| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555874 | A. Building<br>B. Wing | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Southern California Hosp at Culver City D/P Snf | 3828 Delmas Terrace<br>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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an injury of unknown origin (the source of the injury was not witnessed by any person and the source of the injury could not be explained by the resident and the injury is suspicious because of its extent, location, the number of injuries at a time, or the number of injuries over time) to CDPH, Adult Protective Services (APS, the county agency responsible for investigating reports of abuse, neglect, or exploitation of elders and dependent adults), and the Ombudsman within 24 hours for one of three sampled residents (Resident 1) in accordance with state law and the facility's policy and procedure (P&P) titled Abuse, Elder & Dependent Adult.This deficient practice had the potential to place Resident 1 at risk for unidentified abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) and resulted in a delay in the investigation.Findings: During a review of Resident 1's face sheet (FS, summary document summarizing a patient's essential information, acting as the cover sheet for their medical record), dated 3/20/2026, the FS indicated that patient was readmitted to the facility on [DATE]. During a review of Resident 1's History & Physical (H&P, a formal and complete assessment of the patient and the problem), dated 3/13/2026, the H&P indicated Resident 1 was admitted due to chronic respiratory failure post tracheostomy (a long-term inability of the lungs to adequately exchange oxygen and carbon dioxide, necessitating a permanent or long-term surgical airway opening [tracheostomy, a surgical procedure creating an opening in the neck into the trachea to facilitate breathing, bypassing the mouth and nose] to breathe); anoxic brain injury (severe condition caused by a complete cutoff of oxygen to the brain, with cell death beginning after approximately four minutes), and chronic heart failure (a long-term, progressive condition where the heart muscle is weakened or stiff, failing to pump blood effectively). During a review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment care screening tool), dated 1/25/2026, the MDS indicated Resident 1 had severely impaired cognitive skills (ability to think, remember, and reason) for daily decision making and was dependent (helper does all of the effort, resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) on staff for oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, putting on and removing footwear, personal hygiene, rolling left and right, moving from sitting to lying and lying to sitting at the side of bed, sit-to-stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer, and car transfer. During a review of Resident 1's Nursing Narrative Note, dated 3/22/2026 at 5:49 pm, the Note indicated that Resident 1's primary nurse (RN1) notified the charge nurse (CN) that there was redness noted on Resident 1's forehead. The Note further indicated Resident 1's wife and daughter were at bedside and made aware of the redness on Resident 1's forehead; the nurse practitioner (NP, a licensed advanced practice clinician who can assess, diagnose, and manage patient conditions) was notified to assess the resident, vital signs (basic measurements of the body's essential functions, such as temperature, pulse, respirations, and blood pressure) were within normal limits, and Resident 1 appeared comfortable with no signs or symptom of pain or distress. During a review of Resident 1's<br>(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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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Nursing Narrative Note, dated 3/22/2026 at 8:30 pm, the Note indicated Resident 1's wife was notified that the NP assessed Resident 1's forehead discoloration as a mild contusion (a bruise caused by injury to soft tissue resulting in discoloration without breaking the skin), and the plan was to monitor and administer pain medication as needed. During a review of Resident 1's Social Services Note, dated 3/24/2026 at 10:49 am, the Note indicated that the social worker (SW) consulted with Risk Management and the Social Services Manager regarding the need to report a bruise observed on Resident 1's forehead that was reported by nursing with an unknown cause, and Risk Management advised proceeding with consultation with the Long-Term Care (LTC) Ombudsman. The note indicated that the SW attempted to contact the LTC Ombudsman; however, there was no answer and the SW left a voicemail requesting a return call and provided contact information, which was two days (more than 24 hours) after the incident occurred. During a review of Resident 1's Reporting of Suspected Dependent Adult/Elder Abuse Form SOC341, dated 3/24/2026, the SOC341 form indicated that it (the SOC341 form) was completed and faxed on 3/24/2026, which was two days (more than 24 hours) after the incident occurred. During a review of the facility's incident report form, dated 3/26/2026, the incident report form indicated the incident occurred on 3/22/2026 at 1:10 pm, and the date of notification to CDPH was 3/26/2026, which was four days (more than 24 hours) after the incident occurred. During an interview on 4/30/2026 at 11:45 a.m. with the Director of Risk and Quality (DRQ), the DRQ stated that according to Resident 1's Nursing Narrative Note, Resident 1's forehead bruise was discovered on 3/22/2026 at 5:49 pm, and according to the Social Services Note, the SW sent the SOC341 form to APS and called the Ombudsman on 3/24/26, which was two days (more than 24 hours) after the incident occurred. The DRQ also verified the facility incident report was sent to CDPH on 3/26/2026 which was four days (more than 24 hours) after the incident occurred. DRQ stated that was a delay of reporting per state law and facility policy and that they were not aware of the reporting timeline regulation. During an interview on 4/30/2026 at 12:33 p.m. with the Social Worker (SW), the SW stated that according to Resident 1's Social Services Note on 3/24/2026 at 10:49 a.m., the SW was aware the incident happened on 3/22/2026, which was a Sunday, and she (SW) followed up on this incident on 3/24/2026. The SW confirmed she completed and faxed the SOC341 form to APS on 3/24/2026. The SW also confirmed she (SW) called the ombudsman on the same day (3/24/2026), which was two days (more than 24 hours) after the incident occurred. During a review of the facility's policy and procedure (P&P) titled, Abuse, Elder and Dependent Adult, Number SAU.002, dated 5/2025, the P&P indicated, Notify the state licensing agency within 24 hours by phone and within 72 hours by written report . and long term care ombudsman office by phone immediately. the following indicator do not always mean abuse or neglect has occurred, but they can be clues to the need for an abuse investigation. physical indicators, bruises, welts, discoloration, swelling cut lacerations, puncture wounds, cuts, lacerations, puncture wounds, pain or tenderness on touching. |