STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555927	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pih Health Good Samaritan Hospital D/P Snf	1225 Wilshire Blvd Los Angeles, CA 90017

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review, the facility failed to document the removal or release of mittens and wrist restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for one out of one sampled resident (Resident 46). There was no evidence in Resident 46's record indicating that the restraints were removed or released for monitoring or assessment during the shift. Failure to document the removal or release of restraints (such as mittens or wrist restraints) violates the requirement for ongoing monitoring and documentation, which is essential to ensure the restraint is medically necessary and not used for convenience or discipline. This failure had the potential to compromise Resident 46's rights and safety. This had a potential for risk for harm such as skin breakdown, restricted circulation, or psychosocial distress due to prolonged restraint.Findings: During a review of Resident 46's admission Record, the admission Record indicated the facility admitted Resident 46 on 11/26/2025 with diagnoses that included altered mental status (AMS - unusual changes in a person's mental function, emotional response, thinking, or behavior). During a review of Resident 46's History and Physical (H&P - a doctor's comprehensive check-up where they ask detailed questions about your health history and then do a thorough physical examination, putting it all together to understand your condition and plan your treatment), dated 11/27/2025, the H&P indicated Resident 46 had a known history of dementia (a progressive state of decline in mental abilities) and was suspected to have toxic metabolic encephalopathy (when cells in the body do not allow the healthy breakdown of substances leading to inflammation of the brain cells and altered brain function). The H&P indicated Resident 46 was pulling on his Foley (a catheter that is a thin tube with a balloon that stays in the bladder to drain urine for people who can't go on their own) therefore restraint was continued. The H&P indicated the facility would continue Resident 46's restraints until his Foley was removed. During a review of Resident 46's Minimum Data Set (MDS - a resident assessment tool) dated 12/3/2025, the MDS indicated Resident 46 sometimes understood others and sometimes could make himself (Resident 46) understood. During a review of Resident 46's Patient Orders, dated 12/3/2025, the Patient Orders indicated a physician order for Restraints (non-violent) soft left wrist, soft right wrist, mittens (a soft, padded glove put on someone's hand to stop them from scratching, pulling out important tubes, or hurting themselves or others, especially if they are confused or agitated) left hand, mitten right hand criteria for removal of restraints and discontinuation of order - no longer exhibits behavior (the way someone acts); calm and in control; follows directions to stop behaviors During a review of Resident 46's Adult Assessment/Intervention, dated 12/1/2025 at 12 AM, the Adult Assessment/Intervention indicated Resident 46's restraints were on and the Registered Nurse (RN - in general) would assess (examine and evaluate) Resident 46's restraint every 2 hours. The Adult Assessment/Intervention indicated the facility would monitor Resident 46's circulation (flow of blood), sensation (a physical feeling or perception resulting from something that happens to or comes into contact with the body), motor (Resident 46's ability to move his arms, hands and fingers), and skin. The Adult Assessment/Intervention indicated Resident 46 was calm and had a bed alarm for fall (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safety. The Adult Assessment/Intervention indicated interventions for Resident 46's skin was to keep the head of his bed up, position was supine (on his back facing up) and did not indicate the facility removed/released Resident 46's restraints. During a review of Resident 46's Adult Assessment/Intervention, dated 12/1/2025 at 2:02 AM, the Adult Assessment/Intervention indicated Resident 46's restraints were on, and Resident 46 was sleeping. The Adult Assessment/Intervention indicated the facility's skin intervention was to keep Resident 46's head of bed up and documented Resident 46 was in supine position. The Adult Assessment/Intervention indicated Resident 46 was calm and had a bed alarm for fall safety. The Adult Assessment/Intervention did not indicate the facility removed/released Resident 46's restraints. During a review of Resident 46's Adult Assessment/Intervention, dated 12/1/2025 at 4:02 AM, the Adult Assessment/Intervention indicated Resident 46's restraints were on, and Resident 46 appeared to be sleeping. The Adult Assessment/Intervention indicated the facility's skin intervention was to keep Resident 46's head of bed up and documented Resident 46 was in supine position. The Adult Assessment/Intervention indicated Resident 46 had a bed alarm for fall safety. The Adult Assessment/Intervention did not indicate the facility removed/released Resident 46's restraints. During a review of Resident 46's Adult Assessment/Intervention, dated 12/1/2025 at 6:04 AM, the Adult Assessment/Intervention indicated Resident 46's restraints were on, and Resident 46 was confused but calm. The Adult Assessment/Intervention indicated the facility's skin intervention was to keep Resident 46's head of bed up and documented Resident 46 was in supine position. The Adult Assessment/Intervention indicated Resident 46 had a bed alarm for fall safety. The Adult Assessment/Intervention did not indicate the facility removed/released Resident 46's restraints. During a concurrent observation and interview on 12/1/2025 at 12:15 PM with Certified Nursing Assistant 1 (CNA 1) at the doorway of Resident 46's room, Resident 46 was observed to have mittens on both hands and restraints on both wrists. The mittens were observed to have pads on the hands and Resident 46's hands could not be seen. CNA 1 stated she was watching Resident 46 and Resident 31 at the same time. CNA 1 stated Resident 46 had restraints on because he was a fall risk. CNA 1 stated Resident 46 was also being monitored on video and had a bed alarm. During a concurrent and record review on 12/1/2025 at 12:21 PM with Registered Nurse 2 (RN 2), Resident 46's restraint monitoring assessment was reviewed. The restraint monitoring assessment indicated the staff were monitoring that Resident 46's restraints were on, but the box for documenting removing the restraints were not checked. RN 1 stated Resident 46's restraints needed to be removed so staff could check Resident 46's circulation. During an interview on 12/1/2025 at 12:52 PM with the facility's Clinical Director (CD), the CD stated if the staff did not document removing/releasing Resident 46's mittens/wrist restraints it was not done. The CD stated releasing Resident 46's restraints would allow the nurse to assess Resident 46's circulation. The CD stated the staff were documenting checking Resident 46's circulation. The CD stated she did not know how staff was able to assess Resident 46's circulation if the staff were not removing the mittens and wrist restraints for the assessment. During an interview on 12/4/2025 at 10:24 AM with the facility's Director of Quality (DQ), the DQ stated the facility checked to ensure orders for restraints were appropriate to be kept on and for when it was appropriate for removal. The DQ stated the facility's electronic medical record needed to be modified due to issues with the facility's restraint monitoring documentation tool. The QD stated the facility will modify the tool to reflect when staff release a resident's (in general) restraint. During a review of the facility's policy and procedures (P&P) titled, TCU Restraints, Non-Violent, dated 2025, the P&P indicated the resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Restraints may only be utilized to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. PIH Health will work to actively decrease the use of restraints. When restraints are necessary, such activity will be undertaken in a manner that protects the patient's health and safety and preserves his or her dignity, rights, and well-being. All attempts (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will be made to utilize the least restrictive interventions possible in the provision of patient care. Before a resident is restrained, the facility must determine the presence of a specific medical symptom that would require the use of restraints and how the use of restraints would treat the medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being. The P&P indicated A. Prohibitions (to forbid; making a rule to ban something) to use of restraints1. The use of restraints for the following reasons is strictly prohibited:a. Coercion, discipline, convenience, or staff retaliationb. Solely on the patient's history of dangerous behavior, if anyC. Risk of restraints or use1 . The use of restraints has the potential to produce serious consequences such asphysical and psychological harm, and even death. PIH Health will take risk factorsinto account when assessing the need for, selecting the type of, and determining thepatient care needs relative to restraints.The P&P indicated Restraints devices are to be applied/removed in accordance with manufacturer's instructions and used in a manner consistent with the intended purposes. During a review of the manufacturer's product insert titled Posey Peek-A-Boo Mitt 2811 dated 2023, the product insert indicated the following: TO VIEW HAND/FINGERS:6. Reach under the inspection flap, detach the hook-and-loop fastener, andpull back the flap to expose the hand.7. To dose the inspection flap, tuck into the end of the mitt and press thehook-and-loop closure together firmly.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to meet professional standards of dialysis care for one of three sampled residents (Resident 34) by failing to ensure the provision of appropriate emergency equipment like hemodialysis emergency kit (Emergency bleeding control kit to control bleeding in the event of a dialysis-related complication) is available at bedside for Resident 34 who had dialysis fistula (a surgically created connection between an artery and a vein, usually in the arm, to provide reliable, long-lasting access for dialysis). The kit typically includes critical items such as a tourniquet, pressure bandages, gauze, and a clamp or hemostat (a specialized clamp like pliers or scissors used to compress/pinch blood vessels), which are essential for immediate bleeding control. This failure had the potential to result in delayed response to a bleeding episode, placing Resident 34 at risk for significant blood loss, compromised safety, and adverse health outcomes.Findings: During a review of Resident 34's admission Record, the admission Record indicated the facility admitted Resident 34 on 11/12/2025 with diagnoses that included anemia (a condition where the body does not have enough healthy red blood cells) and acute falls (a sudden, unexpected, and often single-event fall that may be caused by an immediate medical issue or an environmental hazard). During a review of Resident 34's History and Physical (H&P - a doctor's comprehensive check-up where they ask detailed questions about your health history and then do a thorough physical examination, putting it all together to understand your condition and plan your treatment) dated 11/13/2025, the H&P indicated Resident 34 had end stage renal disease (ESRD - irreversible kidney failure) on hemodialysis Tuesday, Thursday, and Saturday. The H&P indicated Resident 34 had leukopenia (a condition characterized by a lower-than-normal number of white blood cells in the blood, which can weaken the immune system and increase the risk of infection) and thrombocytopenia (a condition characterized by a lower-than-normal amount of platelets, the blood cells that help form clots to stop bleeding). The H&P indicated a goal for Resident 34 to have a hemoglobin level (measures the amount of oxygen-carrying protein in your red blood cells) greater than 7 and to transfuse (receive donated blood or components of blood) Resident 34 as needed. The H&P indicated Resident 34 had colon cancer (when cells in your large intestine grow out of control). During a review of Resident 34's Minimum Data Set (MDS - a resident assessment tool), dated 11/24/2025, the MDS indicated Resident 34 had the ability to make himself understood and had the ability to understand others. During a review of Resident 34's document titled, Adult Assessment/Intervention, dated 12/1/2025, the Adult Assessment/Intervention, indicated Resident 34 had a arteriovenous fistula (surgically created shortcut that connects an artery to a vein, usually in your arm, making the vein bigger and stronger to handle the needles for cleaning your blood during hemodialysis) on the left upper arm. During a concurrent observation and interview on 12/1/2025 at 11:33 AM in Resident 34's room with Registered Nurse 1 (RN 1), a dialysis emergency kit could not be located. RN 1 stated Resident 34 needed to have a dialysis emergency kit near the bedside in case Resident 34 had a bleeding issue with his dialysis fistula. RN 1 stated Resident 34 could bleed out if there was no dialysis emergency kit to stop the bleeding. RN 1 stated she (RN 1) would get a dialysis emergency kit for Resident 34. During an interview on 12/1/2025 at 12:52 PM with the facility's Clinical Director (CD), the CD stated the staff would call a rapid response (a warning system where specially trained staff such as nurses and doctors rush to a resident's bedside to stabilize them before a small problem becomes a big life-threatening emergency). The CD stated it might take time for staff to get gauze/equipment to stop Resident 34 from bleeding. The CD stated Resident 34 could continue to bleed until pressure could be applied with gauze/equipment to the site of bleeding. The CD stated the facility did not have a policy for a dialysis emergency kit.