated infection and complications related to nephrostomy tube were potentially harmful for the resident.</p> <p>During an interview on 4/8/2025 at 11:00 AM, Treatment Nurse 2 (TN2) stated, I care for Resident 1 regularly since she was transferred to my unit. TN2 had witnessed, Resident 1 had nephrostomy tube dislodged at least twice recently. TN2 stated The most likely cause for the nephrostomy tube dislodgement is lack of proper attention and keeping an eye on the tube by staff when providing care. Possibly not securing the nephrostomy tube well while turning and repositioning the resident. The tube is thin and can easily be hidden under the resident ' s skin folds. TN2 stated because Resident 1 was dependent on staff for care and movement, it was impossible for the resident to pull out the nephrostomy tube.</p> <p>(continued on next page)</p> | | |

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| <p>F 0691</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During an interview on 4/8/2025 at 12:55 PM, Registered Nurse 1, (RN1) stated Resident 1 is in vegetative state unable to move any part of her body, non-verbal. RN1 had witnessed a dislodged nephrostomy tube at least twice requiring Resident 1 to transfer to the GACH for nephrostomy replacement. RN1 stated the plan for the resident was to have at least two staff assist during care to secure the nephrostomy tube. RN1 stated past interventions to prevent dislodgement did not help. RN1 stated, There is always a potential harm and complications to the resident from nephrostomy dislodgement.</p> <p>During a concurrent interview and record review on 4/8/2025 at 1:45 PM, the Director of Staffing Development (DSD) stated, licensed staff training and skills competency for nephrostomy tube was done by the Director of Nursing (DON) and RN Supervisor. The DSD stated unlicensed staff did not receive nephrostomy tube competency trainings. The DSD stated staff were provided daily verbal reminders and in-service during daily staff stand ups/huddles.</p> <p>During an interview on 4/8/2025 at 2:25 PM, the Director of Nursing (DON) stated Resident 1 was a long-term resident in the facility. The DON stated, Resident 1 had a new nephrostomy tube placed on the left side of the body on April 4/1/2025 and transferred back to the facility on [DATE]. The DON stated Resident 1 transferred back to GACH on 4/6/2025 because the new nephrostomy tube was dislodged. The DON stated, Staff is trained and in-serviced on how to care nephrostomy tube. The DON reported having witnessed Resident 1 ' s nephrostomy tube tip dislodged while the suture and tube were still attached to the resident. The DON stated the most likely reason for the nephrostomy tube to be dislodged was improper placement and suturing and the resident ' s body mass could be the factor pushing out the tube.</p> <p>During a review of the facility ' s P&P titled Nephrostomy Care reviewed November 2024, the P&P indicated, Assess the resident for indications of bleeding in the flank area of the nephrostomy tube as ordered, check for placement of the tube and integrity of the tape during assessment.</p> | | |