STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2024
NAME OF PROVIDER OR SUPPLIER Hollenbeck Palms		STREET ADDRESS, CITY, STATE, ZIP CODE 573 S. Boyle Ave. Los Angeles, CA 90033	

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on observation, interview, and record review, the facility failed to ensure one of two (2) sampled residents (Resident 1) was free from physical restraints (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body; cannot be removed easily by the resident; and restricts the resident's freedom of movement or normal access to his/her body) by failing to conduct an assessment for the use of seatbelt (an arrangement of straps designed to hold a person steady in a seat). This deficient practice had the potential to negatively affect Resident 1's physical and psychological wellbeing and quality of life. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated an initial admission to the facility on [DATE], and readmission on 8/9/2024. Resident 1's diagnoses included anxiety disorder (persistent and excessive worry that interferes with daily activities), dementia (a brain disorder that results in memory loss, poor judgment, and confusion), and repeated falls. During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 7/15/2024, the MDS indicated Resident 1 had severely impaired cognitive (person's ability to think, learn, remember, use judgement, and make decisions) skills for daily decision making. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with eating. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with oral hygiene, upper and lower body dressing. The MDS indicated Resident 1 was dependent to staff with toileting hygiene, shower, putting on/taking off footwear and personal hygiene. During a review of Resident 1's Order Summary Report, dated 8/19/2024, timed 2:55 PM, indicated an order to apply/secure seatbelt and release every 2 hours while up in a reclining wheelchair, ordered on 8/14/2024. During an observation on 8/19/2024 at 11:50 AM, in the dining room, Resident 1 was observed sitting in a wheelchair. Resident 1 was observed with a seat belt across her lap that was attached to her wheelchair. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/20/2024 at 10:05 AM, with Resident 1 in the hallway, Resident 1 was observed sitting in a wheelchair. Resident 1 was observed with a seat belt across her lap that was attached to her wheelchair. Resident 1 was observed attempting to unbuckle (to loosen the buckle of) her seat belt, and Resident 1 stated I can't. During a concurrent review of Resident 1's restraint assessments and active orders and interview on 8/19/2024 at 2:58 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 did not a physical restraint assessment prior to the use of seatbelt, which was ordered on 8/14/2024. LVN 1 stated a physical restraint assessment should have been conducted before using the seatbelt to ensure that Resident 1 needed it and for the resident's safety. LVN 1 stated that she had seen Resident 1 with a seatbelt while sitting in wheelchair. LVN 1 stated, with Resident 1 being secured with a seatbelt in her wheelchair, Resident 1 cannot get up easily because the seatbelt would limit the resident's movement. During an interview on 8/20/2024 at 8:40 AM with MDS Nurse (MDSN), MDSN stated that prior to use of seatbelt, the interdisciplinary team (IDT, involving two or more disciplines or fields of study) should conduct a physical restraint assessment for its use because it can be a form of restraint. MDSN stated that the following are included in restraint assessment: - Reason for use of physical restraint - History/Alternatives attempted - Decision to restrain - Restraint order MDSN stated Resident 1 did not and should have had an assessment for the use of seatbelt. MDSN stated there was no documented evidence that the physical restraint assessment from 8/14/2024 to 8/20/024 was conducted for Resident 1. MDSN stated she had seen Resident 1 with a seatbelt. MDSN stated that Resident 1 has episodes of fidgeting (the act of moving about restlessly in a way that is not essential to ongoing tasks or events) and securing her with a seatbelt while in wheelchair will limit her movements and prevent the resident from getting up. During a review of facility's Policy and Procedure, titled Physical Restraints, revised in August 2023, indicated the facility shall use a physical restraint only after assessment by the interdisciplinary team has been completed and the less restrictive measures attempted were unsuccessful.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46087

Based on interview and record review, facility failed to develop a comprehensive resident-centered fall care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs) for one of two sampled residents (Resident 1) per facility policy.

This deficient practice had a potential for Resident 1's increased risk for further falls.

Findings:

During a review of Resident 1's Admission Record, the Admission Record indicated an initial admission to the facility on [DATE], and readmission on 8/9/2024. Resident 1's diagnoses included anxiety disorder (persistent and excessive worry that interferes with daily activities), dementia (a brain disorder that results in memory loss, poor judgment, and confusion), and repeated falls.

During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 7/15/2024, the MDS indicated Resident 1 had severely impaired cognitive (person's ability to think, learn, remember, use judgement, and make decisions) skills for daily decision making. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with eating. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with oral hygiene, upper and lower body dressing. The MDS indicated Resident 1 was dependent to staff with toileting hygiene, shower, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 1 had a fall prior to readmission.

During a review of Resident 1'a Morse scale (a method for determining a resident's likelihood of falling which are completed during a resident's admission, quarterly and after each sustained fall), the Morse scale indicated a score of 55, which categorized Resident 1 as high risk for falling.

During a review of Resident 1's Care Plan titled, Resident 1 is High Risk for Falls due to History of falling, Confusion, and Behavior Problems, initiated on 7/30/2024. Staff interventions included were the following:

- Physical therapy (the treatment of disease, injury, or deformity by physical methods such as massage, heat treatment, and exercise) treatment order.

- Occupational therapy (uses everyday life activities to promote health, well-being, and your ability to participate in the important activities in your life) order.

- Will anticipate and meet needs.

- Will ensure floors are free from spills and/or clutter.

- Will ensure to wear appropriate footwear when out of bed.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Will keep bed in low position at night. - Will place call light within easy reach. - Will provide adequate, reachable working glare free light. During an interview on 8/19/2024 at 2:58 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 had a fall incident on July 2024 and another fall incident recently in August 2024. LVN 1 stated all licensed nurses can initiate and revise the care plans. During a concurrent review of Resident 1's fall care plan initiated on 7/30/24 and interview with LVN 1 on 8/20/2024 at 9:25 AM, LVN 1 stated Resident 1's care plan did not and should have included an intervention for the need of supervision and frequent visual checks. LVN 1 stated this was important to prevent Resident 1 from falling and from injury. During a review of Resident 1's Situation, Background, Assessment, and Recommendation (SBAR, a structured communication framework that can help teams share information about the condition of a patient) Communication Form, dated 8/2/2024, timed at 10:42 AM, the SBAR indicated Resident 1 sustained an incident of fall on 8/2/2024 at 9:25 AM. It indicated to transfer Resident 1 to General Acute Care Hospital (GACH) emergency room due to a fall with severe pain on right hip and leg. The note also indicated a Certified Nurse Assistant (CNA) had observed resident slowly slip off from her wheelchair and CNA had attempted to prevent resident from touching the ground but was unable to fully support resident. The SBAR indicated Resident 1 was assisted slowly and carefully to the floor. During a concurrent review of Resident 1's high risk for fall care plan, revised 8/2/2024, and interview with MDS nurse (MDSN) on 8/20/2024 at 11:30 AM, MDSN stated on 8/2/2024, after Resident 1 had a fall incident, she initiated more interventions in the care plan. MDSN stated that the following interventions were added on 8/2/2024: - Will bring to Group Activity and provide entertainment. - Will offer ice cream to keep her occupied. - Will offer to assist back to bed if tired. MDSN stated for high fall risk residents, interventions such as constant visual monitoring, offer restroom breaks frequently, offer drink and food should have been included in their care plan, as indicated on Facility's Policy and Procedure (P&P) titled Fall Prevention Policy and Procedure. MDSN stated that these interventions should have been initiated and implemented since 7/30/2024 which could have prevented Resident 1's fall incident on 8/2/2024. MDSN stated that an intervention of placing a yellow wrist band as indicated on Facility's P&P titled Fall Prevention Policy and Procedure was not and should have been in Resident 1's high risk for fall care plan to immediately identify residents at greatest risk for falls. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans - Comprehensive, the P&P indicated to include interventions unique to this resident and avoid routine standard of practice that is provided to all residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled Fall Prevention Policy and Procedure, revised in March 2023, the P&P indicated falls and recommendations will be discussed by the Interdisciplinary Team (IDT, staff involved in resident's care) at the weekly Medicare Meeting and any new interventions will be added to the plan of care. Interventions may include but are not limited to anti-roll back brakes on wheelchair, room reassignments, personal alarms, lap cushion/tray, special pads, visual checks, high-risk color-coded bracelet, and monitoring of the resident. It also indicated that residents assessed at high risk for falls for 45 points and above on the Morse scale, will be given a color coded (yellow) wrist bracelet, to identify immediately greatest risk for falls.

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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49537

Based on interview and record review, the facility failed to prevent multiple fall (unintentional descent that results in a coming to a rest on the floor, on or against another surface, on another person, or an object) of one of two sampled residents (Resident 1) by:

1. Failing to develop and implement a fall care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs) for Resident 1's actual fall on 6/30/2024, 7/24/2024, and 8/2/2024 per facility policy.

2. Failing to ensure that care plan for Impaired cognition and High risk for falls dated 7/8/2024 and 7/30/2024 included interventions unique (resident specific) to Resident 1's needs.

3. Failing to ensure CNA 1 did not leave Resident 1 sitting in the wheelchair in the hallway unsupervised by facility staff on 8/2/2024 that led to the resident sliding down from the wheelchair and falling to the floor.

These deficient practices resulted in Resident 1's multiple falls. On 7/24/2024 at 4:00 PM, Resident 1 slid from the wheelchair and CNA (CNA not specified) assisted resident to the floor. The resident was sent to General Acute Care Hospital (GACH) 1 and had right hip hemiarthroplasty (surgical procedure that replaces half of a joint with an artificial component, while leaving the other half intact). The resident returned to the facility on [DATE]. On 8/2/2024 at 9:25 AM, Resident 1 had another fall in the facility, and the resident was sent to GACH 2 via 911 (universal emergency number throughout the United States to request emergency assistance). Resident 1 sustained right hip prosthesis (man-made joint that replaces a damaged hip joint during hip replacement surgery) dislocation (occurs when the ball of a hip implant moves out of the socket) requiring closed reduction (a procedure for treating a hip dislocation without surgery, using manipulation of thigh bone to put the hip back in place).

Findings:

During a review of Resident 1's Admission Record (Face Sheet), the Face sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included fracture (partial or complete break in a bone) of the right femur (thigh bone), dislocation of right hip prosthesis, muscle weakness (lack of muscle strength), Alzheimer's disease (brain disorder that slowly destroys memory and thinking skills), dementia with behavioral disturbance (loss of cognitive functioning such as thinking, remembering and reasoning that interferes with daily activities with agitation including verbal and physical aggression, and wandering), depression (constant feeling of sadness and loss of interest which stops one from doing normal activities), and repeated falls.

During a record review of Resident 1's Morse Fall Scale (a method for determining a resident's likelihood of falling which are completed during a resident's admission, quarterly and after each sustained fall) Report dated 4/6/2024 and 7/8/2024, indicated Resident 1 is at high risk for falls.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a record review of Resident 1's Care Plan for high risk for fall initiated on 7/9/2024 indicated Resident 1 was a high risk for falls related to gait/balance problems, unaware of safety needs, and use of psychotropic medications (relating to or denoting drugs that affect a person's mental state). The care plan indicated the goal to minimize risk or major injury within 90 days. The care plan did not indicate specific interventions on how to monitor/ supervise to prevent resident from falling. During a review of Resident 1's History and Physical (H&P) dated 7/10/2024, indicated Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Date Set ([MDS] a standardized assessment and care screening tool) dated 7/15/2024, indicated Resident 1 had severe cognitive impairment (ability to think, learn, remember, use judgement and making decisions) and was dependent (Helper does all 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) for tub/shower transfer (ability to get on and off the toilet), required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) for sit to stand position, chair/bed-to-chair transfer and toilet transfer. During a review of Resident 1's Situation-Background-Assessment-Recommendation (SBAR-a technique used to provide a framework for communication between members of the health care team) communication form dated 7/24/2024, timed at 4:33 PM, the note indicated Resident 1 had a fall witnessed by a Certified Nurse Assistant (CNA, not specified). The SBAR indicated per CNA, Resident 1 slid down from the wheelchair, and CNA was unable to hold Resident 1 and assisted the resident to sit down on the floor. The SBAR also indicated Resident 1 was transferred to GACH 1 for evaluation. During a review of GACH Emergency Department (ED-the department of a hospital that provides immediate treatment for acute illnesses and trauma) record dated 7/24/2024, indicated Resident 1 had a chief complaint of right hip pain and per report, Resident 1 was on a wheelchair and slid hitting the resident's right hip. During a review of Computed Tomography (CT, a medical imaging technique used to obtain detailed internal images of the body) of pelvis (area of the body below the abdomen that contains the hip bones, bladder and rectum) without contrast (test being performed without use of a contrast, which is a special dye injected into the body to enhance the visibility of certain tissues and structures on the scan, allowing for a clearer image) from GACH, dated 7/24/2024 timed at 10:19 PM, impression indicated fracture right femoral head/neck which is comminuted (bone that is broken in at least two places), angulated (the two ends of the broken bone are at an angle to each other), and displaced (fracture where ends of the bone have moved out of alignment, creating a gap). During a review of GACH's Surgery and Procedure Reports dated 7/26/2024 time at 6:17 AM, indicated a right hip hemiarthroplasty was performed for Resident 1 on 7/25/2024. During a review of Resident 1's progress notes from the facility dated 7/29/2024 timed at 10:47 PM, the progress notes indicated Resident 1 was admitted back to the facility from GACH at 2:30 PM with admitting diagnosis of right hip hemiarthroplasty. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a record review of Resident 1's Morse Fall Scale Report dated 7/29/2024, indicated Resident 1 is at high risk for falls. During a review of Resident 1's SBAR communication form dated 8/2/2024 entered by LVN 1 at 10:42 AM, the note indicated, at 9:25 AM, Charge Nurse (LVN 1) was notified by a CNA (CNA 1) that she had observed resident slowly slip off her wheelchair; CNA had attempted to prevent resident from touching the ground but was unable to fully support resident; resident was assisted slowly and carefully to the floor. The SBAR also indicated, Resident 1 was observed by Charge Nurse (LVN 1) in the hallway, at the East Station, on the floor, in kneeling position, with CNA at her side and Resident 1 stated repeatedly, I am hurt, whilst guarding her right hip and leg. During a review of GACH Emergency Department (ED) record dated 8/2/2024 timed at 10:51 AM, indicated Resident 1 was bib (brought in by ambulance) for a fall from chair, coming in from a SNF (skilled nursing facility) for rehabilitation from recent right hip surgery for fracture, arrived with internally rotated right hip, complained of severe pain. Resident 1's Xray (a form of electromagnetic radiation, similar to visible light. Medical x-rays are used to generate images of tissues and structures inside the body) of the right hip and pelvis dated 8/2/2024 timed at 11:50 AM, result showed right hip replacement, right hip dislocation. The ED record also indicated, right hip hemiarthroplasty posterior (back part) dislocation after falling from her wheelchair on 8/2/2024 status post close reduction. The ED record indicated Resident 1 will likely require non-emergent revision with primary surgeon as right hip grossly unstable following reduction. During an interview on 8/19/2024 at 1:50 PM with CNA 1, CNA 1 stated, on 8/2/2024 (unable to recall time) she was wheeling a resident to the activities room when she passed by Resident 1 in her wheelchair, asleep in the hallway across the East Nursing Station. CNA 1 added, Resident 1 did not have an order to apply a lap belt (a seat belt that goes around a person's lap used while a resident is in a wheelchair to prevent sliding out of the wheelchair) prior to the resident falling from 4/6/2024-8/2/2024. CNA 1 stated when she came back, Resident 1 was already on the floor, right foot was still in the wheelchair footrest and left knee on the floor, head leaning on the side of the treatment cart. CNA 1 stated, there was no facility staff present at the time she passed by Resident 1. During an interview on 8/19/2024 at 2:15 PM with CNA 2, CNA 2 stated, on 8/2/2024 after giving Resident 1 morning care, she got her up to the wheelchair and left resident in the hallway across the Nurses' station where LVN 1 was there to monitor resident and other staff that pass by can also see the resident. CNA 2 stated, I assumed LVN 1 will monitor Resident 1. CNA 2 stated, it is not safe to leave fall risk resident alone in the hallway while sitting on the wheelchair as they may get up and fall, especially Resident 1 since resident has a history from falling out from her wheelchair. CNA 2 stated, she knew not to leave resident alone in the room that was why she left the resident in the hallway assuming other staff can see resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 8/19/2024 at 2:54 PM with LVN 1, SBAR notes dated 8/2/2024 was reviewed in the electronic chart. The SBAR indicated, at 9:25 AM, Charge Nurse (LVN 1) was notified by a CNA that she had observed resident slowly slip off her wheelchair; CNA had attempted to prevent resident from touching the ground but was unable to fully support resident; resident was assisted slowly and carefully to the floor. LVN 1 stated she did not see Resident 1 sliding off her wheelchair and she was only called by CNA 1 to notify her that Resident 1 had fallen. LVN 1 stated she was in another room when the incident happened, and she was not notified by CNA 2 that she will leave Resident 1 at the hallway. LVN 1 added, she last saw Resident 1 on 8/2/2024 at 9:10 AM when she gave Resident 1 Lorazepam (medication to treat anxiety and can make you feel sleepy) one tablet PRN (meaning pro re nata in latin meaning as needed) for verbal aggression and fidgeting in her wheelchair. LVN 1 also gave Tramadol (medication used to treat moderate to severe pain, for example after an operation or a serious injury. Common side effects include feeling sleepy, tired, dizzy, or spaced out) PRN for pain at 7:00 AM. During a concurrent interview and record review on 8/19/2024 at 4:26 PM with Minimum Data Set Nurse (MDSN), Resident 1's record of falls dated from 6/30/2024 to 8/2/2024 were reviewed. The records indicated Resident 1 had incident of fall on 6/30/2024, 7/24/2024, and 8/2/2024. MDSN stated Resident 1 had a fall on 6/30/2024 and was transferred to GACH 1 and returned to the facility on [DATE]. During concurrent interview and record review on 8/19/2024 at 4:26 PM with MDSN, Resident 1's GACH 1 record dated 6/30/2024 to 7/1/2024 indicated, resident came in with chief complaint of right hip pain status post fall. The GACH 1 record (ED notes) dated 6/30/2024 indicated, Resident 1's Xray of pelvis (area below the abdomen that contains the hip bones, bladder and rectum) indicated consistent with right femoral neck fracture (thigh bone that connects the lower leg bones to the pelvic bones) connecting the femoral head to the femoral shaft). The GACH 1 record (orthopedic [doctor that specializes in bone injuries/ diseases] notes) dated 7/1/2024 indicated, due to nondisplaced fracture (broken bones, but the pieces weren't moved far enough during the break to be out of alignment), Resident 1 has a chance to heal without surgical intervention. During the same concurrent interview and record review on 8/19/2024 at 4:26 PM with Minimum Data Set Nurse (MDSN), care plans from 6/30/2024 to 8/19/2024 were reviewed. MDSN stated there were no care plans initiated for Resident 1's actual falls on 6/30/2024, 7/24/2024 and 8/2/2024. MDSN stated, if care plan was initiated for the actual fall on 6/30/2024 and/or 7/24/2024, interventions to avoid fall such as monitoring/supervising Resident 1 while in the wheelchair or use of a lap belt while resident is in the wheelchair, Resident 1's falls on 7/24/2024 and 8/2/2024 could have been prevented. During a concurrent interview and record review on 8/20/2024 at 9:18 AM, with LVN 1, Care Plan focused on Impaired Cognition dated 7/8/2024 and 7/30/2024 were reviewed. Care plan indicated intervention to supervise as needed. LVN 1 stated, supervision was not specific to Resident 1, because it did not indicate how often the facility staff needs to supervise Resident 1. During the same interview and record review on 8/20/2024 at 9:18 AM, with LVN 1, Care Plans dated 7/8/2024 and 7/30/2024 were reviewed. LVN 1 stated, the care plan focused on High risk for falls did not include interventions to not leave resident unattended while in the wheelchair and provide frequent supervision. LVN 1 stated leaving Resident 1 unattended, without supervision was unsafe. LVN 1 added that resident-centered care plans were important for the resident's safety and needs, for staff to know what to do for that specific resident and important to revise when there were new behaviors manifested and new problems that arose. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 8/20/2024 at 10:55 AM with MDSN, Care Plan for high risk for fall dated 7/9/2024 and 7/30/2024 were reviewed. Resident 1's care plan indicated goal to minimize risk of major injury for 90 days, interventions did not include constant and visual monitoring. MDSN stated for high fall risk residents, interventions should include constant, visual monitoring, and if residents were anxious-check the cause. MDS added with the additional interventions mentioned, fall would have been prevented. During a concurrent interview and record review on 8/20/2024 at 10:55 AM with MDSN, Resident 1's Care Plan titled At risk for Impaired Cognition, dated 7/8/2024 and 7/30/2024 were also reviewed. The care plan indicated interventions included to cue, reorient, and supervise as needed. MDSN stated the intervention to supervise as needed was general and should be specific to what the resident need. MDSN stated it should include how often the resident should be supervised, how and/ or when should resident be supervised like for example while in the wheelchair since resident had a history of falling or sliding out from the wheelchair last 7/24/2024 and resident sustained an injury and needed surgery at that time. During a review of facility's Policy and Procedure (P&P), titled Care Plans - Comprehensive, revised on 11/2023, indicated to include interventions unique to this resident and avoid routine standard of practice that is provided to all residents. During a review of facility's P&P, titled Fall Prevention Policy and Procedure, revised in March 2023, indicated falls and recommendations will be discussed by the Interdisciplinary Team (IDT, staff involved in resident's care) at the weekly Medicare Meeting and any new interventions will be added to the plan of care. The P&P interventions may include but are not limited to anti-roll back brakes on wheelchair, room reassignments, personal alarms, lap cushion/tray, special pads, visual checks, high-risk color-coded bracelet, and monitoring of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2024
NAME OF PROVIDER OR SUPPLIER Hollenbeck Palms		STREET ADDRESS, CITY, STATE, ZIP CODE 573 S. Boyle Ave. Los Angeles, CA 90033	

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on observation, interview, and record review, the facility failed to ensure one (1) of two (2) sampled residents (Resident 1) was free from an unnecessary psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) in accordance with the facility policy and procedure by failing to ensure Resident 1 had a specific target behavior for the use of Lorazepam (medication used to treat anxiety [persistent and excessive worry that interferes with daily activities]). This deficient practice had the potential to place Resident 1 at risk for significant adverse (harmful) consequences from the use of unnecessary psychotropic drug, which could result to impairment or decline in the residents' mental, physical condition, functional, and psychosocial status. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated an initial admission to the facility on [DATE], and readmission on 8/9/2024. Resident 1's diagnoses included anxiety disorder, dementia (a brain disorder that results in memory loss, poor judgment, and confusion), and depression, is a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning screening tool), dated 7/15/2024, the MDS indicated Resident 1 had severely impaired cognitive (resident's ability to think, learn, remember, use judgement, and make decisions) skills for daily decision making. The MDS indicated Resident 1 had mood symptoms of poor appetite or overeating and trouble concentrating on things, such as reading the newspaper or watching television. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with eating. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with oral hygiene, upper and lower body dressing. The MDS indicated Resident 1 was dependent to staff with toileting hygiene, shower, putting on/taking off footwear and personal hygiene. The MDS also indicated Resident 1 received antianxiety medication (medications that treat anxiety symptoms and related disorders). A review of Resident 1's Order Listing Report dated 8/20/2024, indicated the following orders: Lorazepam oral tablet 0.5 milligrams (mg, unit of measurement), 1 tablet by mouth every eight (8) hours as needed for anxiety, with order date of 7/29/2024, and discontinued date of 8/9/2024. Lorazepam oral tablet 0.5 mg, 1 tablet by mouth every 8 hours as needed for anxiety, with order date of 8/10/2024, and discontinued date of 8/12/2024. Lorazepam oral tablet 0.5 mg, 1 tablet by mouth every 8 hours as needed for anxiety for 14 days, with order date of 8/12/2024, and discontinued date of 8/19/2024. Lorazepam oral tablet 0.5 mg by mouth every morning and at bedtime for anxiety, with order date of 8/19/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055115	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2024
NAME OF PROVIDER OR SUPPLIER Hollenbeck Palms		STREET ADDRESS, CITY, STATE, ZIP CODE 573 S. Boyle Ave. Los Angeles, CA 90033	

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review of Resident 1's medication administration record for the month of August 2024 and Physician's Order, and interview with LVN 1 on 8/20/2024 at 9:20 AM, LVN 1 verified Resident 1 received Ativan 0.5 mg on 8/1/2024, 8/2/2024, 8/10/2024, 8/11/2024, 8/13/2024, and 8/15/2024. LVN 1 stated that the Lorazepam order was incomplete because it did not have a specific behavior manifestation for anxiety. LVN 1 stated that she administered Lorazepam 0.5 mg by mouth to Resident 1 on 8/2/2024 at 9:10 AM because Resident 1 was observed fidgeting (make small movements) and verbally aggressive to staff because she did not want to get up from bed. During a concurrent record review of Resident 1's medical records and interview with MDS nurse (MDSN) on 8/20/2024 at 11:10 AM, MDSN stated Resident 1's Lorazepam order did not and a specific behavior to be monitored for its use. MDSN stated it was important to include the specific target behavior so the licensed nurses would know when to administer the Ativan. During an interview on 8/20/2024 at 12 PM with Director of Nursing (DON), she stated specific behavior manifestation for anxiety such as verbally aggressive to staff, kicking staff, screaming, attempting to get up without assistance, should have been included in the physician's order to ensure the PRN medication is given as indicated to prevent adverse reactions. During a review of facility's Policy and Procedure (P&P), titled Psychotropic drugs, revised on 3/26/024, the P&P indicated Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record.