STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern California Hosp at Culver City D/P Snf	3828 Delmas Terrace Culver City, CA 90232

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 0610 Level of Harm - Actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 46333 Based on observation, interview, and record review, the facility failed to prevent further potential neglect and have evidence that all alleged violations were thoroughly investigated as indicated in the facility's Abuse Investigation policy for three of three sampled residents (Resident 1, 2 and 3) when: 1. Licensed vocational nurse (LVN - an entry-level health care provider who is responsible for rendering basic nursing care) 1 tied a sheet to the Resident 1 ' s bed frame and broken bedrail. This deficient practice resulted in Resident 1 falling out of bed and had the potential to result in unidentified neglect, mistreatment, and failure to protect Resident 1 from further neglect. 2. LVN 1 refused to assess Resident 2's wound vac (vacuum-assisted closure of a wound is a type of therapy to help wounds heal) and shut the door and turned off the light, leaving Resident 2 in the dark without assistance. This deficient practice resulted in Resident 2's wound not being assessed when an alarm indicating a potential issue that required immediate attention was ignored by LNV 1, which also resulted in Resident 2's mistrust of the facility care and stating, I do not feel safe around LVN 1. 3. LVN 1 failed to report Resident 3's KUB (diagnostic imaging for the kidney, ureter and bladder) used to assess the test result to the provider. This deficient practice resulted in the physician being unaware that Resident 3 ' s KUB results indicated a possible ileus (a condition where the intestine cannot push food and waste out of the body) or obstruction (a partial or complete blockage of the small intestine or large intestine) thus placing Resident 3 ' s well-being and safety at risk by delaying diagnosis and subsequent treatment. Findings: 1. During a review of Resident 1 ' s History and Physical (H&P, the most formal and complete assessment of the patient and the problem), dated 4/14/24, the H&P indicated that Resident 1's medical history included chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood) with recent tracheostomy (a surgical hole created in the windpipe that provides an alternative airway for breathing), cardiac arrest (cessation of function of the heart), and anoxic encephalopathy (a cessation of blood flow to the brain). (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Actual harm Residents Affected - Some	During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/6/18, it indicated Resident 1 was nonverbal, quadriplegia (paralysis below the neck that affects all of a person's limbs), and cognitive (process of thinking) skills for daily decision-making were severely impaired. The MDS also indicated Resident 1 required assistance with all activities of daily living such as eating, toileting, oral hygiene, showering, and dressing. During a review of Resident 1 ' s Nursing Narrative Note, dated 8/6/24, the note indicated, Patient received at 7:07 am sleeping in bed; the report was received at bed site; per the assigned nurse (name of LVN 1), the patient's bed is broken; the sheet was placed on the rails by the night shift nurse to tighten up to work it out as a side rail; per the night shift nurse, the replacement bed was not ordered yet . By 7:50, the RT (respiratory therapist) called me to the room to assess Resident 1, who slid from the mattress on the floor . The patient is closely monitored for any change of condition s/p (status post) or unwitnessed fall or sliding off the mattress on the floor. During a review of Resident 1 ' s Assessment and Care, report dated from 8/1/24 through 8/23/24, the report indicated that LVN 1 continues to be assigned to the care for Resident 1. The report indicated LVN 1 documented care for Resident 1 on 8/8/24, 8/14/24, 8/18/24, 8/20/24, 8/22/24, and 8/23/24 after 8/6/24 when Resident 1 fell . During a concurrent observation and interview on 9/12/24 at 10:58 a.m. with the administrator (ADM) in Resident 1 ' s room (located at the end of the unit hallway), Resident 1 was lying in bed with both right and left bed rails raised up. The ADM stated Resident 1 was unable to move her extremities; however, Resident 1 was able to wiggle her torso which is how she fell . ADM also confirmed the bed was in its lowest position. The bed is approximately 2.5 feet from the ground. During an interview on 9/12/24 at 12:00 p.m. with the Manager of the Subacute (a unit that provides intensive care, but to a lesser degree than acute care) Unit (MS) 1, MS 1 showed photos of the bed sheet tied to the bedframe and to the bed rail. MS 1 stated the day shift nurse came in and saw the broken bedrail with the bedsheet tied and requested for a new bed. While the nurse took the report from the outgoing nurse, Resident 1 fell . The respiratory therapist (RT) found Resident 1 on the floor by the bed. MS 1 stated, The patient (Resident 1) had an unwitnessed fall. MS 1 further stated she asked LVN 1 why she did not report the broken bedrail to the house supervisor, and LVN 1 responded, It ' s up to the day shift to do that. MS 1 confirmed there was no corrective action such as coaching, counseling and/or disciplinary action completed with LVN 1. MS 1 stated the department reported each incident involving LVN 1 to Human Resource. During an interview on 9/12/24 at 12:10 p.m. with the Director of Risk Management (DRM), the DRM stated the root cause analysis was completed by the facility. DRM stated, The conclusion of the analysis is that (LVN 1) identified the bedrail as broken and nonfunctioning but did a workaround by fixing the bedrail herself with the sheets and leaving the patient unattended while the rail was not working. During a concurrent interview and record review on 9/12/24 at 4:00 p.m. with the Director of Quality and Risk (DQR), the facility ' s incident reports (a detailed, written account of the chain of events leading up to an adverse incident or potential adverse incident) dated from March 2023 to September 2024, involving LVN 1 was reviewed. The incident report listed 32 reports regarding quality of care, resident neglect, and professional behavior. (continued on next page)

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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 0610 Level of Harm - Actual harm Residents Affected - Some	During an interview on 9/12/24 at 3:40 p.m. and on 9/27/24 at 3:05 p.m. with the Director of Quality and Risk (DQR), the DQR stated the facility was unable to provide an investigation report that included gathering details and interviews from staff and or residents and intervention and or corrective actions that were taken by the facility for each of the alleged reports that involved LVN 1. During a review of the facility ' s policy and procedure (P&P) titled, Abuse, Elder and Dependent Adult, dated January 2023, the P&P indicated, To assure that State and Federal Law regarding mandatory reporting of all known or suspected incidents of abuse of dependent and elder adults is followed. To assure that the mandated training material for the California Department of Justice are utilized. This procedure applies to the Subacute Unit . Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Deprivation by an individual, including a caretaker, of goods and services that were necessary to attain or maintain physical, mental and psychological wellbeing. Neglect: Failing to protect the resident from avoidable injury. An example of neglect would be to leave a resident, who is prone to falls, in the bathroom unattended .Staff member responsibility, If the incident was witnessed, take measures to protect the resident immediately .charge nurse or supervising nurse: Get the details of the incident from other staff members if appropriate or get any details of the incident from the resident if possible. Note: Any statements made by the resident/staff/visitor/family member on the back of the incident report. If the incident was witnessed, remove the person alleged to have committed the abuse. If it is a staff member, ask them to clock out immediately and to call the Director of Nursing about the incident. Administrator/Director of Nursing or Person Delegated to complete the investigation: The Nursing Manager for the facility will oversee the processes for reporting, investigating, interventions and corrective actions taken during abuse incidents. An investigation will be initiated immediately and completed within 5 days. This will include interviewing all individuals involved, including the resident. During a review of the facility ' s Employee Handbook, dated 2019, handbook indicated, Standards of Conduct: To foster a positive, collaborative working environment, and to ensure we are providing a safe and secure workplace where everyone is treated in a respectful and fair manner, we have established certain minimum standards of conduct regarding behavior towards co-workers, supervisors, and the overall organization. We expect all employees, and others who may from time to time be engaged to provide services, to conduct themselves in an ethical and dignified manner while on company premises, attending company functions or otherwise performing work-related activity . Safety and Security: Our employees know, understand and follow all health and safety policies and regulations that apply to their job and work environment including the reporting of personal injuries no matter how minor. Behavior that puts the safety of our patients/members, customers, employees or visitors in danger is not allowed .Corrective Action: Most employees are dedicated and hard working. Occasionally, however, an employee's work performance or behavior falls below standards. In these cases, we want to take corrective action to improve and prevent recurrence of undesirable behavior or performance. This can include coaching, counseling and corrective action, as is necessary and appropriate. (continued on next page)

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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 0610 Level of Harm - Actual harm Residents Affected - Some	2. During a review of Resident 2 ' s History and Physical (H&P), dated 6/3/24, the H&P indicated, Resident 2 ' s neurological (a branch of medicine that define the structure and function of the brain) assessment is oriented to person (the person knows their name and usually can recognize significant others), place (the person knows where they are, such as the hospital, clinic, or town.), and time (the person knows the time of day, date, day of the week, and season). Resident 2 ' s medical history included chronic lower extremity ulcer (an open sore on an external or internal surface of the body), and recent right hip debrided (remove damaged tissue from a wound). The H&P further indicated Resident 2 was sent to the subacute unit for continuation of care. During a review of Resident 2 ' s Order Summary, dated 7/26/23 through 7/26/23, the order summary indicated vacuum assisted closure should be on continuously. During an interview on 9/12/24 at 11:00 a.m. with Resident 2, in Resident 2 ' s room, Resident 2 stated, I do not feel safe, and I do not think other patients are safe in the care of (name of LVN 1). Resident 2 stated and show a video recording in September while under LVN 1 care, his wound vac was alarming. Resident 2 stated when he requested for help from LVN 1, LVN 1 stood at the foot of bed with another nurse and looked at the machine without assessing Resident 2 ' s wound or the machine, and just left the room. Resident 2 stated they called LVN 1 for assistance again as the wound vac continued to alarm. The LVN 1 came in and shut off the wound vac. LVN 1 walked out of the room, turn off the room light and shut the door while Resident 2 was asking LVN 1, why did she turn off the wound vac. Resident 2 stated as LVN 1 was leaving, LVN stated, I do things my own way. During an interview on 9/27/24 at 11:05 a.m. with the former manager of the subacute unit (MS) 3, MS 3 stated Resident 2 reported to her that (that name of LVN 1) did not assist when the wound vac was alarming and turned off the light and closed the door. MS 3 stated after being made aware of the incident she spoke to LVN 1, but she did not write up LVN 1. MS 3 stated the nursing staff are not familiar with the wound vac. However, MS 3 confirmed that a standard of nursing care is to assess the patient wound and wound dressing as well as assess the tubing of the wound vac to see if there is kink that may cause the alarm. MS 3 further confirmed that from watching the video the nurse did not assess these areas and did get assistance from wound care nurse or nurses in the acute area that are more familiar with the wound vac. During a concurrent interview and record review on 9/16/24 at 4:00 p.m. with the Director of Quality and Risk, the facility ' s incident reports (a detailed, written account of the chain of events leading up to an adverse incident or potential adverse incident) dated from March 2023 to September 2024, involving LVN 1 was reviewed. The incident report listed 32 reports. regarding quality of care, resident neglect, and professional behavior. During an interview on 9/12/24 at 3:40 p.m. and on 9/27/24 at 3:05 p.m. with the Director of Quality and Risk (DQR), DQR stated the facility was unable to provide an investigation report that included gathering details and interviews from staff and/or residents and intervention and/or corrective actions that were taken by the facility for each of the alleged report that involved LVN 1. (continued on next page)

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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 0610 Level of Harm - Actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure (P&P) titled, Abuse, Elder and Dependent Adult I, dated January 2023, the P&P indicated, To assure that State and Federal Law regarding mandatory reporting of all known or suspected incidents of abuse of dependent and elder adults is followed. To assure that the mandated training material for the California Department of Justice are utilized. This procedure applies to the Subacute Unit . Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Deprivation by an individual, including a caretaker, of goods and services that were necessary to attain or maintain physical, mental and psychological wellbeing. Neglect: Failing to protect the resident from avoidable injury. Residents have the right to refuse treatment and care. An example of neglect would be to leave a resident, who is prone to falls, in the bathroom unattended .Staff member responsibility, If the incident was witnessed, take measures to protect the resident immediately. Remove the resident from the area to a safe place or ask the individual in question to please leave the room or the area .charge nurse or supervising nurse: Get the details of the incident from other staff members if appropriate or get any details of the incident from the resident if possible. Note: Any statements made by the resident/staff/visitor/family member on the back of the incident report. If the incident was witnessed, remove the person alleged to have committed the abuse. If it is a staff member, ask them to clock out immediately and to call the Director of Nursing about the incident. Administrator/Director of Nursing or Person Delegated to complete the investigation: The Nursing Manager for the facility will oversee the processes for reporting, investigating, interventions and corrective actions taken during abuse incidents. An investigation will be initiated immediately and completed within 5 days. This will include interviewing all individuals involved, including the resident. During a review of the facility ' s Employee Handbook, dated 2019, handbook indicated, Standards of Conduct: To foster a positive, collaborative working environment, and to ensure we are providing a safe and secure workplace where everyone is treated in a respectful and fair manner, we have established certain minimum standards of conduct regarding behavior towards co-workers, supervisors, and the overall organization. We expect all employees, and others who may from time to time be engaged to provide services, to conduct themselves in an ethical and dignified manner while on company premises, attending company functions or otherwise performing work-related activity . Safety and Security: Our employees know, understand and follow all health and safety policies and regulations that apply to their job and work environment including the reporting of personal injuries no matter how minor. Behavior that puts the safety of our patients/members, customers, employees or visitors in danger is not allowed .Corrective Action: Most employees are dedicated and hard working. Occasionally, however, an employee's work performance or behavior falls below standards. In these cases, we want to take corrective action to improve and prevent recurrence of undesirable behavior or performance. This can include coaching, counseling and corrective action, as is necessary and appropriate. 3. During a review of Resident 3 ' s History and Physical (H&P), dated 3/30/24, the H&P indicated, Resident 3 ' s medical history that included chronic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition), and dysphagia (difficulty swallowing.) with a percutaneous endoscopic gastronomy (a surgery to place a feeding tube to deliver nutrition through the tube). During a review of Resident 3 ' s KUB result report, dated 4/3/24, the report indicated, Gaseous distention of bowel loops measuring up to 9.6 cm, could be due to ileus (a condition where the intestine cannot push food and waste out of the body) or obstruction. (continued on next page)

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Southern California Hosp at Culver City D/P Snf	3828 Delmas Terrace Culver City, CA 90232

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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 0610 Level of Harm - Actual harm Residents Affected - Some	During a concurrent interview and record review on 9/16/24 at 4:00 p.m. with the Director of Quality and Risk (DQR), the facility ' s incident reports (a detailed, written account of the chain of events leading up to an adverse incident or potential adverse incident) dated from March 2023 to September 2024, involving LVN 1 was reviewed. The incident report listed more than 30 reports, among the incidents reported was a report dated 4/3/24, indicated LVN 1 did not report a result of Resident 3 ' s KUB (A imaging of the kidney, ureter, and bladder, may be performed to assess the abdominal area for causes of abdominal pain). The outgoing nurse gave report that Resident 3 had a KUB completed and to notify the physician when result comes back. The reporting nurse came back to work 3 days later and decided to look into the result of the KUB and discovered the KUB result indicated and obstruction (a blockage that keeps food or liquid from passing through the small intestine or large intestine). The reporting nurse called the physician, the physician stated he did not get notified of the KUB result indicating an obstruction. During an interview on 9/12/24 at 3:40 p.m. and on 9/27/24 at 3:05 p.m. the DQR, the DQR stated the facility was unable to provide an investigation report that included gathering details and interviews from staff and/or residents and intervention and/or corrective actions that were taken by the facility for each of the alleged report that involved LVN 1. During a review of the facility ' s policy and procedure (P&P) titled, Abuse, Elder and Dependent Adult I, dated January 2023, the P&P indicated, To assure that State and Federal Law regarding mandatory reporting of all known or suspected incidents of abuse of dependent and elder adults is followed. To assure that the mandated training material for the California Department of Justice are utilized. This procedure applies to the Subacute Unit . Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Deprivation by an individual, including a caretaker, of goods and services that were necessary to attain or maintain physical, mental and psychological wellbeing. Neglect: Failing to protect the resident from avoidable injury. An example of neglect would be to leave a resident, who is prone to falls, in the bathroom unattended .Staff member responsibility, If the incident was witnessed, take measures to protect the resident immediately .charge nurse or supervising nurse: Get the details of the incident from other staff members if appropriate or get any details of the incident from the resident if possible. Note: Any statements made by the resident/staff/visitor/family member on the back of the incident report. If the incident was witnessed, remove the person alleged to have committed the abuse. If it is a staff member, ask them to clock out immediately and to call the Director of Nursing about the incident. Administrator/Director of Nursing or Person Delegated to complete the investigation: The Nursing Manager for the facility will oversee the processes for reporting, investigating, interventions and corrective actions taken during abuse incidents. An investigation will be initiated immediately and completed within 5 days. This will include interviewing all individuals involved, including the resident. (continued on next page)

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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 0610 Level of Harm - Actual harm Residents Affected - Some	During a review of the facility ' s Employee Handbook, dated 2019, handbook indicated, Standards of Conduct: To foster a positive, collaborative working environment, and to ensure we are providing a safe and secure workplace where everyone is treated in a respectful and fair manner, we have established certain minimum standards of conduct regarding behavior towards co-workers, supervisors, and the overall organization. We expect all employees, and others who may from time to time be engaged to provide services, to conduct themselves in an ethical and dignified manner while on company premises, attending company functions or otherwise performing work-related activity . Safety and Security: Our employees know, understand and follow all health and safety policies and regulations that apply to their job and work environment including the reporting of personal injuries no matter how minor. Behavior that puts the safety of our patients/members, customers, employees or visitors in danger is not allowed .Corrective Action: Most employees are dedicated and hard working. Occasionally, however, an employee's work performance or behavior falls below standards. In these cases, we want to take corrective action to improve and prevent recurrence of undesirable behavior or performance. This can include coaching, counseling and corrective action, as is necessary and appropriate.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46333 Based on observation, interview, and record review, the facility failed to ensure the facility's policies and procedures were followed for of one of three sampled residents (Resident 1), when Resident 1's bedrail was tied with a sheet after it was found to be broken and the facility staff failed to monitor Resident 1 while the bedrail remained broken. This failure resulted in Resident 1 falling out of bed and had the potential for risk of entrapment or strangulation due to the sheet tied from the bed rail to the lower bed frame. Findings: During a review of Resident 1' s History and Physical (H&P, the most formal and complete assessment of the patient and the problem), dated 4/14/24, the H&P indicated that Resident 1's medical history included chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood) with recent tracheostomy (a surgically whole created in the windpipe that provides an alternative airway for breathing), cardiac arrest (cessation of function of the heart), and anoxic encephalopathy (a cessation of blood flow to the brain). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated June 6, 2018, the MDS indicated Resident 1 was nonverbal. Resident 1 is quadriplegia (paralysis below the neck that affects all of a person's limbs). Resident 1 cognitive skills for daily decision-making are severely impaired. Resident 1 required assistance with all activities of daily living such as eating, toileting, oral hygiene, showering, and dressing. During a review of Resident 1 ' s Nursing Narrative Note, dated 8/6/24, the note indicated, Patient received at 7:07 am sleeping in bed; the report was received at bed site; per the assigned nurse (name of LVN 1), the patient's bed is broken; the sheet was placed on the rails by the night shift nurse to tighten up to work it out as a side rail; per the night shift nurse, the replacement bed was not ordered yet . By 7:50, the RT (respiratory therapist) called me to the room to assess the patient (name of Resident 1) who slid from the mattress on the floor . The patient is closely monitored for any change of condition s/p (status post) or unwitnessed fall or sliding off the mattress on the floor. During a concurrent observation and interview on 9/12/24 at 10:58 a.m. with the administrator (ADM) in Resident 1 ' s room, Resident 1 was lying in bed with both right and left bed rails raised up. Resident 1 eyes were opened; however, when Resident 1 name was called, Resident 1 was unable to respond. The ADM confirmed that Resident 1 was nonverbal and unable to make her needs known. The bed was in its lowest position. The bed is approximately 2.5 feet from the ground. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/12/24 at 12:00 p.m. with the Manager of the Subacute (a unit that provides intensive care, but to a lesser degree than acute care) Unit (MS) 1, MS 1 showed photos of the bed sheet tied to the bedframe and to the bed railed. MS 1 stated the day shift nurse came in and saw the broken bedrail with the bedsheet tied and requested for a new bed. While the nurse took the report from the outgoing nurse, the patient (Resident 1) fell . The respiratory therapist found the patient (Resident 1) on the floor by the bed. MS 1 stated, The patient (Resident 1) had an unwitnessed fall. MS 1 further stated she asked LVN 1 why she did not report the broken bedrail to the house supervisor, and LVN 1 responded, it is not her responsibility. MS 1 further stated the LVN 1 responded and said, It is up to the day shift to do that. During an interview on 9/12/24 at 12:10 p.m. with the Director of Risk Management (DRM), the DRM stated the root cause analysis was completed by the facility. DRM stated, The conclusion of the analysis is that (name of LVN 1) identified the bedrail as broken and nonfunctioning but did a workaround by fixing the bedrail herself with the sheets and leaving the patient unattended while the rail was not working. During a review of the facility 's policy and procedure (P&P) titled, Medical Equipment Failure and Clinical Intervention, dated January 2024, the P&P indicated, It is the policy of (name of the facility) to respond to a failure of medical equipment and provide emergency clinical interventions when appropriate . In the event of malfunction or failure of a piece of High-Risk Equipment, staff shall follow the Clinical Intervention Protocol until replacement equipment can be obtained. In the event of an emergency involving a medical equipment malfunction or failure, the medical and clinical staff members are instructed to take the required steps to ensure the safety of the patient and attempt to locate the appropriate replacement equipment. Medical equipment that is involved in an event that caused or has the potential for serious injury to patient, or is involved in the death of a patient, will be removed from service immediately and secured to prevent tampering until the appropriate individuals arrive for further inspection. During a review of the facility' s P&P titled, Falls Prevention Program, dated December 2022, the P&P indicated, To establish a framework for assessing risk factors for patient falls, reducing the risk for falling, protecting patients from injury if a fall should occur, and monitoring the effectiveness of the hospital fall prevention program . Plan of Care Strategies; General strategies for patients at risk for falls may include, but are not limited to: Use of up to 2 or 3 side rails to assist turning side to side. Placing the bed in the lowest position possible. Call light within patient reach. Remind patient to use call button to call for assistance. Reorientation as necessary while awake. Place patient in rooms close to the Nurses Station. Personal items (e.g., glasses, hearing aids, dentures) within reach. Referral to appropriate discipline for specific assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern California Hosp at Culver City D/P Snf	3828 Delmas Terrace Culver City, CA 90232

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46333 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was cared for by a health care clinician that has a current Basic Life Support (BLS, care that first-responders, healthcare providers and public safety professionals provide to anyone who is experiencing cardiac arrest [the heart stop functioning], respiratory distress or an obstructed airway) in accordance with the facility job description for Licensed Vocational Nurses. (LVN). LVN 1 who was assigned to work on the facility subacute unit (a unit that provide intensive care, but to a lesser degree than acute care), did not have a up to date BLS certification. This deficient practice had the potential of delayed provisions of emergency care for Resident 1 and the 39 residents in the subacute unit who wishes to have full treatment in a life-threatening situation. Findings: During a review of Resident 1 ' s History and Physical (H&P, the most formal and complete assessment of the resident and the problem), dated [DATE], the H&P indicated, Resident 1 medical history included chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood) with recent tracheostomy (a surgically whole created in the windpipe that provides an alternative airway for breathing), cardiac arrest (cessation of function of the heart) , anoxic encephalopathy (a cessation of blood flow to the brain). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated [DATE], indicated Resident 1 POLST (Practitioner Orders for Life Sustaining Treatment form enables patients to indicate their preferences regarding life-sustaining treatment) specified Resident 1 or responsible party wishes to have resuscitation/ CPR (cardiopulmonary resuscitation, It can help save a life during cardiac arrest, when the heart stops beating) for Resident 1. During a review of Resident 1 ' s Assessment and Care, report dated from [DATE] through [DATE], the report indicated, LVN 1 documented care for Resident 1 on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. During a concurrent interview and record review on [DATE] at 3:00 p.m. with the Operational Manager of Humane Resource (OMHR), LVN 1 ' s BLS certification, was reviewed. LVN 1 ' s BLS indicated, the certification was expired on [DATE], nine months and 26 days expired. The OMHR stated a report was sent out to the unit manager regarding LVN 1 ' s BLS expiration. The OMHR stated LVN 1 was hired in 2022 and has been an active employee and was currently working in the Subacute unit full time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555874	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southern California Hosp at Culver City D/P Snf	3828 Delmas Terrace Culver City, CA 90232

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:05 a.m. with the Manager of the Subacute (care in a unit that is intensive, but to a lesser degree than acute care) unit (MS) 1, MS 1 stated LVN 1 ' s BLS expiration was missed because the report provided by human resources (HR) is not always up to date because the employee upload the certificate into the system, but HR does not see it. MS 1 stated, This process will be change, we will have the employee copied (sending a copy of the email to) the manager in the emailed from here forward. MS 1 further stated it is important for employee to have current BLS as required because they do not have a code blue (response to a patient have a cardiac or respiratory arrest or medical emergency) all the time, thus keeping current with certification will allow fresh skills to performed during a code. During a review of LVN 1 ' s job description under Required Qualifications, undated, the job description indicated, Basic Life Support, was a requirement to be qualified to work in the LVN position on the Subacute department.