STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055115	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hollenbeck Palms	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)
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** Based on observation, interview, and record review, the facility failed to develop a resident centered fall care plan (document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs) for one (1) of three (3) sampled residents (Resident 1), who had a prior history of falls. This deficient practice resulted to Resident 1 falling on the floor and transfer to General Acute Care Hospital (GACH) on 5/21/2026 and undergoing a left knee open reduction internal fixation (ORIF, a major surgery used to repair severe bone fractures that cannot be properly healed with a simple cast or splint) on 5/26/2026. Findings: During a review of Resident 1's admission Record, dated 2/12/2019, the admission Record indicated the facility admitted Resident 1 on 2/12/2019 and readmitted to the facility on [DATE] with diagnoses that included ataxia (loss of muscle control), difficulty in walking, and repeated falls. During a review of Resident 1's Minimum Data Set (MDS, resident assessment tool), dated 3/3/2026, the MDS indicated Resident 1 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 1 required supervision or touching assistance with toilet transfer, and walking 10, 50, and 150 feet. During a review of Resident 1's Fall Risk Assessment (a nursing tool that uses a scoring system to evaluate resident's risk of fall) dated 4/29/2026, the Fall Risk Assessment indicated Resident 1 was a high risk for fall due to use of walker, prior falls, weak gait (steps are short, resident may shuffle) and overestimates (when residents/patients think they can perform tasks beyond the resident/patients' physical capacity, and the primary risks are falls and or injury) or forgets limits. During a review of Resident 1's GACH 2 Discharge (DC) Summary, dated 5/27/2026, the DC Summary indicated discharge diagnoses included status post (S/P) fall with left distal femur fracture S/P ORIF, and a history of left femur neck fracture S/P repair in 2022. During a concurrent observation of Resident 1 in Resident 1's room and interview on 6/10/2026 at 11:50 AM, Resident 1 was seated in a wheelchair visibly grimacing (wrinkled brows or a twisted mouth-used to express physical pain, disgust, or disapproval), and Resident 1 was holding Resident 1's left knee. Resident 1 stated Resident 1's left knee hurt. Resident 1 stated Resident 1 fell on 5/21/2026 when Resident 1's four-wheeled walker caught on the metal floor transition strip at the entrance to the activity room. Resident 1 stated the metal floor transition strip caused Resident 1 to lose balance, fall, and hit her left knee on the floorDuring an interview on 6/10/2026 at 12:12 PM, the Activity Director (AD) stated Resident 1's fall incident occurred at approximately 1:40 PM on 5/21/2026 while the AD was assisting another resident (Resident 3) to the activity room, with Resident 1 following behind the AD. The AD stated when the AD turned around, the AD saw Resident 1 in the process of falling, with Resident 1's walker moving forward during the fall. The AD stated Resident 1 landed on the floor, and the AD immediately walked to Resident 1 and assisted Resident 1 sitting up on a chair. The AD reported that the AD was the only staff member in the activity room at the time of Resident 1's fall. During a concurrent interview and record review with the Licensed Vocational Nurse (LVN) 1 on 6/10/2026 at 1:27 PM, Resident 1's fall risk assessment, dated 4/29/2026, was reviewed. The fall risk assessment indicated Resident 1 was a high risk. LVN 1 (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident 1 had multiple fall incidents before the recent fall on 5/21/2026. LVN 1 stated Resident 1 required assistance when walking and should have been supervised and assisted by a Certified Nursing Assistant (CNA) on 5/21/2026 when Resident 1 was walking to the activity room to keep the resident safe. LVN 1 stated LVN 1 did not see any other staff in the activity room other than the AD on 5/21/2026. LVN 1 stated Resident 1's left knee was observed swollen after the fall. During an interview on 6/10/2026 at 2:15 PM, CNA 1 stated Resident 1 required supervision and assistance while walking with the four-wheel walker due to Resident 1 was assessed as high risk for fall and had gait/balance problem. CNA 1 stated it is important to keep an eye on Resident 1 to ensure Resident 1 gets to where she was going safely. During a concurrent interview and review of Resident 1's MDS mobility assessment dated [DATE], with the Registered Nurse Supervisor (RN) 1 on 6/10/2026 at 3:10 PM, Resident 1's MDS mobility assessment indicated Resident 1 required supervision or touching assistance while walking with the four-wheeled walker for Resident 1's safety. RN 1 stated Resident 1 required contact guard assistance, which included for staff to hold the resident while walking as indicated in Resident 1's MDS mobility assessment. During an interview on 6/10/2026 at 4:18 PM, CNA 2 stated Resident 1's fall could have been prevented if a staff had been supervising the resident when the resident was walking to the activity room on 5/21/2026. During an interview on 6/11/2026 at 1:32 PM, LVN 1 stated Resident 1's care plan should have included supervision and assistance during ambulation to ensure the resident was safe and to prevent another fall. During a concurrent interview and review of Resident 1's care plan, with the Registered Nurse Supervisor (RN) 1 on 6/11/2026 at 2:26 PM, RN 1 stated Resident 1's care plan should have been more resident centered to include supervision and contact guard assistance to ensure she does not fall from unsteady gait while the resident is ambulating with her 4 wheeled walker. During a concurrent interview and review of Resident 1's care plan, with the Minimum Data Set (MDS) coordinator on 6/11/2026 at 2:30 PM, the MDS coordinator stated Resident 1's care plan should be specific to include supervision to prevent another fall incident. During a review of the facility's P&P titled, Care Plan - Comprehensive, revised 3/2025, the P&P indicated the Inter Disciplinary Team (IDT, comprised of team members from different disciplines working together, with a common purpose, to set goals, make decisions, and share resources and responsibilities) shall develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment within seven (7) days after completion of the comprehensive assessment and after each MDS assessment, except discharge assessment.

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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** Based on observation, interview, and record review, the facility failed to provide supervision (the act of overseeing, managing, or directing a person, group, or process to ensure tasks are completed correctly and safely) or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance [when a caregiver keeps one or two hands on the patient's body at all times to steady the patient's balance) as indicated in the Minimum Data Set (MDS, resident assessment tool) for one (1) of three (3) sampled residents (Resident 1), who had a prior history of falls. As a result, on 5/21/2026, when Resident 1 ambulated to the activity room with a four-wheeled walker (a mobility aid designed to roll alongside with a patient without the need to lift it) without assistance or supervision, Resident 1's four-wheeled walker caught on the metal floor transition strip (a piece of trim used to bridge the gap where two different types of flooring meet) at the entrance to the activity room. Resident 1 fell to the floor and sustained a left distal femur (thigh bone) fracture. Resident 1 was transferred to General Acute Care Hospital 1 (GACH 1) on 5/21/2026 and subsequently to GACH 2 on 5/22/2026, where the resident underwent open reduction internal fixation (ORIF, a major surgery used to repair severe bone fractures that cannot be properly healed with a simple cast or splint) on 5/26/2026.Findings:Cross Reference F656 During a review of Resident 1's admission Record, dated 2/12/2019, the admission Record indicated the facility admitted Resident 1 on 2/12/2019 and readmitted to the facility on [DATE] with diagnoses that included ataxia (loss of muscle control), difficulty in walking, and repeated falls. During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 1 required supervision or touching assistance with toilet transfer, and walking 10, 50, and 150 feet. During a review of Resident 1's Fall Risk Assessment (a nursing tool that uses a scoring system to evaluate resident's risk of fall) dated 4/29/2026, the Fall Risk Assessment indicated Resident 1 was a high risk for fall due to use of walker, prior falls, weak gait (steps are short, resident may shuffle) and overestimates (when residents/patients think they can perform tasks beyond the resident/patients' physical capacity, and the primary risks are falls and or injury) or forgets limits. During a review of Resident 1's GACH 2 Discharge (DC) Summary, dated 5/27/2026, the DC Summary indicated Resident 1's transfer from GACH 1 to GACH 2 on 5/22/2026 was for higher level of care for trauma orthopedic (a branch of medicine that focuses on diagnosing and treating injuries that affect the bones, joints, muscles, tendons, ligaments, and nerves) consult. The DC Summary indicated discharge diagnoses included status post (S/P) fall with left distal femur fracture S/P ORIF, and a history of left femur neck fracture S/P repair in 2022. The DC Summary further indicated an Assessment/Plan for Resident 1 which included the need for a complex operative fixation (using hardware to hold broken bones) of the severely comminuted (shattered) injury. The DC Summary also indicated Resident 1 had a computed tomography scan (CT scan, an imaging procedure that combines a series of X-ray [radiograph, a medical imaging test that create/produce images/pictures of structures inside the body] images taken from different angles) of the left lower extremities on 5/23/2026, which indicated an acute intra-articular fracture (a broken bone where the crack extends directly into a joint and damages the smooth cartilage) of the distal femur involving portions of the intramedullary rod (a strong metal rod that surgeons insert directly down the hollow, marrow-filled center of a broken bone), and moderate knee joint lipohemarthrosis (fat and blood mixing inside the joint cavity which happens when a bone breaks so deeply that it cracks into the joint, causing fatty bone marrow and blood to leak inside). During a concurrent observation of Resident 1 in Resident 1's room and interview on 6/10/2026 at 11:50 AM, Resident 1 was seated in a wheelchair visibly grimacing (wrinkled brows or a twisted mouth-used to express physical pain, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	disgust, or disapproval), and Resident 1 was holding Resident 1's left knee. Resident 1 stated Resident 1's left knee hurt. Resident 1 stated Resident 1 fell on 5/21/2026 when Resident 1's four-wheeled walker caught on the metal floor transition strip at the entrance to the activity room. Resident 1 stated the metal floor transition strip caused Resident 1 to lose balance, fall, and hit her left knee on the floor. During an interview on 6/10/2026 at 12:12 PM, the Activity Director (AD) stated Resident 1's fall incident occurred at approximately 1:40 PM on 5/21/2026 while the AD was assisting another resident (Resident 3) to the activity room, with Resident 1 following behind the AD. The AD stated when the AD turned around, the AD saw Resident 1 in the process of falling, with Resident 1's walker moving forward during the fall. The AD stated Resident 1 landed on the floor, and the AD immediately walked to Resident 1 and assisted Resident 1 sitting up on a chair. The AD reported that the AD was the only staff member in the activity room at the time of Resident 1's fall. During a concurrent interview and record review with the Licensed Vocational Nurse (LVN) 1 on 6/10/2026 at 1:27 PM, Resident 1's fall risk assessment, dated 4/29/2026, was reviewed. The fall risk assessment indicated Resident 1 was a high risk for fall due to use of the walker, prior falls, weak gait and the resident was overestimating or forgetting limits. LVN 1 stated Resident 1 was assessed at high risk for fall and Resident 1 had multiple fall incidents before the recent fall on 5/21/2026. LVN 1 stated Resident 1 required assistance when walking and should have been supervised and assisted by a Certified Nursing Assistant (CNA) on 5/21/2026 when Resident 1 was walking to the activity room to keep the resident safe. LVN 1 stated LVN 1 did not see any other staff in the activity room other than the AD when LVN 1 arrived in the activity room on 5/21/2026 after being notified of Resident 1's fall. LVN 1 stated, after Resident 1 fell to the floor, Resident 1 pointed to Resident 1's left knee with facial grimacing. LVN 1 stated upon assessment, Resident 1's left knee was observed swollen. During a concurrent observation in Resident 1's room and interview with Resident 1 on 6/10/20226 at 1:50 PM, Resident 1 was seen lying in bed resting. Resident 1 stated Resident 1 had surgery on the left knee and Resident 1 is not allowed to walk at this time. Resident 1 stated Resident 1 has not been allowed to use the walker after the fall (on 5/21/2026) and Resident 1 used the wheelchair to go around. During an interview on 6/10/2026 at 2:15 PM, Certified Nursing Assistant 1 (CNA 1) stated Resident 1 required supervision and assistance while walking with the four-wheel walker due to Resident 1 was assessed as high risk for fall and had gait/balance problem. CNA 1 stated it is important to keep an eye on Resident 1 to ensure Resident 1 gets to where she was going safely. During a concurrent interview and review of Resident 1's MDS mobility assessment dated [DATE], with the Registered Nurse Supervisor (RN) on 6/10/2026 at 3:10 PM, Resident 1's MDS mobility assessment indicated Resident 1 required supervision or touching assistance while walking with the four-wheeled walker for Resident 1's safety. The RN stated Resident 1 required contact guard assistance, which included for staff to hold the resident while walking as indicated in Resident 1's MDS mobility assessment. During an interview on 6/10/2026 at 4:18 PM, CNA 2 stated Resident 1 no longer ambulated after the injury to Resident 1's left knee. CNA 2 stated Resident 1 required assistance to transfer from the bed to the wheelchair and from the wheelchair back to the bed. CNA 2 stated Resident 1's fall was avoidable. CNA 2 stated Resident fall could have been prevented if a staff had been supervising Resident 2 when the resident was walking to the activity room on 5/21/2026. During an interview on 6/10/2026 at 4:36 PM, the RN stated Resident 1 previously ambulated with a four-wheeled walker but after the fall (on 5/21/2026) Resident 1 is wheelchair-bound (a person who is unable to walk and relies on a wheelchair for mobility/moving freely), and required assistance for transfers between the bed and the wheelchair. The RN stated the metal floor transition strip at the entrance to the activity room posed an accident hazard for residents. During a concurrent observation of a metal floor transition strip on the floor across the entrance to the activity room and an interview with the Maintenance Service Supervisor (MSS) on 6/11/2026 at 1:40 PM, the metal floor transition strip was elevated from the floor. The MSS measured the threshold of the metal floor transition strip going in and out of the activity room. The MSS stated (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the metal floor transition strip was raised 3/8 of an inch toward the outside of the activity room and flat toward the inside of the activity room. During an interview on 6/11/2026 at 3:31 PM, the Registered Physical Therapist (RPT, healthcare professional who helps people improve movement, reduce pain, and regain physical function after an injury, illness, surgery, or disability) stated Resident 1 was able to walk around with the four-wheeled walker with supervision before the fall on 5/21/2026. During a review of the facility's Policy and Procedure (P&P) titled, Fall Prevention, revised 7/2024, the P&P indicated that the facility assesses residents risk for fall, follow -up and evaluate falls of residents in order to assess the residents condition; identify the reason for the fall to reduce the potential of future reoccurrence. During a review of the facility's P&P titled, Safety and Supervision of Residents, revised 10/4/2022, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. P&P also indicated that the residents' safety and supervision and assistance to prevent accidents are facility-wide priorities. During a review of the facility's P&P titled, Resident Safety - Hazardous Areas, Devices and Equipment, revised 8/2024, the P&P indicated all hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure residents safety and mitigate accident hazards to the extent possible.