

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555874	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Southern California Hosp at Culver City D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review, the facility failed to ensure one of one sampled resident's (Resident 1) medical order (a directive issued by a licensed physician) for a stat (immediately) electroencephalogram (EEG, a non-invasive test that records the brain's electrical activity to help diagnose conditions like epilepsy, head injuries, and other brain issues) was completed as directed by the physician. This deficient resulted in delay and can potentially cause the patient's condition to worsen or resulted in injury or harm such as prolonged seizures, permanent cognitive impairment, or the need for more invasive treatments, all of which can be prevented with timely action. During a review of Resident 1's Face Sheet (a summary of patient data), undated, the Face Sheet indicated Resident 1 was admitted to the skilled nursing facility (SNF 1, a licensed clinical care setting that provides 24-hour medical support and rehabilitation services to residents who require more intensive care than what can be delivered at home do not need acute hospitalization) on 5/29/2025 with the admitting diagnosis of acute respiratory failure (a serious condition where the lungs can't adequately oxygenate the blood or remove carbon dioxide, leading to low oxygen and/or high carbon dioxide in the blood). During a review of Resident 1's Order Summary, dated 11/18/2025, the Summary indicated that a medical order for a stat EEG was placed on 11/18/2025 at 1:49 p.m. During an interview on 11/20/2025 at 11:42 a.m. with Facility Manager (FM) 1, FM 1 stated that a stat EEG order was placed by Medical Doctor (MD) 2 on 11/18/2025. MD 2 was covering MD 1 who was the primary care physician (the doctor who serves as the main point of contact for an individual's general health concerns, preventive care, and referrals to specialists) of Resident 1. The EEG test was a contracted service and was done by an outside company. The EEG technician was scheduled to come today (11/20/2025) at 5:30 p.m. MD 3 was the house neurologist (a medical doctor specializing in the diagnosis, treatment, and management of disorders affecting the brain, spinal cord, and nervous system), and he interpreted the EEG results. During an interview on 11/20/2025 at 12:59 p.m. with Director of Respiratory Department (DRD), DRD stated that the EEG Technician came on 11/19/2025 to do the EEG test on Resident 1 but was instructed by MD 3 to hold off from doing the EEG test. There was no written order to hold the EEG test. The EEG test was placed on hold until 11/20/2025. DRD added that it was a verbal order to hold the EEG test, but MD 3 was not the ordering provider. The EEG technician should have reached out to MD 2, who was the ordering provider, and/or inform the nurse assigned that the EEG order was on hold. During a review of the facility's policy and procedure (P&P) titled Telephone and Verbal Orders, last reviewed 7/2025, the P&P indicated: A. Verbal Orders- Non-emergent Verbal Orders shall not be accepted.- Emergent Verbal Orders, defined as those orders given on-site during the performance of an operative or invasive procedure, resuscitative event, or in the other life-threatening situations, shall be accepted by a RN, LVN, Pharmacist, or Respiratory Therapist within the scope of their practice.- The licensed staff shall read back the verbal orders to clarify; emergent verbal orders must be signed by the physician prior to leaving the nursing unit.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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