STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555700	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beverly Hills Rehabilitation Centre	580 S San Vicente Blvd. Los Angeles, CA 90048

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 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** 43454 Based on interview, and record review, the nursing staff failed to revise a care plan for at risk of bleeding and hospitalization s for one of four sampled residents (Resident 1), who had bleeding and emesis (the action or process of vomiting) on several occasions. This deficient practice had the potential to place Resident 1 at risk for recurrent bleeding and hospitalization s. Findings: A review of the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (loss of the ability to move in one side of the body) following unspecified cerebrovascular disease (CVD - a group of conditions that affect the blood vessels and blood flow in the brain and spinal cord) affecting left dominant side, chronic respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of the Minimum Data Set (MDS - resident assessment tool) dated 10/24/2024, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required total dependence from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 1's Progress Notes indicated the following: i. On 4/19/2024, Resident 1 vomited times 1 (x1) with brown color emesis. ii. On 8/3/2024, Resident 1 vomited coffee ground x1 small amount, transferred to Emergency department (ER). iii. On 8/10/2024, Resident 1 has fresh blood on her secretions, oral care rendered. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	iv. On 8/10/2024, Resident 1's bleeding had increased significantly, with clotting present . observed that patient (Resident 1) was not also bleeding from nose . transferred to ER at General Acute Care Hospital 1 (GACH 1) v. On 11/10/2024, at 5:15 a.m., (Resident 1) bleeding from the mouth and nose approximately 30 milliliters (ml - unit of measurement), dark blood coming out with small clots, at 6:35 a.m., vomited coffee ground emesis moderate amount, transferred to ER. vi. On 11/15/2024, (Resident 1) noted with increased oral secretions with bleeding in the mouth and nose . transferred to ER. vii. On 12/8/2024, Patient (Resident 1) noted with bleeding in moderate amount, coming out from the mouth and nostrils with big clot . transferred to ER. A review of Resident 1's Care Plan on at risk of bleeding, there was no interventions revised when Resident 1 has actual bleeding on several occasions and no interventions revision when Resident 1 was hospitalized . During an interview with Assistant Director of Nursing (ADON) on 12/16/2024 at 1:11 p.m., ADON stated, Resident 1's family member refused to get the treatment that was being recommended by GACH which put Resident 1 at risk of further bleeding. ADON stated, there should be a revision of the Care Plan's interventions for each actual bleeding and change of condition and hospitalization s. ADON stated, they need to revise the interventions to further develop plan of care. A review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised January 2024, the P&P indicated, A comprehensive, person-centered care plan should include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs . the Interdisciplinary team should review and updates the care plan: when there has been a significant change in the resident's condition; when the resident has been readmitted to the facility from a hospital stay.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555700	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024

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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 0694

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide for the safe, appropriate administration of IV fluids for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43454

Based on observation, interview and record review, the facility failed to ensure proper care for one of one sampled resident (Resident 1)'s peripheral intravenous (PIV-a small, flexible tube placed into a small vein for intravenous therapy such as medication fluids) line and site by failing to ensure labeling with date on the PIV site; assessing/ monitoring PIV site with proper documentation and timely removal of PIV when IV therapy has been discontinued for Resident 1.

These deficient practices had the potential to place residents at risk for developing infections at the IV site which could also lead to sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood or other tissues and the body's response to their presence, potentially leading to the malfunctioning of various organs, shock, and death).

Findings:

A review of the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (loss of the ability to move in one side of the body) following unspecified cerebrovascular disease (CVD - a group of conditions that affect the blood vessels and blood flow in the brain and spinal cord) affecting left dominant side, chronic respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).

A review of the Minimum Data Set (MDS - resident assessment tool) dated 10/24/2024, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required total dependence from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).

A review of Resident 1's Order Summary Report, indicated Ceftriaxone (used to treat bacterial infections in many different parts of the body) for intravenous (IV) antibiotic medication was completed on 12/15/2024.

During an observation of Resident 1 on 12/16/2024 at 12:19 p.m. with Licensed Vocational Nurse 1, observed Resident 1's PIV line with no date on the transparent dressing. LVN 1 stated, Resident 1 was receiving intravenous antibiotic medications by Registered Nurses.

During an interview with Director of Nursing (DON) and Administrator (ADM) on 12/16/2024 at 2:39 p.m., DON stated, Resident 1 was receiving IV antibiotic, and the medication treatment has been completed on 12/15/2024. DON stated, the PIV dressing site should have been dated so that they know when to change the dressing and change the PIV line. ADM stated, the PIV line should have been discontinued after the IV antibiotic was also completed to prevent infection.

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NAME OF PROVIDER OR SUPPLIER Beverly Hills Rehabilitation Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 580 S San Vicente Blvd. Los Angeles, CA 90048	

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Peripheral IV Catheter Insertion, revised 1/2024, the P&P indicated, Label on dressing should include date and time of dressing placement, initials, gauge size, and length of catheter . Remove the peripheral catheter if therapy is discontinued.

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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 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** 43454 Based on observation, interview and record review, the facility failed to maintain an infection control measure and prevention by failing to 1. Ensure the staff wear a gown to have a complete personal protective equipment (PPE-mask, gown, eye protection, gloves) before providing close-contact care for resident on Enhanced barrier precautions during high contact resident care activities. 2. Perform proper hand hygiene including changing gloves in between procedure while doing treatment care for three of three sampled residents (Resident 1, 2, and 3) per facility policy. These deficient practices have the potential to result in the spread of disease and infection to other residents, visitors, and staff. Findings: 1. A review of the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (loss of the ability to move in one side of the body) following unspecified cerebrovascular disease (CVD - a group of conditions that affect the blood vessels and blood flow in the brain and spinal cord) affecting left dominant side, chronic respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of the Minimum Data Set (MDS - resident assessment tool) dated 10/24/2024, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required total dependence from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 1's physician order summary report indicated: i. cleanse gastrostomy site (g-tube - a feeding tube that is surgically inserted into the stomach through the skin and stomach wall) with normal saline (a sterile solution of water and salt that is used in medicine for a variety of purposes, including wound cleaning) cover with dry dressing every day, dated 11/22/2024. ii. Enhanced barrier precautions during high contact resident care activities, dated 5/2/2024. During an observation with Treatment Nurse 2 (TXN2) in Resident 1's room on 12/16/2024 at 11:41 a.m., observed TXN1 doing dressing changes on Resident 1 g-tube dressing. TXN1 removed the old g-tube dressing, cleanse with NS and applied a new dressing. TXN2 was not wearing a gown prior to entering the room and did not do a proper hand sanitize in between changing of gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with TNX 2 on 12/16/2024 at 11:50 a.m., TXN 2 stated, Resident 1 is on enhanced precautions due her g-tube site and staff need to wear full PPE when doing high-contact care. When asked if he (TXN 2) was wearing full PPE while doing skin treatment, TXN 2 stated, no. TXN 2 stated, he did not check the order prior to starting the dressing changes. TXN 2 further stated, he did not hand sanitize in between changing of gloves while doing dressing changes. 2. A review of the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including and hemiparesis following unspecified cerebrovascular disease affecting left dominant side, DM, and respiratory failure. A review of the MDS dated [DATE], indicated Resident 2's cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 2 required total dependence from staff for ADLs. A review of Resident 2's physician order summary report indicated: i. Enhanced barrier precautions during high contact resident care activities, dated 10/26/2024. During an observation with Certified Nursing Assistant 1 (CNA1) in Resident 2's room on 12/16/2024 at 10:56 a.m., observed CNA1 changing Resident 2's incontinent brief and changing linen with the help of Certified Nursing Assistant Student 1 (CNAS 1). CNA1 and CNAS1 was observed not wearing any gown while changing Resident 2's incontinent brief and linen change. During an interview with CNA1 on 12/16/2024 at 11:07 a.m., CNA1 stated, he did not notice the signage of enhanced barrier precaution outside Resident 2's room. CNA1 stated, staff need to wear full PPE including gown while cleaning and changing incontinent brief for residents who are on enhanced barrier precaution. CNA1 stated, him and the CNAS1 were not wearing full PPE, and this put residents at risk of infection. 3. A review of the Admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnosis including and hemiparesis following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting right dominant side, DM, and respiratory failure. A review of the MDS dated [DATE], indicated Resident 3's cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 3 required total dependence from staff for ADLs. A review of Resident 3's physician order summary report indicated: i. Enteral feed: cleanse site daily with soap and water every day, dated 11/22/2024. ii. Foley catheter (FC - a thin, flexible tube that drains urine from the bladder into a collection bag outside the body) care daily and as needed, dated 11/22/2024. During an observation with Treatment Nurse 1 (TXN1) in Resident 3's room on 12/16/2024 at 11:14 a.m., observed TXN1 doing dressing changes on Resident 2 g-tube dressing. TXN1 removed the old g-tube dressing, cleanse with NS and applied a new dry dressing. TXN1 did not changed gloves during the whole dressing changes care. TXN1 then did a FC care by flushing the foley catheter tubing while wearing the same soiled gloves from start to finish. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with TXN1 2 on 12/16/2024 at 11:25 a.m., TXN 1 stated, he wore the same gloves all throughout the procedure and did not change gloves in between. TXN 1 stated, this puts other residents and himself at risk of infection by not following the proper infection control guidelines. During an interview with Infection Preventionist Nurse (IPN) on 12/16/2024 at 12:41 p.m., IPN stated, staff must wear full PPE when doing care such as dressing changes, changing linen and incontinent brief. IPN stated, staff must perform hand hygiene such as hand sanitizing in between changing gloves and must put on new gloves when doing skin treatment and FC care. IPN stated, is it important to follow proper infection control policy and guidelines to prevent spread of infection. A review of the facility's policy and procedure (P&P) titled, Isolation - Transmission-Based Precautions and Enhanced Barrier Precautions, revised 4/2024, the P&P indicated, Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a multidrug-resistant organisms (MDRO - bacteria that are resistant to more than one antibiotic and can cause serious infections): wear gowns and gloves while performing the following high-contact tasks associated with the greatest risk for MDRO contamination of staff hands, clothes, and the environment such as: during morning and evening care; device care, for example urinary catheter, feeding tube . any care activity where close contact with the resident is expected to occur such as bathing, peri-care, assisting with toileting, changing incontinence briefs, respiratory care. A review of the facility's P&P titled, Enteral Nutrition, revised 4/2024, the P&P indicated, gastric tube stoma site requires a daily dressing change or with frequency as ordered by the following physician. Dressing change must follow all of infection control guidelines.