

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  02/24/2026
NAME OF PROVIDER OR SUPPLIER  Hollenbeck Palms		STREET ADDRESS, CITY, STATE, ZIP CODE  573 S. Boyle Ave. Los Angeles, CA 90033	
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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to notify the physician that a medication was not given as ordered for one (1) of two (2) sampled residents (Resident 1) as indicated in the facility's Policy and Procedure (P&amp;P), titled Medication and Treatment Administration Records, when: Registered Nurse 1 (RN 1) did not notify the physician when bisoprolol fumarate (medication used to treat hypertension [high blood pressure -BP]) was not given on 10/18/2025 at 8 PM. RN 1 did not notify the physician of Resident 1's low blood pressure and heart rate (HR) readings on 10/18/2025 at 7:03 PM. This deficient practice had the potential to result in delays in the necessary care and treatment of Resident 1, which could affect the resident's overall wellbeing. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility initially admitted Resident 1 on 8/24/2023 and readmitted on [DATE] with diagnoses that included but not limited to chronic congestive heart failure (CHF-a serious condition in which the heart does not pump blood as efficiently as it should, causing blood to back up and fluid to build up in the lungs, legs, and body), hypertension, and atrial fibrillation (common heart condition causing an irregular, often rapid heart rate). During a review of Resident 1's Care Plan for cardiovascular problems dated 9/22/2025, the care plan indicated to monitor the resident's vital signs as needed and to notify the doctor of significant abnormalities. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 9/25/2025, the MDS indicated Resident 1 had severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 1 required substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with sit to stand, chair/bed to chair transfer, toilet transfer, tub/shower transfer, and walking 10 feet (ft-unit of measure for height, distance and short lengths). The MDS also indicated Resident 1 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 resident to complete the activity) with eating, shower/bathing self, upper and lower body dressing, putting on/taking off footwear, and oral/toileting/personal hygiene. During a review of Resident 1's Weights and Vitals Summary Record dated 10/18/2025 and timed at 7:03 PM, BP was 72/51 millimeters of mercury (mmHg-standard unit of pressure for blood pressure (low blood pressure if 90/60 mmHg or lower). During a review of Resident 1's Progress Notes dated 10/18/2025 at 9:52 PM, the progress notes indicated vital signs were BP 72/51, HR or pulse 57 beats per minute (normal HR for adults is 60 to 100 beats per minute). The progress notes did not indicate if the physician was notified. During a review of the Order Summary dated 10/31/2025, the Order summary indicated an order on 9/19/2025 for Bisoprolol Fumarate oral tablet 10 milligrams (mg-a metric unit of mass equal to one-thousandth of a gram, primarily used to measure medical dosages or nutritional supplements), give one tablet every 12 hours for hypertension and hold for systolic (top number in a blood pressure reading, measuring the maximum force of your blood pushing</p> <p>(continued on next page)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  055115	Facility ID:  If continuation sheet Page 1 of 2

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  02/24/2026
NAME OF PROVIDER OR SUPPLIER  Hollenbeck Palms		STREET ADDRESS, CITY, STATE, ZIP CODE  573 S. Boyle Ave. Los Angeles, CA 90033	
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>against artery walls when the heart contracts and beats) BP less than 110 and HR less than 60. During a phone interview on 2/24/2026 at 3:23 PM with RN 1, RN 1 stated bisoprolol was not given on 10/18/2025 for the evening dose because the resident's BP and HR were low. RN 1 stated the physician was not notified and should have been notified that bisoprolol was not given to Resident 1 and that Resident 1's BP and HR were on 10/18/2025 at 7:03 PM. RN 1 stated she did not recheck Resident 1 BP and HR after getting the low BP of 72/51 and HR of 57 beats per minute and it placed Resident 1 at risk for change in condition and delay in care or treatment that could have led to the resident's hospitalization and/ or death. During a concurrent interview and record review on 2/24/2026 at 3:35 PM with Assistant Director of Nursing (ADON), the progress note dated 10/18/2025 and timed at 9:52 PM was reviewed. ADON stated the progress notes indicated Resident 1's BP and HR were low on 10/18/2025 (specific time not indicated). ADON stated the progress notes did not indicate that RN 1 notified the physician that bisoprolol was not given and that Resident 1's BP and HR were low. ADON also stated the progress notes did not indicate that RN 1 rechecked the BP and HR. During a concurrent interview and record review on 2/24/2026 at 4 PM with the ADON, the P&amp;P titled Medication and Treatment Administration Records, revised 1/2026, was reviewed. The P&amp;P indicated medications and treatments shall be administered as prescribed by the physician and shall be recorded by the responsible licensed nurse as the medication and/or treatment is provided. The attending physician shall be notified in the event an order cannot be administered as prescribed. ADON stated the P&amp;P indicated the attending physician shall be notified in the event that an order cannot be administered as prescribed and when a resident's routine medication was withheld, the explanation is to be recorded in the nurses' notes/comments. ADON stated the physician should have been notified that the bisoprolol was not given due to Resident 1's low BP and HR by RN 1. The ADON also stated RN 1 should have also documented in the resident's progress notes the reason why the bisoprolol was not given. ADON stated RN 1 did not follow the facility's P&amp;P of notifying the doctor of Resident's low BP and HR and that Resident 1 did not receive the Bisoprolol. ADON stated this placed the resident at risk for delayed care, a change in condition that could result in paramedics (persons trained to give emergency medical care to injured or ill people outside of a hospital setting) being called, hospitalization, and even death.</p>		