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	02/27/2026

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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review, the facility failed to: 1. Provide a Payroll Based Journal information for quarter 4.This failure had resulted in the facility not providing the required information regarding the quantity of staff assigned for safe and comprehensive care for all residents, as required by federal regulations.During a review of the Fiscal Year Quarter 4 2025 PBJ Staffing Data Report for the facility, dated 2/20/2026, the Fiscal Year Quarter 4 2025 PBJ Staffing Data Report indicated the facility failed to submit data for the quarter. During an interview on 02/27/2026 at 10:34 AM, with the NM, the NM stated the information was submitted, just as it was for the previous quarters. The NM explained that the same happened for the last recertification survey, the PBJ Q4 data was not received, and there was no confirmation email after uploading the Quarter 4 staffing information. The NM did not state there was a phone call to the District Office to resolve the matter for the fiscal year of 2024.During a record review of the State Operations Manual (SOM), dated 7/23/2025, the SOM indicates, the facility is responsible for submitting staffing data through the CMS Payroll-Based Journal (PBJ) system. The facility's failure to submit PBJ data as required will be reflected on their CASPER report and result in a deficiency citation.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure expired food items were discarded and open food packets were labeled.These deficient practices had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever potentially leading to other serious medical complications and hospitalization. Findings: During a concurrent observation and interview, on 2/24/2026 at 9:03 a.m., in the kitchen, with the Dietary Services Supervisor (DSS), the following was observed:Dairy Fridge: A bottle of Italian dressing and a block of parmesan cheese was observed without a label or date. Walk-in Cooler #1: 1 open carton of heavy cream and 1 open gallon of milk were observed without a label or date and 1 opened container of garlic spread with an expiration date of 2/21/26. Walk in Cooler #2: An opened bag of oregano was observed unlabeled and undated.Walk-in Freezer: An open, unlabeled bag of tortillas with tilapia was observed on top of a shelf.Spices and Seasonings Rack: Three 5-pound opened containers of onion powder, black pepper, and garlic powder, and a box of opened corn starch was observed unlabeled and undated. During the interview, the DSS stated all food items should be labeled and dated. The DSS stated all expired items should be discarded. The DSS stated the risk of not labeling food items and discarding expired foods could result in residents contracting foodborne illnesses.During a review of the facility's policy and procedures (P&P), titled Proper Food Storage Techniques, dated 8/21/2023, the P&P indicated Discard all food or beverage items that are past the expiration date label and Cover, label, and date unused portions and open packages.

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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** Based on observation, interview, and record review, the facility failed to: 1. Perform hand hygiene for one of eight residents, Resident 11, after touching Resident 11's suction canister (a medical container used to collect and store mucus, blood, or saliva) .This failure had the potential to spread infectious organisms to other areas inside Resident 11's and outside Resident 11's room.Findings:During a review of Resident 11's admission Note, dated 8/7/2025, the admission Note indicated Resident 11 has renal failure.During a review of Resident 11's History & Physical, the History & Physical indicated Resident 11 has a medical history of Respiratory Failure, Diabetes Mellitus, and an open wound.During a review of Resident 11's Minimal Data Set (MDS), dated the MDS indicated Resident 11 has functional limitations in range of motion of the upper and lower extremities and is dependent on staff for oral hygiene, toileting hygiene, bathing, getting dressed, putting on and taking off footwear, and personal hygiene. Resident 11 is also dependent on staff for rolling left to right, transitioning from sitting to lying and lying to sitting, changing from sitting to a standing position, moving from bed to chair, and transitioning to the toilet and shower.During a review of Resident 11's Care Plan Report (CP), dated 11/1/2023, the CP indicated Resident 11 is unable to perform self-care due to activity intolerance, limited mobility and their disease process.During an observation on 2/24/2026, at 9:30 a.m., in room [ROOM NUMBER]-A, CNA1 touched the outside of Resident 11's suction canister, while identifying the date the canister was changed and did not perform hand hygiene upon exiting the room. During an interview on 2/24/2026, at 9:32 a.m., outside room [ROOM NUMBER]A, with CNA1, CNA1 stated they should perform hand hygiene upon exiting the room.During an interview on 2/27/2026, at 8:47 a.m., in the Activities Room, with CN1, CN1 stated staff are supposed to perform hand hygiene before entering a resident's room, before touching a resident, upon exiting the resident's room, before putting on gloves and after changing gloves, or any time they believe hands are not clean.During a review of the facility's policy and procedure titled, Hand Hygiene, dated 1/2026, the P&P indicated, alcohol-based hand rub (ABHR) is the preferred method for hand hygiene when hands are not visibly soiled. Use ABHR after contact with patient surroundings or medical equipment.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:1. Provide a signed document offering, or declining, the COVID, influenza, and pneumococcal immunizations to one of eight residents, Resident 4 and failed to provide a signed document offering, or declining, the influenza vaccine to one of eight residents, Resident 11.This failure had the potential to neglect Residents 4 and 11 rights to refuse or receive immunizations from seasonal respiratory infections.During a review of Resident 4's admission Note, dated 12/11/2025, the admission Note indicated Resident 4 has chronic respiratory failure (a long-term, ongoing condition where the lungs cannot properly exchange oxygen and carbon dioxide).During a review of Resident 4's History & Physical (H&P), dated 12/12/2025, the H&P indicated Resident 4 has hypertension (high blood pressure), congestive heart failure (a chronic, progressive condition where the heart muscle cannot pump efficiently enough to meet the body's oxygen needs, leading to fluid backup in the lungs and body) , and hyperlipidemia (high levels of cholesterol in the blood).During a review of Resident 4's Minimum Data Set (MDS), dated [DATE], the MDS indicated Resident 4 is dependent on facility staff for oral, personal, and toileting hygiene, showering, upper and lower body dressing, putting on and taking off footwear. Resident 4 is dependent on staff repositioning themselves in bed, getting in and out of bed, and transferring from bed to chair and getting on and off the toilet.During a review of Resident 4's Care Plan Report (CP), dated 2/11/2025, the CP indicated Resident 4's ability to physically function is altered and staff are to anticipate Resident 4's functional needs.During a review of Resident 11's admission Note, dated 8/7/2025, the admission Note indicated Resident 11 has renal failure (kidneys loose function to filter water and waste products from the body).During a review of Resident 11's History & Physical, the History & Physical indicated Resident 11 has a medical history of Respiratory Failure (a condition when the lungs cannot get enough oxygen into the blood) , Diabetes Mellitus (a disease that result in too much sugar in the blood), and an open wound.During a review of Resident 11's Minimal Data Set (MDS), dated the MDS indicated Resident 11 has functional limitations in range of motion of the upper and lower extremities and is dependent on staff for oral hygiene, toileting hygiene, bathing, getting dressed, putting on and taking off footwear, and personal hygiene. Resident 11 is also dependent on staff for rolling left to right, transitioning from sitting to lying and lying to sitting, changing from sitting to a standing position, moving from bed to chair, and transitioning to the toilet and shower.During a review of Resident 11's Care Plan Report, dated 11/1/2023, the Care Plan Report indicated Resident 11 is unable to perform self-care due to activity intolerance, limited mobility and their disease process.During a record review and interview on 2/25/2025 at 4:08 p.m. with Infection Preventionist (IP), IP stated they did not have documentation of an offer of vaccines for Resident 4 and an offer of the influenza vaccine to Resident 11. The IP stated if there is no vaccine information documented for the residents they could deteriorate from an infection, or if there is no vaccine status known within 72 hours of admission it could affect the resident's health. IP also stated it important to know the vaccine status to keep immunizations up to date and offering vaccines is part of the admission process.During a review of the facility's policy and procedure (P&P) titled, Pneumococcal and Influenza Vaccine, dated 7/2019, the P&P indicated:C. 1. During the initial assessment, the RN (registered nurse) will complete the Pneumococcal/Influenza Vaccination Order to indicate if the vaccinations are indicated according to criteria in Allscripts.C. 2. If the patient meets any inclusion criteria and no exclusion criteria, the RN will inform the patient that they are eligible for the vaccination(s), give the patient the vaccination information sheet(s), and administer the vaccination(s).

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure dignity was maintained for one of four sampled residents (Resident 3), who was left in bed exposed. This deficient practice had the potential to violate Resident 3's rights.Findings:During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3 diagnoses included chronic respiratory failure (a long-term, ongoing condition where the lungs cannot properly exchange gases, leading to chronically low oxygen or high carbon dioxide levels in the blood), dysphagia (difficulty swallowing), anoxic encephalopathy (a brain injury caused by a total lack of oxygen to the brain leading to cell death and impaired function) and a history of cardiac arrest (the sudden, unexpected stop of the heart's pumping function).During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 11/2/2025, the MDS indicated Resident 3's cognitive (thinking) skills for daily decision making were severely impaired. The MDS indicated Resident 3 was dependent on staff with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a concurrent observation and interview, on 2/26/2026 at 10:02 a.m., with Licensed Vocational Nurse 1 (LVN 1), Resident 3 was observed non-verbal, lying in bed. The hospital gown was shifted up to Resident 3's waist, exposing her diaper, thighs, and legs. There was no sheet or blanket observed. Resident 3's curtain was open. LVN 1 stated all residents were offered blankets upon admission. LVN 1 stated if a resident could not speak and did not have a blanket, staff would feel their skin to determine if they were cold. LVN 1 stated if a resident felt cold, a sheet would be provided. LVN 1 stated all residents should have a blanket to cover themselves. LVN 1 stated the risk of not providing a blanket to a resident could result in the resident being exposed or feeling cold.The facility did not provide a policy and procedure upon request.