STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555638	A. Building B. Wing	11/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Angeles Comm Hospital	4081 East Olympic Blvd Los Angeles, CA 90023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 47923 Based on observation, interview, and record review, the facility failed to: 1. Post the report of complaint investigation results by California Department of Public Health ([CDPH] state licensing and certification agency) during the three preceding years in the areas of the facility that are prominent and accessible to the residents, visitors, family members, or resident representative. This deficient practice placed the residents, visitors, family members, or resident representative at risk of not knowing the status of the facility non-compliance outcome results and past performance history. Findings: During a concurrent observation and interview on 11/23/2024 at 1:09 p.m., with the Director of Nursing (DON) at odd nursing station hallway, the DON stated the survey binder posted on the wall included only the last recertification survey conducted by the CDPH last year. The DON stated the facility was visited by the CDPH for a complaint visit last year and this year. The DON stated the complaint investigation results by the CDPH in the past 2 years were not included in the survey binder. The DON stated all survey results should be posted and accessible to residents, visitors and family members for them to know the findings identified by the CDPH and facility's plan of correction. The DON stated it was a violation of resident's rights by not posting the complaint investigation results by CDPH. During an interview on 11/24/2024 at 1:19 p.m., with the Associate Chief of Nursing (ACON), the ACON stated posting of survey and complaint investigation results are federal requirements. The ACON stated it was the responsibility of the DON to post the survey and complaint investigation results. The ACON stated it was important to post the survey and complaint investigation results so the resident, resident representative and facility staff could review the facility's plan of action so the deficient practice would not happen again. (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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	555638	A. Building B. Wing	11/24/2024

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's admission packet, titled Attachment F Resident [NAME] of Rights, dated 5/2011, the form indicated A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents and must post a notice of their availability.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set ([MDS] - a resident assessment tool) was completed accurately for one of 12 sampled residents (Resident 8) by failing to: 1. Ensure Resident 8's Psychiatric/Mood Disorder under section I (Active Diagnoses) diagnosis of Psychotic Disorder (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) was encoded correctly. This deficient practice resulted in incorrect data transmitted to Center for Medicare and Medicaid Services (CMS) and had the potential to negatively affect Resident 8's plan of care. Findings: During a review of Resident 8's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 8 was admitted to the facility on [DATE]. The Face Sheet indicated Resident 183's diagnoses included chronic respiratory failure (a serious condition that makes it difficult to breathe on your own) with tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe to help a person to breathe) and gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problem). During a review of Resident 8's MDS, dated [DATE], the MDS indicated, Resident 8's cognitive (ability to think and reason) skills for daily decision making was severely impaired. The MDS indicated, Resident 8 was dependent (helper does all of the effort) on staff with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 8's Patient Orders (a document containing active physician order), dated 11/23/2024, the Patient Order indicated, Resident 8 has an active order of Quetiapine (a psychotropic drug - any drug that affects brain activities associated with mental process and behavior) 50 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) every 12 hours (9 a.m. and 9 p.m.) for psychosis manifested by pulling out tubes. During a concurrent interview and record review on 11/23/2024 at 6:30 p.m., with the Minimum Data Set Nurse (MDS Nurse), Resident 8's MDS assessment, dated 10/31/2024, was reviewed. The MDS Nurse stated Resident 8's MDS assessment was completed inaccurately. The MDS Nurse stated there was a wrong entry on the MDS assessment under Section I. The MDS Nurse stated there should be a checked mark on MDS assessment under Section I5950 for psychotic disorder since Resident 8 was receiving Quetiapine for psychosis. The MDS Nurse stated accuracy of MDS assessment was important for facility reimbursement and for proper care of resident . During an interview on 11/24/2024 at 1:19 p.m., with the Associate Chief Nursing Officer (ACON), the ACON stated accuracy of MDS assessment was essential because it reflects the care provided by facility staff to resident. The ACON stated Resident 8's MDS assessment should be corrected and modified immediately to reflect his diagnosis of psychotic disorder. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's undated policy and procedure titled, Assessment and Care Planning, the P&P indicated, The assessment is certified for accuracy by means of a signature of individuals who complete any portion of the assessment.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to: 1. Complete and re-submit the Preadmission Screening and Resident Review ([PASRR - a tool to determine if the person had, or was suspected of having a mental illness, intellectual disability, or related condition) Level one (I) screening and refer one of two sampled residents (Resident 8) who had a new diagnosis of psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) to the appropriate state-designated authority for PASRR Level two (II) evaluation and determination. This deficient practice had the potential to result in Resident 8 not receiving specialized services for mental illness. Cross Reference F641. Findings: During a review of Resident 8's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 8 was admitted to the facility on [DATE]. The Face Sheet indicated Resident 183's diagnoses included chronic respiratory failure (a serious condition that makes it difficult to breathe on your own) with tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe to help a person to breathe) and gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problem). During a review of Resident 8's Patient Orders (a document containing active physician order), dated 11/23/2024, the Patient Order indicated, Resident 8 has an active order of Quetiapine (a psychotropic drug - any drug that affects brain activities associated with mental process and behavior) 50 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) every 12 hours (9 a.m. and 9 p.m.) for psychosis manifested by pulling out tubes. During a review of Resident 8's MDS, dated [DATE], the MDS indicated, Resident 8's cognitive (ability to think and reason) skills for daily decision making was severely impaired. The MDS indicated, Resident 8 was dependent (helper does all of the effort) on staff with oral hygiene, toileting hygiene, and personal hygiene. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/23/2024 at 6:16 p.m., with the Director of Nursing (DON), Resident 8's PASRR level I Screening completed 4/21/2023, was reviewed. The PASRR Level I screening indicated, Resident 8 had no serious mental illness diagnosis and not receiving psychotropic medications. The PASRR level I screening also indicated, Resident 8's case was closed and, and a PASRR level II mental health evaluation was not required. The DON stated she was responsible for completing and submitting PASRR. The DON stated Resident 8 was receiving Quetiapine 50mg every 12 hours for psychosis manifested by pulling out tubes as ordered by the physician on 9/5/2024. The DON stated she should have submitted a new PASRR level I for Resident 8 since he had a new diagnosis of psychosis. The DON stated once the PASRR level 1 was submitted, then the state mental health agency would decide if level II evaluation was necessary. The DON stated it was important for Resident 8 to be referred to PASRR state mental health agency so she could avail additional resources, support, and services for treatment of his psychosis. During a review of PASRR reference manual, dated 2/2023, the PASRR reference manual indicated, An additional requirement has been added for NF's to promptly notify the state mental health and/or intellectual or developmental disability authority, as applicable, if there is a significant change in the physical or mental condition of an individual who is mentally ill or has an intellectual or developmental disability. This would warrant a re-evaluation to determine if NF is still the most appropriate setting and/or if the individual could benefit from specialized services for his/her mental illness or intellectual disability.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review the facility failed to: 1. Ensure one of six sampled residents (Resident 25) had a revised care plan for interventions on the non-behavioral restraint (a device or method used to restrict a patient's movement preventing them from removing medical tubes or lines) flow sheet. This deficient practice of not having a revised care plan for the Non-Behavioral Restraint Flow Sheet had the potential to increase Resident 25's discomfort. Findings: During a review of Resident 25's Admission Record (Face Sheet), the Face Sheet indicated Resident 25 was admitted to the facility on [DATE]. Resident 25's initial diagnose was respiratory failure (a serious condition that makes it difficult to breathe on your own). During a review of Resident 25's History and Physical (H&P), dated 1/7/2024, the H&P indicated, Resident 25's diagnoses included seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), pneumonia (an infection/inflammation in the lungs), and supplemental oxygen therapy (a medical treatment that provides extra oxygen to people who have difficulty breathing). During a review of Resident 25's Minimum Data Set ([MDS] a resident assessment tool), dated 10/6/2024, the MDS indicated Resident 25's cognition (ability to learn, reason, remember, understand, and make decisions) was severely impaired and never/rarely made decisions. The MDS indicated Resident 25 was dependent for eating, oral hygiene, and showering. The MDS indicated Resident 25's limb restraints used in bed daily. During an observation on 11/23/2024 at 9:40 a.m. in Resident 25's room, Resident 25 had non-behavioral soft restraints attached to his right and left wrist. During a review of Resident 25's Sub-Acute Restraints Care Plan titled, Physical mobility impaired related to use of bilateral restraints, dated 11/1/2024, the Sub-Acute Restraints Care Plan Indicated Resident 25 will not pull tubes out. The staff interventions included to release restraints for 15 minutes every two hours, reposition the restraints every two hours under direct supervision for comfort, and check for circulation. During a review of Resident 25's blank restraint flow sheet, titled Non-Behavioral Restraint Order and Flow Sheet, dated 5/2015, the Non-Behavioral Restraint Order and Flow Sheet had no indication of how long to the release restraints and how often to reposition the restraints. (continued on next page)

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	555638	A. Building B. Wing	11/24/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/24/2024 at 9:27 a.m. with Minimum Data Set (MDS) Nurse, Resident 25's Sub-Acute Restraints Care Plan titled, Physical mobility impaired related to use of bilateral restraints, dated 11/1/2024, was reviewed. The Sub-Acute Restraints Care Plan Indicated Resident 25 will not pull tubes out. The staff interventions included to release restraints for 15 minutes every two hours, reposition the restraints every two hours under direct supervision for comfort, and check for circulation. In addition, Resident 25's Non-Behavioral Restraint Order and Flow Sheet, dated 5/2015, the Non-Behavioral Restraint Order and Flow Sheet had no indication of how long to release the restraints and how often to reposition the restraints. The MDS Nurse stated the Non-Behavioral Order and Restraint Flow Sheet should reflect the care plan approaches and interventions was reviewed. The MDS Nurse stated on the Non-Behavior Order and Restraint Flow Sheet did not indicate to release the restraints for 15 minutes and reposition the restraints every two hours in comparison to the care plan. The MDS Nurse stated not having the proper time on the Non-Behavior Order and Restraint Flow Sheet had the potential for the restraints to stay on longer than necessary. The MDS Nurse stated if the restraints were to stay on longer it had the potential to cause discomfort for Resident 25. During a concurrent interview and record review on 11/14/2024 at 9:53 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 25's Sub-Acute Restraints Care Plan titled, Physical mobility impaired related to use of bilateral restraints, dated 11/1/2024, was reviewed. The Sub-Acute Restraints Care Plan Indicated Resident 25 will not pull tubes out. The staff interventions included to release restraints for 15 minutes every two hours, reposition the restraints every two hours under direct supervision for comfort, and check for circulation. In addition, Resident 25's Non-Behavioral Restraint Order and Flow Sheet, dated 5/2015, the Non-Behavioral Restraint Order and Flow Sheet had no indication of how long to release the restraints and how often to reposition the restraints was reviewed. LVN 3 stated the Non-Behavioral Restraint Order and Flow Sheet does not give specific times when to release the restraints and when to reposition the restraints. LVN 3 stated having the time on the Non-Behavioral Restraint Order and Flow Sheet would help to keep track of how long it took before Resident 25 before he would pull on the tubing. LVN 3 stated the release of the restraints, the length of time would be documented, and would be a good indicator to notify the physician to discontinue the restraints to keep the resident comfortable. During a review of the facility's policy and procedure (P&P) titled, Assessment/Reassessment/Care Planning Documentation Instructions, dated 10/2022, the P&P indicated care planning document the maps the information from the care plan in real time. The P&P documentation of use of protective restraints and restraint monitoring. The P&P identification of goals, interventions, and evaluation of patient progress. During a review of the facility's policy and procedure (P&P) titled, Assessment and Care Planning, dated 10/2022, the P&P indicated the comprehensive care plan is prepared to meet the needs of the resident. The P&P indicated to update the resident care plan post admission and no less than three months thereafter.

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	555638	A. Building B. Wing	11/24/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review the facility failed to: 1. Ensure one out six sampled residents (Resident 11) hair was shampooed twice a week. The deficient practice had the potential for Resident feeling unkept and not clean. Findings: During a review of Resident 11's Admission Record (Face Sheet), the Face Sheet indicated Resident 11 was admitted to the facility on [DATE]. Resident 11's diagnose was chronic respiratory failure (a serious condition that occurs when the lungs can't get enough oxygen into the bloodstream and can't remove enough carbon dioxide). During a review of Resident 11's History and Physical (H&P), dated 1/7/2024, the H&P indicated, Resident 11's diagnoses included sepsis (a life-threatening blood infection), tracheostomy (a surgical procedure that creates an opening in the neck and inserts a tube into the windpipe to help with breathing), and encephalopathy (a group of conditions that cause brain dysfunction). The H&P indicated Resident 11 was unable to give any information regarding her state of health. During a review of Resident 11's Minimum Data Set ([MDS] a resident assessment tool), dated 10/5/2024, the MDS indicated Resident 11's cognition (ability to learn, reason, remember, understand, and make decisions) persistent vegetative state (when a person has severe brain damage and is in a state of partial arousal, and not aware of their surrounds)/no discernible(something that can be seen, smelled, and tasted) consciousness severely impaired and never/rarely made decisions. The MDS indicated Resident 11 was dependent for eating, oral hygiene, showering, and personal hygiene. During an observation on 11/23/2024 at 10:30 a.m. in Resident 11's room, Resident 11 hair was matted and had an abundance amount of dandruff (flakes of skin to fall off the scalp) throughout her hair. During a review of Resident 11's Care Plan, titled Resident 11 requires total assist in all Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves) secondary to medical condition, dated 3/2023, the Care Plan indicated provide total care in all ADLs. The Care Plan indicated to bath and shampoo as scheduled and as ordered. During a concurrent observation and interview on 11/23/2024 at 6:10 p.m. with Certified Nursing Assistant (CNA) 1, in Resident 11's room, Resident 11's hair was matted and had an abundance amount of dandruff through her hair. CNA 1 stated hair care is provided on the residents' shower day which would be twice a week. CNA 1 stated Resident 11's hair looked dirty. CNA 1 stated it was important to wash the resident hair to avoid dryness and dandruff to the hair. CNA 1 stated after the hair is washed its important to comb the hair out to avoid the hair from tangling up. (continued on next page)

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	555638	A. Building B. Wing	11/24/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 11/23/2024 at 6:22 p.m. with Associate Chief Nursing Officer (ACNO), the ACNO stated Resident 11's hair is part of the ADLs, and her hair should have been shampooed on her shower days. The ACNO stated the CNAs were to provide hair care by softening the hair to prevent the matting and loosen the knots in the hair. The ACNO stated the hair care is a part of Resident 11's hygiene. The ACNO stated clean hair would help to keep Resident 11 comfortable and to prevent infection on her scalp. During a review of the facility's policy and procedure (P&P) titled, Hair and Scalp, Care, dated unknown, the P&P indicated to provide comfort, increase circulation, maintain cleanliness, provide an attractive appearance, and improve resident's self-image. The P&P indicated shampoo of the hair shall be performed as part of a resident's bathing program. The P&P indicated to observe the condition of hair and scalp. The P&P indicated if hair is tangled cream rinse may be sued to assist with removal.

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	555638	A. Building B. Wing	11/24/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on observation, interview, and record review, the facility failed to: 1. Ensure the corrugated (a flexible tube that delivers oxygen to a patient from an oxygen source, such as a tank or concentrator) oxygen (air) was labeled with a date of change for one of five sampled residents (Resident 183). This deficient practice had the potential to cause respiratory infection for Resident 183. Findings: During a review of Resident 183's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 183 was admitted to the facility on [DATE]. The Face Sheet indicated Resident 183's diagnoses included chronic respiratory failure (a serious condition that makes it difficult to breathe on your own) with tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe to help a person to breathe) and gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problem). During a review of Resident 183's Admission Nursing Note, dated 11/2/2024, the Admission Nursing Note indicated, Resident 183's current functional level was totally dependent on staff with bathing, dressing, and eating. During a review of Resident 183's Patient Orders (a document containing active physician order), dated 11/22/2024, the Patient Order indicated, Resident 183 had an active order of oxygen therapy via cool aerosol (a mist of sterile water that is delivered to the upper airways) at Fraction of Inspired Oxygen ([Fio2] percentage of oxygen in the gas mixture a person inhales) at 28 percent [%] unit of measurement) daily. During a concurrent observation and interview on 11/23/2024 at 9:51 a.m., with Respiratory Therapist 1 (RT 1) in Resident 183's room, Resident 183 was observed in bed asleep with tracheostomy and on oxygen therapy continuously. RT 1 stated the corrugated oxygen tubing of Resident 183 was not dated. RT 1 stated it was her first day to work with Resident 183. RT 1 stated it was unknown when Resident 183's corrugated oxygen tubing was changed because it was not dated and labeled. RT 1 stated it was important to label and put the date it was changed the corrugated oxygen tubing for infection control purposes. During an interview on 11/23/2024 at 6:04 p.m., with the Director of Nursing (DON), the DON stated it is facility's policy to label with a date of change all respiratory equipment. The DON stated a clogged oxygen tubing would not deliver the right amount of oxygen concentration that could likely result in shortness of breath of resident. During an interview on 11/24/2024 at 1:19 p.m., with the Associate Chief Nursing Officer (ACNO), the ACNO stated all oxygen tubing should be changed and dated at the same time once a week or as needed to prevent further infection that can develop in the oxygen tubing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555638	A. Building B. Wing	11/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Routine Responsibilities and Equipment Schedule, dated 4/1/2014, the P&P indicated, all equipment will be changed as needed or when visibly dirty and dated.

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	555638	A. Building B. Wing	11/24/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to: 1. Ensure a pharmacy consultant (a professional responsible for reviewing each resident's medication profile monthly to identify and report changes) recommendation to review and provide justification for restarting of Quetiapine (a psychotropic drug - any drug that affects brain activities associated with mental process and behavior) for one of out of five sampled residents (Resident 8) was acknowledged and acted upon. This deficient practice for failing to respond to recommendation from the pharmacy consultant placed Resident 8 at risk for unnecessary medication administration. Cross Reference F758. Findings: During a review of Resident 8's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 8 was admitted to the facility on [DATE]. The Face Sheet indicated Resident 183's diagnoses included chronic respiratory failure (a serious condition that makes it difficult to breathe on your own) with tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe to help a person to breathe) and gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problem). During a review of Resident 8's Patient Orders (a document containing active physician order), dated 11/23/2024, the Patient Order indicated, Resident 8 has an active order of Quetiapine (a psychotropic drug - any drug that affects brain activities associated with mental process and behavior) 50 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) every 12 hours (9 a.m. and 9 p.m.) for psychosis manifested by pulling out tubes. During a review of Resident 8's MDS, dated [DATE], the MDS indicated, Resident 8's cognitive (ability to think and reason) skills for daily decision making was severely impaired. The MDS indicated, Resident 8 was dependent (helper does all of the effort) on staff with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 8's Psychiatric Progress Notes, dated 9/24/2024, 10/29/2024, and 11/19/2024, the Psychiatric Progress notes, did not indicate, Resident 8 had a diagnosis of mental illness of psychosis and receiving Quetiapine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555638	A. Building B. Wing	11/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Angeles Comm Hospital	4081 East Olympic Blvd Los Angeles, CA 90023

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/24/2024 at 11:15 a.m., with the Director of Nursing (DON), Resident 8's Consultant Pharmacist Medication Regime Review (MRR), dated 9/30/2024, was reviewed. The MRR report indicated, Resident 8 was started back on Quetiapine on 9/2024 but documentation could not be found in the resident's record as to why it was re-started. Also, the psych progress notes from 9/24/2024 did not include the use of Quetiapine or diagnosis. Please review and make sure justification is provided for restarting this medication. The DON stated she was responsible for following up all pharmacy consultant recommendation to resident's physician. The DON stated the timeline to follow-up pharmacy consultant recommendation is 1 month before the next scheduled visit of the pharmacy consultant. The DON stated the facility did not follow-through the pharmacy consultant recommendation, dated 9/30/2024, to Resident 8's physician. The DON stated it was important to address all pharmacy consultant recommendations to be compliant with the regulations and to avoid residents receiving unnecessary medications. During a review of the facility's policy and procedure (P&P) titled, Medication Regimen Review, dated 6/5/2024, the P&P indicated, The attending/prescriber should address the consultant pharmacist recommendation no later than their next scheduled visit to the facility to assess the resident, per facility policy and state or federal regulations. The P&P also indicated the attending physician should document in the resident's health record that the identified irregularity has been reviewed and what, if any action has been taken to address it.

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	555638	A. Building B. Wing	11/24/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47923 Based on interview and record review, the facility failed to: 1. Ensure there were consistent indication and behavior was specifically identified and non-pharmacological interventions were attempted to support the use of Quetiapine (a psychotropic drug - any drug that affects brain activities associated with mental process and behavior) for one of five sampled residents (Resident 8). This deficient practice had the potential to develop an undesired effect due to unnecessary psychotropic drug use for Resident 8. Findings: During a review of Resident 8's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 8 was admitted to the facility on [DATE]. The Face Sheet indicated Resident 183's diagnoses included chronic respiratory failure (a serious condition that makes it difficult to breathe on your own) with tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe to help a person to breathe) and gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problem). During a review of Resident 8's Patient Orders (a document containing active physician order), dated 11/23/2024, the Patient Order indicated, Resident 8 has an active order of Quetiapine (a psychotropic drug - any drug that affects brain activities associated with mental process and behavior) 50 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) every 12 hours (9 a.m. and 9 p.m.) for psychosis manifested by pulling out tubes. During a review of Resident 8's MDS, dated [DATE], the MDS indicated, Resident 8's cognitive (ability to think and reason) skills for daily decision making was severely impaired. The MDS indicated, Resident 8 was dependent (helper does all of the effort) on staff with oral hygiene, toileting hygiene, and personal hygiene. During a concurrent interview and record review on 11/23/2024 at 6:16 p.m., with the Director of Nursing (DON), Resident 8's Psychiatric Progress Notes, dated 9/24/2024, 10/29/2024, and 11/19/2024, were reviewed. The DON stated, Resident 8's Psychiatric Progress Notes, did not indicate Resident 8's had a diagnosis of mental illness of psychosis and receiving Quetiapine. The DON stated Resident 8's Quetiapine was ordered on 9/4/2024. The DON stated the facility had no documentation of Resident 8's behavior of pulling out tubes and attempted behavioral interventions 72 hours prior to initiating Quetiapine. The DON stated Resident 8 had no pattern of pulling out tubes behavior that would necessitate the use of Quetiapine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555638	A. Building B. Wing	11/24/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/23/2024 at 6:30 p.m., with the Director of Staff Development (DSD), the DSD stated pulling out of tubes was not a specific behavior of a resident with psychotic feature. The DSD stated facility's psychiatrist attended monthly meeting to discuss all residents receiving psychotropic medications. The DSD stated he could not explain why the psychiatrist did not identify Resident 8's diagnosis of psychosis. The DSD stated Resident 8's Quetiapine was considered as unnecessary medication. The DSD stated use of psychotropic medications could affect or alter resident's behavior, chemical imbalance (occurs when there is to much or too little of a substance that helps the body function normally), and cardiac complications that would likely result in resident's hospitalization . During an interview on 11/24/2024 at 1:19 p.m., with the Associate Chief Nursing Officer (ACON), the ACON stated the facility should have utilized least restrictive measures such as hand mittens (type of glove that covers the hand and wrist), redirection of behavior, and providing a staff as one on one sitter to closely monitor Resident 8's behavior of pulling out tubes before he was started on Quetiapine. The ACON stated psychotropic medication has sedating effect to the resident that would put their safety at risk. During a review of facility's policy and procedure (P&P) titled, Psychoactive Medications, dated 10/2022, the P&P indicated, When psychoactive medications are ordered, the assessment process will be utilized to assure alternative interventions/behavior management programs have been attempted prior to the use of psychoactive medications. The P&P also indicated when psychoactive medications are initiated on the unit, the resident's medical record will contain completed assessments, documented interventions, before the drug is administered.

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	555638	A. Building B. Wing	11/24/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 46832 Based on observation, interview and record review, the facility failed to: 1. Ensure the medication error rate was less than 5%. This deficient practice resulted in medication errors. Findings: During an observation of 27 medication administration opportunities, on 11/25/2024, at 8:15 a.m., 2 routine medications out of 27 were not administered at its scheduled time. During a concurrent medication administration observation and record review, on 11/25/2024, at 8:19 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated protocol for administering medication was one hour before and one hour after the scheduled time. LVN 1 stated a nebulizer (a device for producing a fine spray of liquid) medication, levalbuterol (a medication used to prevent or relieve the wheezing, shortness of breath, coughing, and chest tightness), was to be administered 7:00 a.m. by the respiratory therapist (a health professional who evaluates and treats patients with breathing or lung disorders) that morning for Resident 27. LVN 1 stated from observation of the Medication Administration Record (MAR- a report detailing the drugs administered to a patient by a healthcare professional), the medication was not administered nor documented as being administered at that time. LVN 1 stated the risk of not administering routine medications at a scheduled time could result in medication errors. During a concurrent medication administration observation and record review, on 11/25/2024, at 8:40 a.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 was observed administering medications to Resident 17. LVN 2 stated a nebulizer medication, albuterol/ipratropium (a medication used to help control the symptoms of lung diseases, such as asthma, chronic bronchitis, and emphysema), was to be administered 7:00 a.m. by the respiratory therapist. LVN 2 stated from observation of the MAR, the medication was not administered. LVN 2 stated the risk of not administering routine medication at a scheduled time could result in medication errors or overmedicating a resident. During a concurrent observation, interview, and record review, on 11/25/24, at 9:46 a.m., with the Director of Respiratory Therapy (DRT), the DRT stated if a medication had a red box on its scheduled time, it indicated the medication was not administered. The DRT observed a picture of Resident 27's and Resident 17's nebulizer medication respectively on each MAR and acknowledged the medications were not administered at the scheduled times. The DRT stated both medications were administered after their scheduled times. The DRT stated the risk of not administering medication at its scheduled time could result in a medication error, overmedicating the residents, and a lack of communication between staff. The DRT stated, I will speak to all the respiratory therapists about administering medications on time. (continued on next page)

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	555638	A. Building B. Wing	11/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Angeles Comm Hospital	4081 East Olympic Blvd Los Angeles, CA 90023

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedures, titled Medication Administration, dated 10/2022, indicated, Medications shall be charted immediately after being administered. and Documentation of medication doses administered shall be charted as soon as possible after administration to any individual resident.

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	555638	A. Building B. Wing	11/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Angeles Comm Hospital	4081 East Olympic Blvd Los Angeles, CA 90023

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on observation and interview, the facility failed to: 1.Ensure an intravenous (fluids given directly into the blood stream) medication, Amikacin (an antibiotic used to treat serious infections that are caused by bacteria), was refrigerated as labeled. This deficient practice had the potential to result in administering an ineffective medication. Findings: During a concurrent observation and interview, on [DATE], at 1:51 p.m., of the intravenous medication cart (IV cart- a medical cart used to store and transport IV supplies and equipment), with Registered Nurse 1 (RN 1), RN 1 stated intravenous medications were stored in the IV cart or refrigerator, if needed. RN 1 observed an IV medication, dextrose (a sterile solution used to provide your body with extra water and carbohydrates) 5% with Amikacin, had a refrigerate label. RN 1 stated the IV medication was scheduled to be given at 9:00 p. m. RN 1 stated the medication should had been refrigerated and not in the IV cart. RN 1 stated the risk of not refrigerating a medication could result in a medication being ineffective or expired. During a review of the policy and procedures, titled Medication Storage, dated ,d+[DATE], the policy and procedures indicated, Drugs shall be stored under the proper conditions of sanitation, temperature, light, moisture, ventilation, organization, segregation and security.

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	555638	A. Building B. Wing	11/24/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review the facility failed to: 1. Ensure Resident 19's peripheral line (a small flexible tube inserted into a vein near the skin surface to administer fluids and medications) to his right forearm dressing was changed every 72 hours (three days) per policy and procedure. 2. Ensure Resident 17's peripheral line to his right-hand dressing was changed every 72 hours per policy and procedure. 3. Ensure the Medication Cart (Cart 1) was cleaned after a sticky liquid medication had spilled onto other medications. These deficient practices of not changing the peripheral lines dressing placed Resident 19 and 17 at risk for infection at the insertion site. In addition, the sticky liquid medication spill had the potential to result in cross-contamination with other medications. Findings: a. During an observation on 11/23/2024 at 9:46 a.m. in Resident 19 room, Resident 19 had a right forearm peripheral line with a dressing dated 11/16/2024. During a review of Resident 19's Admission Record (Face Sheet), the Face Sheet indicated Resident 19 was admitted to the facility on [DATE]. Resident 19's diagnoses included were ventilator dependent (a patient is unable to breathe independently) and respiratory distress (a patient is having difficulty breathing). During a review of Resident 19's History and Physical (H&P), dated 4/26/2024, the H&P indicated, Resident 19's diagnose tracheostomy (a surgical procedure that creates an opening in the neck and inserts a tube into the windpipe to help with breathing). The H&P indicated Resident 19 opens eyes only responsive to painful stimuli. During a review of Resident 19's Minimum Data Set ([MDS] a resident assessment tool), dated 10/23/2024, the MDS indicated Resident 19's cognition (ability to learn, reason, remember, understand, and make decisions) persistent vegetative state (when a person has severe brain damage and is in a state of partial arousal, and not aware of their surrounds)/no discernible(something that can be seen, smelled, and tasted) consciousness severely impaired and never/rarely made decisions. The MDS indicated Resident 19 was dependent for eating, oral hygiene, showering, and personal hygiene. During an interview on 11/24/2024 at 8:17 a.m. with Director of Nursing (DON), the DON stated the peripheral lines dressings should be changed every 96 hours (every 4 days). The DON stated it was important to change the peripheral lines every 4 days to decrease the risk of infection to the insertion sites. (continued on next page)

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	555638	A. Building B. Wing	11/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During an observation on 11/23/2024 at 10:03 a.m. in Resident 17 room, Resident 17 had a right-hand peripheral line with a dressing dated 11/17/2024. During a review of Resident 17's Admission Record (Face Sheet), the Face Sheet indicated Resident 17 was admitted to the facility on [DATE]. Resident 17's diagnose was respiratory failure (a serious condition that occurs when the lungs can't get enough oxygen into the bloodstream and can't remove enough carbon dioxide). During a review of Resident 17's History and Physical (H&P), dated 2/9/2024, the H&P indicated, Resident 17's diagnose tracheostomy (a surgical procedure that creates an opening in the neck and inserts a tube into the windpipe to help with breathing. During a review of Resident 17's Minimum Data Set ([MDS] a resident assessment tool), dated 11/21/2024, the MDS indicated Resident 17's cognition (ability to learn, reason, remember, understand, and make decisions) persistent vegetative state (when a person has severe brain damage and is in a state of partial arousal, and not aware of their surrounds)/no discernible(something that can be seen, smelled, and tasted) consciousness severely impaired and never/rarely made decisions. The MDS indicated Resident 17 was dependent for eating, oral hygiene, showering, and personal hygiene. During an interview on 11/24/2024 at 8:30 a.m. with Registered Nurse (RN) 1, RN 1 stated the dressing for peripheral lines should be changed every 4 days. RN 1 stated when the dressing is removed the staff is to check for infiltration (leakage of intravenous fluids into surrounding tissues), redness, and swelling around the insertion site. RN 1 stated the dressing change is to prevent infection. During a review of the facility's policy and procedure (P&P) titled, Intravenous (IV) Policies, General, dated 9/2022, the P&P indicated to provide and maintain standard, and safety related to IV therapy. The P&P indicated responsibility of nurse on unit was IV sites are to be dressed with dry sterile dressing on insertion, dressings to be changed every 72 hours and documented. The P&P indicated the indwelling cannula should not be left in place longer than 72 hours. C. During a concurrent observation and interview, on 11/23/2024, at 1:32 p.m., with Licensed Vocational Nurse (LVN 1), LVN 1 observed a red sticky substance (Ketoconazole shampoo- an antifungal medication that treats yeast and fungal infections of the skin and scalp) had spilled in Medication Cart 1 onto other medications. LVN 1 stated the protocol was to keep medication carts free of spills. LVN 1 stated the risk of the medication cart being soiled could result in cross-contamination and ineffectiveness of medications. During a review of the policy and procedures, titled Medication Storage, dated 8/2023, the policy and procedures indicated, Drugs shall be stored under the proper conditions of sanitation, temperature, light, moisture, ventilation, organization, segregation and security.

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	555638	A. Building B. Wing	11/24/2024

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832 Based on observation, interview and record review, the facility failed to meet a minimum of 80 square feet (sq. ft.) per resident in one room (room [ROOM NUMBER]). This failure to provide adequate space created the potential for adversely affecting the quality of life, safety, health, and the provision of care of residents who may had occupied room [ROOM NUMBER]. Findings: During the entrance conference, on 11/23/2024 at 9:13 a.m., the facility's Director of Nursing (DON) stated the facility had requested and submitted a room waiver for a room variance. The DON provided a copy of room waiver request letter to continue with the waiver request, dated 9/27/2024, indicating room [ROOM NUMBER] (one room with an approved capacity of 2), totaled in size of 157 square feet while the required room size was 160 square feet per room. During an observation, on 11/25/2024, at 2:55 p.m., with the Director of Nursing and the Maintenance Supervisor (MS), the MS measured room [ROOM NUMBER]. The MS indicated the actual square footage of room [ROOM NUMBER] was 155 square feet and did not meet the required room size as followed: Room number Floor square footage Bed per room room [ROOM NUMBER] 157 sq. ft. 2 During a concurrent observation and interview, on 11/25/24 at 3:04 p.m., with the Director of Nursing (DON), the DON stated room [ROOM NUMBER] was an unoccupied, non-vent (a room that does not have ventilator or tracheostomy access) room. The DON stated the facility had sent a room waiver every year for approval due to not meeting the required square feet requirements. The DON stated the facility had submitted a room waiver for approval for 2024. The DON stated although the room measured to be 157 sq ft, there was no harm to a resident's safety or well-being. Multiple observations made to the rooms through 11/23/2024 to 11/24/2024, indicated the room sizes of the above rooms did not adversely affect the residents' health and/or safety.