

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 10/25/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537</p> <p>Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect for one of one sampled resident (Resident 1) by failing to ensure facility staff did not stand above Resident 1's eye level while assisting the resident to eat.</p> <p>This deficient practice had the potential to affect Resident 1's self-esteem and self-worth and violates Resident 1's right to be treated with dignity.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the facility initially admitted the resident on 6/30/2016 and readmitted on [DATE] with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), polyosteoarthritis (arthritis-inflammation and stiffness of the joints, affects five or more joints at the same time), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertensive heart disease with heart failure (a group of conditions that occur when chronic high blood pressure damages the heart and causes it to fail), and palliative care (a specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness).</p> <p>During a record review of Resident 1's History and Physical (H&P), dated 5/15/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/17/2024, indicated Resident 1 had severely impaired cognitive skills (the mental abilities that the brain uses to think, process information, pay attention, and remember things) for daily decision making. Resident 1 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating and was dependent with oral/toileting/personal hygiene, shower/bathing self, upper and lower body dressing and putting on/taking off footwear.</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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a dining observation on 10/23/2024 at 7:44 AM at the [NAME] dining room, Resident 1 was sitting on a wheelchair while being assisted with eating by Certified Nurse Assistant 4 (CNA 4). CNA 4 was observed standing on the Resident 1's right side and was not within eye level of the resident. CNA 4 was instructed by the Director of Staff Development (DSD) to get a chair and sit down while helping Resident 1 with her breakfast. CNA 4 stated, I am fine standing. DSD repeated her instructions to CNA 4 but CNA 4 still refused to sit down.</p> <p>During an interview on 10/25/24 at 8:55 AM with DSD, DSD stated all staff assisting residents with feeding during mealtimes should be sitting down at eye level of the residents. CNA 4 should have been seated while assisting Resident 1 with her breakfast, CNA 4 did not follow the facility's policy. DSD stated that residents could feel disrespected and affect their dignity.</p> <p>During a review of the Policy and Procedure (P &P), titled, Feeding the Resident, revised 1/2020, the P&P indicated regardless of resident ability or eating habits, promote dignity and a pleasant environment during mealtime.</p> <p>During a review of the facility's P&P titled, Quality of Life - Dignity, revised 11/2023, the P&P indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523</p> <p>Based on interview and record review, the facility failed to ensure a copy of the advance directive (a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them) was readily available in the residents' medical chart for two of 10 sampled residents (Residents 6 and 108) in accordance with the facility's policy and procedure titled Advance Directives.</p> <p>This failure had the potential to result in nursing staff not knowing if Residents 6 and 108 had specific resident wishes to follow in case of an emergency.</p> <p>Findings:</p> <p>During a review of Resident 6's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of cerebral infarction (a serious condition that occurs when blood flow to the brain is blocked, causing brain tissue to die), epilepsy (a sudden, abnormal burst of electrical activity in the brain that causes temporary changes in behavior, movement, or awareness), personal history of malignant neoplasm of breast (abnormal growth of tissue), muscle weakness and difficulty walking.</p> <p>During a review of Resident 6's History and Physical Examination (H&P), dated 2/29/2024, the H&P indicated the resident does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 6's Minimum Data Set (MDS - a federally mandated resident assessment care screening tool), dated 9/06/2024, the MDS indicated the resident was severely impaired with cognitive skills (the mental processes that allow people to think, process information, and remember thing) for daily decision making. Resident 6 needed partial/moderate assistance (helper does less than half the effort) with bed mobility, transfers (how resident moves to and from bed, chair, wheelchair, standing position), toilet use, and substantial assistance (helper does more than half the effort) for personal hygiene.</p> <p>During a review of Resident 6's Physician Orders for Life-Sustaining Treatment (POLST- a medical order that allows patients with serious illnesses to specify their preferences for end-of-life care), dated 4/03/2024, the POLST indicated Advance Directive dated 5/14, (year not added) available and reviewed, however, there was no Advance Directive copy inside Resident 6's physical paper chart or in the electronic chart.</p> <p>During an interview with Social Service Director (SSD) on 10/25/2024 at 8:03 AM, SSD stated that on admission if a resident does not have an advance directive, the SSD would discuss it with the resident and their family. SSD stated she would give them a form to go over and if they have any specific wishes or decisions they can decide then. SSD stated some residents already have an advance directive and will bring a copy. SSD added the residents should have a copy of the advance directive in the chart.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review with SSD on 10/25/2024 at 8:12 AM, SSD confirmed there was no advance directive in the Resident 6's medical chart. SSD stated the resident's medical record should have a copy of the advance directive for nursing reference. SSD stated this was important to have in the event the resident cannot make decisions in case of an emergency. SSD added the advance directive can also inform nursing staff if the resident has a responsible party who can make medical decisions for them.</p> <p>2. During a review of Resident 108's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] and re admitted on [DATE] with diagnoses cellulitis of left lower limb (a superficial infection of the skin), obesity (abnormal or excessive fat accumulation that presents a risk to health), personal history of urinary tract infection (is an infection in any part of the urinary system [the body's filtration system that removes waste and excess fluid from the blood to create urine]), unspecified urine incontinence (the inability to control the flow of urine), personal history of malignant (spreads to different sites) neoplasm (abnormal growth of tissue) of the skin muscle weakness and difficulty walking.</p> <p>During a review of Resident 108's MDS, dated [DATE], the MDS indicated Resident 108 was independent with cognitive skills for daily decision making. Resident 108 was dependent (helper does all of the effort to complete an activity) on assistant from staff for personal, toileting hygiene, and showers. Resident 108 needed substantial/maximal assistance (helper does more than half the effort) for toilet transfers, sit to sit to lying, sit to stand, chair/bed to chair transfer and roll left and right.</p> <p>During a review of Resident 108's POLST, dated 3/23/2023, the POLST indicated Advance Directive was discussed with patient, however, there was no Advance Directive copy inside Resident 108's physical paper chart or in the electronic chart.</p> <p>During an interview and record review of Resident 108's medical record with License Vocational Nurse (LVN1) on 10/22/2024 at 12:20 PM, LVN1 confirmed there was no advance directive inside Resident 108's medical record or on Resident 108's electronic medical record in the computer. LVN1 stated a copy of the Advance Directive should have been in Resident 108's medical record so the staff caring for the resident are aware of the residents preferences. LVN 1 stated, It can cause harm to a resident if there was an emergency, the staff can go against the residents wishes.</p> <p>During a concurrent interview and record review with SSD on 10/25/2024 at 9:35 AM, SSD confirmed there was no advance directive copy inside Resident 108's chart. SSD stated, Her husband had stated he would bring it in about a week ago but he has not and I did not follow up.</p> <p>During an interview on 10/25/2024 at 9:12 AM with the Director of Nursing (DON), the DON stated, the Advanced Directive should be kept in the resident's medical chart so that in case of any emergency, staff can refer to it and know what the resident's wishes are. The DON stated emergencies can happen anytime. The DON added if the resident had already completed an advance directive, the resident should bring a copy to the facility. Otherwise, the facility should follow up with the resident or the family to bring a copy.</p> <p>During a concurrent interview with the DON on 10/25/2024 at 9:16 AM, the DON stated, The advance directive is one of the most important documents upon admission. If we have the POLST, that is just a quick reference in case of an emergency, but the advanced directive is equally as important.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facilities Policy and Procedures (P&P) titled Advanced Directive, revised 11/2023 indicated,</p> <p>This facility shall:</p> <ol style="list-style-type: none"> 1. Provide written information to the resident or resident representative at the time of admission regarding: <ol style="list-style-type: none"> a. Their right to accept or refuse medical treatment and the right to formulate an advance directive. b. The facility's policies to implement such decisions and directives. 3. Include documentation in the resident's health record at the time of admission that the resident has been provided with written information regarding advance directive and whether the resident has executed such a document. 8. Duties of Health care Provides: A supervising health care provider who knows of the existence of an advance directive .shall promptly record this information in the patient's health record. If it is in writing, a copy shall be requested and placed in the patient's health record. 		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of two sampled resident (Resident 19) 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) when the facility failed to conduct an assessment for the use of geriatric chair (Geri chair, a large, padded, and mobile reclining chair that prevents a resident from rising).</p> <p>This deficient practice had the potential to result in limiting Resident 19's mobility and cause injury. This also had the potential for Resident 19 not to be treated with respect and dignity with the use of restraints.</p> <p>Findings:</p> <p>During a review of Resident 19's Admission Record, the Admission Record indicated Resident 19 was originally admitted to the facility on [DATE]. Resident 19's diagnoses included dementia (a progressive state of decline in mental abilities), osteoporosis (progressive bone disease that weakens bones and makes them susceptible to break in the bones), and history of falling.</p> <p>During a review of Resident 19's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/04/2024, the MDS indicated Resident 19's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 19 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated the chair prevents rising was not used.</p> <p>During a review of Resident 19's Order Summary Report, dated 10/22/2024, indicated an order of may be up in Geri-chair when out of bed as tolerated for comfort and positioning, ordered on 1/15/2024.</p> <p>During an observation on 10/22/2024 at 12:27 PM, in the dining room, Resident 19 was observed sitting in a Geri chair.</p> <p>During an interview with Certified Nurse Assistant 6 (CNA 6) on 10/24/2024 at 2:18 PM, CNA 6 stated Resident 19 was using a regular wheelchair before. CNA 6 stated that Resident 19 has episodes of leaning forward, sliding, pushing, kicking, and biting staff when she was in a wheelchair. CNA 6 stated that Resident 19 has limited movement now wherein she can no longer lean forward and reach the staff while in a Geri-chair.</p> <p>During a concurrent record review of Resident 19's medical records and interview with Assistant Director of Nursing (ADON) on 10/25/2024 at 11:04 AM, ADON stated Resident 19 did not and should have an assessment prior to use of Geri chair. ADON stated Resident 19 have an order to use Geri chair on 1/15/2024. ADON was not able to provide documentation of the restraint assessment for Resident 19 from 1/15/2024 to 10/25/2024. ADON stated that she had seen Resident 19 in a Geri chair.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing (DON) on 10/25/2024 at 11:45 AM, the DON stated, she had seen Resident 19 in Geri Chair. The DON stated that prior to use of Gerichair, the interdisciplinary team (IDT, involving two or more disciplines or fields of study) should conduct an assessment for its use because it can be a form of restraint. The DON stated that Gerichair is a device that limits movement, and that means it is considered as a restraint. DON stated that the following are included in restraint assessment:</p> <ul style="list-style-type: none"> o Reason for use of physical restraint o History/Alternatives attempted. o Decision to restrain. <p>During a review of facility's Policy and Procedure (P&P), titled Physical Restraints, revised in August 2023, the P&P indicated the facility shall use a physical restraint only after an assessment by the interdisciplinary team has been completed and the less restrictive measures attempted were unsuccessful.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523</p> <p>Based on observation, interview and record review, the facility failed to provide incontinent care and keep the resident free of foul odors to one of ?? sampled residents (Resident 108) who is dependent (helper does all the effort to complete an activity) on assistant from staff for personal, toileting hygiene, and showers.</p> <p>These deficient practices resulted in the residents feeling frustrated and embarrassed, due to lack of or delay in receiving sufficient services to maintain personal hygiene and incontinent care and had the potential to lead to skin breakdown, social isolation and to negatively impact Resident 108's self-esteem.</p> <p>Findings:</p> <p>During a review of Resident 108's admission record, the admission record indicated the resident was initially admitted to the facility on [DATE] and re admitted on [DATE] with diagnoses cellulitis of left lower limb (a superficial infection of the skin), obesity (abnormal or excessive fat accumulation that presents a risk to health), personal history of urinary tract infection (is an infection in any part of the urinary system [the body's filtration system that removes waste and excess fluid from the blood to create urine]), unspecified urine incontinence (the inability to control the flow of urine), personal history of malignant (spreads to different sites) neoplasm (abnormal growth of tissue) of the skin, muscle weakness and difficulty walking.</p> <p>During a review of Resident 108'S Minimum Data Set (MDS - a federally mandated resident assessment care screening tool), dated 10/16/2024, the MDS indicated Resident 108 was dependent from staff for personal, toileting hygiene, and showers. Resident 108 needed substantial/maximal assistance (helper does more than half the effort) for toilet transfers, sit to sit to lying, sit to stand, chair/bed to chair transfer and roll left and right.</p> <p>During an observation of Resident 108 in the presence of License Vocational Nurse (LVN) 1 on 10/22/2024 at 9:03 AM, Resident 108 was lying in bed, arms crossed on her chest, and crying softly. Resident 108 stated nobody is been here all morning. I am all wet. Last night was the same thing. I went to the bathroom in my diaper. I used the call light at 2 AM or 3 AM and when the nurse (unable to recall name staff) came in she said she had so many people to take care of and she said that since I only had a small amount of poop I could wait. She left the room and came back two (2) hours later. I waited until she came back to be changed.</p> <p>During an observation and interview with Certified Nurse Assistant (CNA) 2 on 10/22/2024 at 9:22 AM, observed CNA2 coming out of Resident 108's room. CNA2 stated Resident 108 told her she was soiled. CNA2 stated she was finishing another resident's shower and would be back to change Resident 108's diaper. CNA2 stated she did not know how long Resident 108 was soiled for but that she was busy at the moment. CNA2 did not ask another staff for assistance in changing Resident 108's diaper and left Resident 108 soiled.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with LVN1 on 10/22/2024 at 9:25 AM, LVN1 stated, If the resident is soiled and uses the call light for assistance, then someone should check in right away. The nurse should not have left her (Resident 108) soiled for a long period of time. The CNA (CNA2) should have cleaned her (Resident 108) immediately. If CNA2 was busy, then she (CNA2) should have asked another staff for help. LVN1 also stated if the resident was left soiled for a long period of time it can cause harm to Resident 108 and the resident can have skin breakdown and feel very uncomfortable.</p> <p>During an interview with CNA3 on 10/24/2024 at 9:56 AM, CNA3 stated if a resident is soiled and told me they have been waiting for over an hour to be change, I would apologize, and I would change them immediately. If I was busy at that moment, I would look for another staff to help me so the resident would be cleaned right away. If a resident has been left soiled for long period of time, they can begin to have a bed sores (injuries to the skin and the tissue below the skin that are due to pressure on the skin for a long time), skin redness, irritation, and itchiness to their skin. This can cause them pain and eventually if the skin breaks it can cause an infection. Emotionally the patient might feel irritated and bad, embarrassed and it would feel like neglect (to give little attention to or fail to care for) to them, especially if the patient is dependent on staff for assistance and their medical condition is new to them. Emotional harm is caused by making them feel neglected and not tend to them right away.</p> <p>During an interview with Director of Nursing (DON) on 10/25/2024 at 9:20 AM, DON stated, a resident should not be left soiled for long period of time. It can cause harm to the resident. Harm can be rashes, break in the skin, wounds. It can also cause psychosocial (mental, emotional, social, and spiritual parts of a person's life) and emotional harm.</p> <p>A review of the facility's policy and procedure titled, AM Care PM Care, Hours of Sleep (HS) Care, revised 4/2023, indicated the following objectives:</p> <ul style="list-style-type: none"> c To refresh each resident after their night of sleep. c To assist the resident to the bathroom and/or to change the brief during HS (Hour of Sleep) Care c Assist Resident to the bathroom for toileting or change check (rounds/ check if the resident needs to be changed) and change brief: provide basic hygiene with wipes or washcloths and towel. <p>A review of the facility's policy and procedure titled, Quality of Life-Dignity, revised 7/2023, indicated, each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. The policy also indicated, treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth and staff shall promote dignity and assist residents as needed by promptly responding to the resident's request for toileting assistance.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523</p> <p>Based on observation, interview and record review, the facility did not ensure three of six sampled resident's (Resident 37, 6, and 10) environment was free from accidental hazards (a source of danger that has the potential to cause harm) when hot water temperatures inside the resident's bathrooms were measured to be above 120 degrees Fahrenheit (F- unit of measurement for temperature).</p> <p>This deficient practice placed Residents 37, 6 and 10 at risk for scalding (very hot) and burns (injury related to exposure to heat or flame) related to hot water temperatures.</p> <p>Findings:</p> <p>1. During a review of Resident 37's admission record, the admission record indicated the resident was initially admitted to the facility on [DATE] and re admitted on [DATE] with a diagnosis of aphasia (language disorder that makes it difficult to communicate with others) following cerebral infarction (a serious condition that occurs when an area of the brain tissue dies due to a lack of blood flow), difficulty in walking, hemiplegia (total or partial paralysis of one side of the body that results from disease of or injury to the motor centers of the brain) and hemiparesis (one-sided muscle weakness) following unspecified cerebrovascular disease (a condition that can damage brain tissue) affecting right dominant side (the side of the brain or body that is more active or used more than the other side), low back pain and anxiety disorder (condition in which a person has excessive worry and feelings of fear).</p> <p>During a review of Resident 37's History and Physical (H&P), dated 11/29/2023, H&P indicated the resident does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 37'S Minimum Data Set (MDS - a federally mandated resident assessment care screening tool), dated 9/05/2024, the MDS indicated the resident needed partial/moderate assistance (helper does less than half the effort) with bed mobility, transfers (how resident moves to and from bed, chair, wheelchair, standing position), toilet use, personal and oral hygiene.</p> <p>During a review of Resident 37's Care Plan initiated on 11/27/2023 and revised on 10/23/2024 indicated, Resident 37 was at risk for communication problem. Interventions indicated, will ensure to provide a safe environment.</p> <p>2. During a review of Resident 6's admission record, the admission record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of cerebral infarction, epilepsy (a sudden, abnormal burst of electrical activity in the brain that causes temporary changes in behavior, movement, or awareness), personal history of malignant neoplasm of breast (abnormal growth of tissue), muscle weakness and difficulty walking.</p> <p>During a review of Resident 6's (H&P), dated 2/29/2024, H&P indicated the resident does not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 6's MDS, dated [DATE], the MDS indicated the resident needed partial/moderate assistance with bed mobility, transfers, toilet use, and substantial assistance (helper does more than half the effort) for personal hygiene.</p> <p>3. During a review of Resident 10's admission record, the admission record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of anorexia (an eating disorder that causes people to weigh less than is considered healthy for their age and height), muscle weakness, difficulty in walking, dysphagia (swallowing difficulties), constipation (a condition in which a person has uncomfortable or infrequent bowel movements), other Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks), and hearing loss.</p> <p>During a review of Resident 10'S MDS, dated [DATE], the MDS indicated the resident was dependent (helper does all of the effort) for oral, personal and toileting hygiene, showers, and transfers.</p> <p>During an observation in Resident 37's bathroom (shared bathroom with Resident 6) on 10/22/2024 at 8:08 AM, Resident 37 was inside bathroom using the sink washing her hands sitting on her wheelchair. Observed Resident 37 continue to try to wash hands but would quickly remove hands from running water. Resident 37 exited bathroom without fully washing her hands.</p> <p>During an interview with Certified Nurse Assistant (CNA2) on 10/22/2024 at 8:30 AM, CNA2 stated Residents 37, Resident 6 and Resident 10 would sometimes use their wheelchairs to wheel themselves to the bathroom to wash their hands without asking for assistance.</p> <p>During a concurrent observation and interview with Engineer Assistant on 10/22/2024 at 8:51 AM, Engineer Assistant using a thermometer (an instrument for measuring and indicating temperature) tested water coming out from the faucet/ sink in Resident 37 and Resident 6's bathroom. Observed Engineer Assistant test water for 3 seconds and stated, the water temperature should be below 120 Fahrenheit, right now, the thermometer is reading at 128.6 Fahrenheit. Water is hot for the residents; it would be scalding hot to touch and they can suffer a burn.</p> <p>During a concurrent observation and interview with Engineer Assistant on 10/22/2024 at 8:55 AM, Engineer Assistant used a thermometer and tested the water coming out from the faucet/ sink in Resident 10's bathroom and stated, the water temperature in here is 127.7 Fahrenheit. This too can place the resident at risk for a burn.</p> <p>During a concurrent interview with Engineer Assistant on 10/25/2024 at 3:50 PM, Engineer Assistant stated, We do not check the resident rooms water temperature, we only check the boiler temperature in the building. What happens is, that sometimes someone will complain about the water temperature, so we just adjust the boiler. I think that is how it (water from Reisdent 37, 6 and 10's bathroom sink) got so hot. Engineer Assistant also stated, they do not measure weekly and document the water temperatures in designated areas to ensure the water temperatures are within the acceptable range for resident's use.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facilities Policies & Procedures (P&P) titled, Monitoring Water Temperatures-Protocol revised 4/2023 indicated, the facility recognizes potential risk for scalding and burns related to water temperatures. The Chief Engineer monitors water temperatures to minimize risk for injuries for residents, visitors, and employees. The P&P also indicated, the Chief Engineer directs weekly measurements and documentation of water temperatures in designated areas using thermometers in accordance with manufacturer guidelines. The findings will be included in the preventive maintenance program logs. The P&P indicated, scalding, and burning injuries present potential risk for residents and patients. The P&P also indicated the table below:</p> <p>Water Temperature Time to Receive Third Degree Burn (This type of burn destroys the outer layer of skin [epidermis] and the entire layer beneath)</p> <p>100 F Safe Temperatures for Bathing*</p> <p>127 F 1 minute</p> <p>133 F 15 seconds</p> <p>140 F 5 seconds</p> <p>148 F 2 seconds</p> <p>155 F 1 second</p> <p>In addition, the P&P indicated, burns can occur even at water temperatures below those identified in the table depending on an individual's condition and the length of exposure and based upon the time of the exposure and the temperature of the water, the severity of the harm to the skin is identified by the degree of burn.</p> <p>A review of the facility's policy and procedure titled, Safe Environment-Resident Rights revised 10/2024, indicated, The resident has a right to a safe, clean, and comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 51) who was on continuous oxygen (colorless, odorless, and tasteless gas) therapy received oxygen as ordered in accordance with the facility policy.</p> <p>This deficient practice had the potential to cause complications associated with oxygen therapy and could result in the resident not receiving proper treatment.</p> <p>Findings:</p> <p>During a review of Resident 51's Admission Record, the Admission Record indicated Resident 51 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 51's diagnoses included shortness of breath, dependence on supplemental oxygen, and anemia (a condition where the body does not have enough healthy red blood cells).</p> <p>During a review of Resident 51's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/19/2024, the MDS indicated Resident 51's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 51 required setup or clean up assistance (helper sets up or cleans up, resident completes activity) with eating. The MDS also indicated Resident 51 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) with oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 51 was on continuous oxygen therapy while in the facility.</p> <p>During a review of Resident 51's Order Summary Report as of 10/22/2024, the Order Summary Report indicated a physician's order for continuous oxygen at 2 liters (L, unit of measurement) per minute, ordered on 9/5/2023.</p> <p>During an observation in the dining room on 10/22/2024 at 10:54 AM, Resident 51's oxygen tank was observed empty. The oxygen gauge indicator was pointing to the red area which indicated the oxygen tank was empty.</p> <p>During a concurrent observation and interview with Assistant Director of Nursing (ADON) on 10/24/2024 at 2:05 PM, ADON stated residents should be administered oxygen as ordered. ADON stated it was important for the licensed nurse to check the oxygen regulator to ensure oxygen tank is not empty.</p> <p>During a review of Facility's Policy and Procedure titled, Oxygen Administration, formulated on 4/2023, indicated provide oxygen therapy per physician orders.</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>45523</p> <p>Based on observation, interview, and record review, the facility failed to follow its policy by failing to:</p> <ol style="list-style-type: none"> 1. Post the nurse staffing information in a prominent location (accessible to residents and visitors). 2. Ensure the Daily Report of Nursing Staff (nurse staffing information) posted on 10/22/24 and 10/23/24 was accurate to reflect the correct date and total number of projected hours and the actual hours of licensed and unlicensed nursing staff directly responsible for resident care per shift. <p>This deficient practice had the potential to inaccurately reflect the actual nurses providing direct care to the residents.</p> <p>Findings:</p> <p>During initial observation of the facilities entrance and lobby on 10/22/2024 at 8:06 AM, the Nurse Staffing Information was not posted in a prominent location (accessible to residents and visitors). Observed Daily Report of Nursing Staff dated 10/20/2024 posted at information board located at nursing station [NAME] wing. Nursing station East wing did not have Daily Report of Nursing Staff posted.</p> <p>During a follow up observation on 10/22/2024 at 4:07 PM, observed Daily Report of Nursing Staff dated 10/21/2024 posted at information board located at nursing station [NAME] wing. Nursing station East wing still did not have Daily Report of Nursing Staff posted.</p> <p>During a concurrent observation on 10/23/2024 at 7:30 AM, observed Daily Report of Nursing Staff, indicated a date of 10/21/2024, posted on the information board located at nursing station [NAME] wing. Nursing station East wing still did not have Daily Report of Nursing Staff posted.</p> <p>During a concurrent observation at the [NAME] wing nurse's station and interview with Director of Staff Development (DSD) on 10/23/2024 at 9:04 AM, DSD stated the Nurse Staffing Information posted was not updated, and last date the Nurse Staffing Information document posted was 10/21/24. DSD further stated, Today's date is 10/23/2024.</p> <p>During a follow up interview with DSD on 10/23/24 at 9:10 AM, the DSD stated, My shift begins at 6:30 AM, I usually post the nursing hours at 8:30 AM. I prioritize the floor to make sure it has coverage. I cannot really sit down to do the nursing hours. DSD confirmed, per facility policy, she should post the nursing hours first thing in the morning when she comes in at 6:30 AM. DSD stated, The Nursing hours are posted in the [NAME] nursing station, East nursing station does not have a posting meaning the residents, visitors and staff on the East wing don't have access to the nursing hours.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Posting Direct-Care Staffing Numbers, revised 7/2023, the P&P indicated the Facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to the residents.</p> <p>(continued on next page)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>1. Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.</p> <p>3. Shift staffing information shall be recorded on the Nursing Staff Directly Responsible for Resident Care form for each shift. The information recorded on the form shall include:</p> <p>b. The date for which the information is posted.</p> <p>c. The shift for which the information is posted.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087</p> <p>Cross reference: F759</p> <p>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of one of five sampled residents (Resident 35) in accordance with the facility policy by failing to administer Resident 35's 8 AM due medications on 10/24/2024 as indicated on the physician's order.</p> <p>This deficient practice had the potential for Resident 35 to experience tachycardia (a fast heartbeat of more than 100 times per minute), high blood pressure (when your blood pressure is consistently higher than normal), and decline in overall health status.</p> <p>Findings:</p> <p>During a review of Resident 35's Admission Record, indicated Resident 35 was originally admitted to the facility on [DATE]. Resident 35's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a medical condition that causes weakness or an inability to move on one side of the body) affecting left side, and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for residents with swallowing problems).</p> <p>During a review of Resident 35's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/17/2024, the MDS indicated Resident 35's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 35 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/taking off footwear and personal hygiene.</p> <p>During a review of Resident 35's Physician's orders, the Physician's Orders indicated the following:</p> <p>Amlodipine (a medication used to treat high blood pressure) tablet 10 milligram (mg, unit of measurement), give 1 tablet via gastrostomy tube (G-tube, is a small, flexible tube that's surgically inserted into the stomach through the abdomen to provide nutrition, fluids, and medicine) one time a day for hypertension (HTN-high blood pressure). Ordered on 3/30/2023.</p> <p>Aspirin (a medication that reduces pain, fever, inflammation, and blood clotting) chewable 81 mg, give 1 tablet via G-tube one time a day for angina (chest pain or discomfort). Ordered on 2/6/2020.</p> <p>Carvedilol (a medication that slows down the heart rate making it easier for the heart to pump blood around the body) 25 mg, 1 tablet via G-tube two times a day, for HTN, hold if systolic blood pressure (SBP, the first and higher number in a blood pressure reading) lower than 100 and heart rate lower than 60. Ordered on 3/30/2023.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Isosorbide (a medication used for management of angina) tablet 30 mg, give 1 tablet via G-tube one time a day for angina. Ordered on 10/24/2024.</p> <p>Losartan (a medication used to treat high blood pressure) 100 mg, give 1 tablet via G-tube one time a day for HTN, hold in SBP lower than 100 and heart rate lower than 60. Ordered on 3/30/2023.</p> <p>Multivitamins with minerals liquid, give 5 milliliter (ml, unit of measurement) via G-tube one time a day for supplement. Ordered on 2/06/2020.</p> <p>Potassium (mineral that is important for many body functions) liquid 20 milliequivalent (unit of measurement)/15 ml, give 15 ml via G-tube one time a day for supplement. Ordered on 4/17/2023.</p> <p>Fluticasone (used to treat sneezing, itchy or runny nose) nasal (used to describe things relating to the nose) spray, 2 spray in both nostrils (one of the two holes in your nose), one time a day for allergy (overreaction to a substance that is typically harmless to most people). Ordered on 2/06/2020.</p> <p>Artificial tears (eye drops that help relieve dry eyes), instill 2 drops in both eyes one time a day for dry eyes. Ordered on 2/06/2020.</p> <p>During a concurrent observation of medication administration and interview with the Licensed Vocational Nurse 1 (LVN 1) on 10/24/2024 at 9:30 AM, LVN 1 was observed preparing the following medications for Resident 35:</p> <ul style="list-style-type: none"> o Amlodipine tablet 10 mg, 1 tablet. o Aspirin chewable 81 mg, 1 tablet. o Carvedilol 25 mg, 1 tablet. o Isosorbide tablet 30 mg, 1 tablet. o Losartan 100 mg, 1 tablet. o Multivitamins with minerals liquid, 5 ml. o Potassium liquid 20 MEQ/15 ml, 15 ml. o Fluticasone nasal spray. o Artificial tears. <p>During an observation on 10/24/2024 at 10:22 AM, in Resident 35's room, LVN 1 administered all of Resident 35's nine (9) medications.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent record review of Resident 50's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) and interview on 10/24/2024 at 3:25 PM, LVN 1 verified that following medications are due to be given at 8 AM:</p> <p>Amlodipine tablet 10 mg, 1 tablet.</p> <p>Aspirin chewable 81 mg, 1 tablet.</p> <p>Carvedilol 25 mg, 1 tablet.</p> <p>Isosorbide tablet 30 mg, 1 tablet.</p> <p>Losartan 100 mg, 1 tablet.</p> <p>Multivitamins with minerals liquid, 5 ml.</p> <p>Potassium liquid 20 MEQ/15 ml, 15 ml.</p> <p>Fluticasone nasal spray.</p> <p>Artificial tears.</p> <p>LVN 1 stated she failed to administer Resident 35's 8 AM scheduled medications on time because she administered it late, after 9 AM. LVN 1 stated failing to administer medication to a resident per the physician's order can lead to medical complications possibly resulting in hospitalization . LVN 1 stated all 9 routine medications that was due to be given at 8 AM were given at 10:22 AM.</p> <p>During a concurrent record review of Resident 35's medical records and interview with Assistant Director of Nursing (ADON) on 10/24/2024 at 4:43 PM, the ADON stated missed blood pressure medications might lead to uncontrolled high blood pressure. ADON stated the process for administering medications late or early included calling the physician and documenting a justification. ADON confirmed there were no justifications documented for the late administration of Resident 35's 9 medications. The ADON stated their medication administration time in the morning is scheduled at 8 AM, and medications can be administered one hour before or after 8 AM.</p> <p>During an interview on 10/25/2025 at 11:55 AM with Director of Nursing (DON), the DON confirmed LVN 1 administered Resident 35's due 8 AM medications late on 10/24/2024. The DON stated medications may be administered one-hour before or after the scheduled time and should not go beyond that time as it is a medication error. The DON stated, it is important to give the medication on time and as ordered by the physician to ensure efficacy of the medications and to avoid possible adverse reactions or side effects that resident can experience.</p> <p>During a review of Facility's Policy and Procedure (P&P) titled, Medication and Treatment Administration Records, revised on 11/2023, the P&P indicated medications and treatments shall be administered as prescribed by the physician, times adjusted to 8:00 am, 1:00 pm, 5:00 pm and 9:00 pm.</p> <p>(continued on next page)</p>		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Facility's P&P titled, Administering Medications, revised on 11/14/2019, the P&P indicated medications must be administered within one (1) hour of their prescribed time.		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087</p> <p>Cross reference: F755</p> <p>Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Nine (9) medication errors out of 27 total opportunities for error, to yield an overall medication error rate of 33.3 % for one (1) of five (5) residents observed for medication administration (Residents 35). Licensed Vocational Nurse 1 (LVN 1) failed to administer Resident 35's medications within 60 minutes of scheduled time of 8 AM on 10/24/2024.</p> <p>This deficient practice had the potential to result in Resident 35 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and the potential to result in Resident 35's health and well-being to be negatively impacted.</p> <p>Findings:</p> <p>During a review of Resident 35's Admission Record, the Admission Record indicated Resident 35 was originally admitted to the facility on [DATE]. Resident 35's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a medical condition that causes weakness or an inability to move on one side of the body) affecting left side, and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for residents with swallowing problems).</p> <p>During a review of Resident 35's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/17/2024, the MDS indicated Resident 35's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 35 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/taking off footwear and personal hygiene.</p> <p>During a review of Resident 35's Physician's Order, dated 10/24/2024, the Physician's Order indicated the following:</p> <ol style="list-style-type: none"> 1. Amlodipine (a medication used to treat high blood pressure) tablet 10 milligram (mg, unit of measurement), give 1 tablet via gastrostomy tube (G-tube, is a small, flexible tube that's surgically inserted into the stomach through the abdomen to provide nutrition, fluids, and medicine) one time a day for hypertension (HTN-high blood pressure). Ordered on 3/30/2023. 2. Aspirin (a medication that reduces pain, fever, inflammation, and blood clotting) chewable 81 mg, give 1 tablet via G-tube one time a day for angina (chest pain or discomfort). Ordered on 2/6/2020. 3. Carvedilol (a medication that slows down the heart rate making it easier for the heart to pump blood around the body) 25 mg, 1 tablet via G-tube two times a day, for HTN, hold if systolic blood pressure (SBP, the first and higher number in a blood pressure reading) lower than 100 and heart rate lower than 60. Ordered on 3/30/2023. <p>(continued on next page)</p>		

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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.			
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Isosorbide (a medication used for management of angina) tablet 30 mg, give 1 tablet via G-tube one time a day for angina. Ordered on 10/24/2024.</p> <p>5. Losartan (a medication used to treat high blood pressure) 100 mg, give 1 tablet via G-tube one time a day for HTN, hold in SBP lower than 100 and heart rate lower than 60. Ordered on 3/30/2023.</p> <p>6. Multivitamins with minerals liquid, give 5 milliliters (ml, unit of measurement) via G-tube one time a day for supplement. Ordered on 2/06/2020.</p> <p>7. Potassium (mineral that is important for many body functions) liquid 20 milliequivalent (unit of measurement)/15 ml, give 15 ml via G-tube one time a day for supplement. Ordered on 4/17/2023.</p> <p>8. Fluticasone (used to treat sneezing, itchy or runny nose) nasal (used to describe things relating to the nose) spray, 2 spray in both nostrils (one of the two holes in your nose), one time a day for allergy (overreaction to a substance that is typically harmless to most people). Ordered on 2/06/2020.</p> <p>9. Artificial tears (eye drops that help relieve dry eyes), instill 2 drops in both eyes one time a day for dry eyes. Ordered on 2/06/2020.</p> <p>During a concurrent medication administration observation for Resident 35 and interview with LVN 1 on 10/24/2024, at 10:22 AM, LVN 1 was observed administering Resident 35's medications. LVN 1 stated that the following medications were Resident 35's scheduled medications for 8 AM:</p> <p>Amlodipine tablet 10 mg, 1 tablet.</p> <p>Aspirin chewable 81 mg, 1 tablet.</p> <p>Carvedilol 25 mg, 1 tablet.</p> <p>Isosorbide tablet 30 mg, 1 tablet.</p> <p>Losartan 100 mg, 1 tablet.</p> <p>Multivitamins with minerals liquid, 5 ml.</p> <p>Potassium liquid 20 MEQ/15 ml, 15 ml.</p> <p>Fluticasone nasal spray, 2 spray in both nostrils.</p> <p>Artificial tears 2 drops in both eyes.</p> <p>During an interview with LVN 1 at 10/24/2024 at 10:35 AM, LVN 1 verified that she administered Resident 35's 8 AM medication late because she gave them after 9 AM. She stated that medications can be administered one hour before or after the scheduled time. LVN 1 stated, If medications were not administered on time, for example blood pressure medications, it can affect the blood pressure of the residents which can cause a change in the residents' condition.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/24/2024 at 4:42 PM, the Assistant Director of Nursing (ADON) stated that it was important to administer medication as ordered to get the full benefit of the medication and to prevent complications of inconsistent timing of medication administration. The ADON stated their medication administration time in the morning is scheduled at 8 AM, and medications can be administered one hour before or after 8 AM.</p> <p>During a review of Facility's Policy and Procedure (P&P) titled, Medication and Treatment Administration Records, revised on 11/2023, the P&P indicated medications and treatments shall be administered as prescribed by the physician, times adjusted to 8:00 am, 1:00 pm, 5:00 pm and 9:00 pm.</p> <p>During a review of Facility's P&P titled, Administering Medications, revised on 11/14/2019, the P&P indicated medications must be administered within one (1) hour of their prescribed time.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of five (5) sampled residents (Resident 35) was free from significant medication error (the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications [not recommendations] regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services) by administering Amlodipine (a medication used to treat high blood pressure), Carvedilol (a medication that slows down the heart rate making it easier for the heart to pump blood around the body) and Losartan (a medication used to treat high blood pressure) to Resident 35 outside of physician ordered parameters.</p> <p>This deficient practice increased the risk for Resident 35 to may have experience serious medical complications such as bradycardia (a condition where the heart beats slower than 60 beats per minute) or poor blood pressure control, which could possibly result in hospitalization and/or death.</p> <p>Findings:</p> <p>During a review of Resident 35's Admission Record, the Admission Record indicated Resident 35 was originally admitted to the facility on [DATE]. Resident 35's diagnoses included bradycardia, hypertension, and angina (chest pain or discomfort)</p> <p>During a review of Resident 35's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/17/2024, the MDS indicated Resident 35's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 35 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/taking off footwear and personal hygiene.</p> <p>During a review of Resident 35's Physician's order, dated 10/24/2024, indicated the following orders:</p> <ol style="list-style-type: none"> 1. Amlodipine tablet 10 milligram (mg, unit of measurement), give 1 tablet via gastrostomy tube (G-tube, is a small, flexible tube that's surgically inserted into the stomach through the abdomen to provide nutrition, fluids, and medicine) one time a day for hypertension (HTN-high blood pressure). Hold if systolic blood pressure (SBP, the first and higher number in a blood pressure reading) lower than 100 and heart rate (the number of times your heart beats per minute) lower than 60. Ordered on 3/30/2023. 2. Carvedilol 25 mg, 1 tablet via G-tube two times a day, for HTN, hold if SBP lower than 100 and heart rate lower than 60. Ordered on 3/30/2023. 3. Losartan 100 mg, give 1 tablet via G-tube one time a day for HTN, hold in SBP lower than 100 and heart rate lower than 60. Ordered on 3/30/2023. <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent medication administration observation for Resident 35 and interview with Licensed Vocational Nurse 1 (LVN 1) on 10/24/2024, at 10:20 AM, LVN 1 stated Resident 35's SBP was 184 and heart rate was 59. LVN 1 administered the following medications:</p> <p>Amlodipine tablet 10 mg, 1 tablet.</p> <p>Carvedilol 25 mg, 1 tablet.</p> <p>Losartan 100 mg, 1 tablet.</p> <p>During an interview with LVN 1 on 10/24/2024 at 3:25 PM, LVN 1 stated Resident 35's blood pressure this morning was 184/76 millimeters of mercury (mm/Hg, unit of measurement) and heart rate was 59. LVN 1 stated she did not notify Resident 35's Doctor because there was no order to call for high blood pressure and heart rate of lower than 60. LVN 1 stated she did not and should have rechecked Resident 35's blood pressure and heart rate prior to administering the following medications:</p> <p>Amlodipine tablet 10 mg, 1 tablet.</p> <p>Carvedilol 25 mg, 1 tablet.</p> <p>Losartan 100 mg, 1 tablet.</p> <p>LVN 1 stated the normal blood pressure is 120/80, and she added that in general, a SBP higher than 180 needs a doctor notification.</p> <p>During a concurrent record review of Resident 35's medical records and interview with Assistant Director of Nursing (ADON) on 10/24/2024 at 4:50 PM, the ADON stated an abnormal blood pressure reading should be rechecked and should be reported to the doctor. ADON stated Resident 35's order for amlodipine, carvedilol and losartan has a parameter order to hold for heart rate less than 60. ADON stated for Resident 35's blood pressure of 184/76 and heart rate of 59, LVN 1 should have rechecked the blood pressure and heart rate, and then informed the Doctor prior to administering amlodipine, carvedilol and losartan as these medications might lower Resident 35's heart rate.</p> <p>During a review of the Facility's Policy and Procedure (P&P) titled Administering medications, revised on 11/14/2019, the P&P indicated medications shall be administered in a safe and timely manner, and as prescribed. It also indicated vital signs (example: blood pressure and heart rate) must be checked/verified for each resident prior to administering medications.</p> <p>During a review of Facility's P&P titled, Digital Wrist Blood Pressure, Measuring and [NAME] Allyn Spot Vital Signs LXi Device (a device to monitor blood pressure and temperature), revised on 11/2023, the P&P indicated hypertension is usually defined as blood pressure over 140/90 mm/Hg (although the elderly often have persistent systolic readings from 140 to 160 mm/Hg. It also indicated hypertension should be reported to the physician. If a resident has a hypertensive reading, staff should record several readings taken at different times of the day. Staff should note any pertinent medications and/ or recent changes of condition when reporting to the physician.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537</p> <p>Based on observation, interview and record review, the facility failed to ensure food were handled, prepared, and stored in a manner that prevents foodborne illness (food poisoning) for 56 of 56 residents receiving food from the facility's kitchen, by failing to ensure:</p> <ol style="list-style-type: none"> 1. Food items stored in the kitchen refrigerators and freezer (thirty-eight [38] food items), walk-in freezer (eleven [11] food items), dry storage area 1 (where breads and vegetables are stored) (three [3] food items) were labeled with open date and/or use by date (last date recommended for use of the product while at peak quality), and/or expiration date and sealed after opening. 2. Two (2) dented canned products were discarded and one (1) cracked and leaking peanut butter jar was discarded from the dry storage area 2 (where canned products, sugars and jars are stored). In addition, the facility failed to ensure the container with blue lid in the dry storage area 2 was free of dirt, dust, and dead fly. 3. Expired food products were removed and discarded. 4. Temperature logs for the kitchen refrigerators and dry room was monitored and documented daily every morning and afternoon shift. <p>These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness for 56 of 56 medically compromised residents who received food from the kitchen.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation in the facility's kitchen and interview on [DATE] at 7:42 AM with the Kitchen Manager (KM) 1, the following were observed in the three kitchen refrigerators labeled #1, #2, and #4, and one freezer (#3): <p>In Refrigerator #1, six bowls of sliced fruits and two cups white cream in one tray, the bowls and cups were not labeled with use by or expiry date (date after which something should no longer be used).</p> <p>In Refrigerator #1, one jar of orange guava passion fruit juice not labeled with date opened and use by date. In addition, the jar's manufacturer expiration date was partially erased.</p> <p>In Refrigerator #1, there were 3 stack of food trays in the 2nd shelf. The first tray on the top, contained six cups of almond milk, labeled with preparation date on [DATE] and no label of use by date. The second tray in the middle contained 21 covered cups of juice with label of preparation date of [DATE] and no label of use by date.</p> <p>In Refrigerator #2, one opened box of milk, not labeled with dated opened and use by date.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In Refrigerator #2, one half full grape juice, not labeled with dated opened and use by date.</p> <p>In Refrigerator #2, one bowl of cut fruits, labeled with preparation date that smudged off (unreadable) and was not labeled with use by date.</p> <p>In Refrigerator #2, one opened/used soymilk carton, not labeled with date opened and use by date.</p> <p>In Refrigerator #2, one bowl of tuna salad, label indicated preparation date of [DATE], and not labeled with use by date.</p> <p>In Refrigerator #2, three trays, stacked on top of each other: top tray with assorted dressing (35 pieces of small containers) labeled with preparation date of [DATE]; middle tray with 29 small containers of assorted dressing- not labeled with preparation date and use by date; and bottom tray with 15 small containers of assorted dressing not labeled with preparation date and use by date.</p> <p>In Refrigerator #2, one container of jelly, labeled with preparation date indicated [DATE], and not labeled with use by date.</p> <p>In Refrigerator #2, one bowl of feta cheese, labeled with preparation date of [DATE], and not labeled with use by date.</p> <p>In Refrigerator #2, one bowl egg salad, labeled with preparation date [DATE], and no use by date.</p> <p>In Refrigerator #2, one half empty jar of mayonnaise, not labeled with opened and use by date.</p> <p>In Refrigerator #2, one tray of Jello, labeled with preparation date of [DATE] and not labeled with use by date.</p> <p>In Refrigerator #2, one bowl of sliced onion, labeled with preparation date of [DATE] and not labeled with use by date.</p> <p>In Refrigerator #2, one bowl of sliced Jello, labeled with preparation date [DATE] and no label of use by date.</p> <p>In Refrigerator #2, two containers of cut fruits, labeled with preparation date [DATE], and no label of use by date.</p> <p>In Refrigerator #2, one tray with 18 small containers of salsa, labeled with preparation date [DATE], and no label of use by date.</p> <p>In Refrigerator #2, one big tray of sliced honey dew and cantaloupe, labeled pudding, preparation date of [DATE] and no label of use by date.</p> <p>In Refrigerator #2, one tray of pudding, labeled with preparation date of [DATE] and no label of use by date.</p> <p>In Refrigerator #2, one bowl of sliced cucumber, labeled with preparation date of [DATE] and no label of use by date.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In Freezer #3, fifteen (15) ice cream in small bowls in the freezer, all uncovered and no label of date opened and/ or use by date.</p> <p>In Freezer #3, one wrapped meat, unable to read the label of item name, labeled with preparation date of [DATE] and no use by date.</p> <p>In Freezer #3, one wrapped meat, labeled [NAME] steaks, preparation date of [DATE] and no label of use by date.</p> <p>In Refrigerator #4, one deformed plastic container with yellow liquid/juice, not labeled with item name and use by date.</p> <p>In Refrigerator #4, one plastic container labeled Barbecue (BBQ) sauce with preparation date of [DATE], and label of use by date.</p> <p>In Refrigerator #4, one plastic container labeled BBQ sauce with dried brown spillage outside the lid of the container, labeled with preparation date of [DATE], and no label of use by date.</p> <p>In Refrigerator #4, one big Jalapeno jar, not labeled with date opened and use by date.</p> <p>In Refrigerator #4, tomato puree in metal container, labeled with preparation date of [DATE], and no label of use by date.</p> <p>In Refrigerator #4, one metal bin with meat, labeled turkey, not labeled with use by date.</p> <p>In Refrigerator #4, one parmesan cheese pack, plastic was open, labeled with preparation date of [DATE], and not labeled with use by date.</p> <p>In Refrigerator #4, one resealed parmesan cheese pack, labeled with preparation date on [DATE], no label of use by date.</p> <p>In Refrigerator #4, one bowl of sliced pickles, labeled with preparation date [DATE], no use by date.</p> <p>In Refrigerator #4, one opened sour cream, labeled with prep date [DATE], no use by date.</p> <p>In Refrigerator #4, One opened cottage cheese, labeled with preparation date [DATE], no use by date.</p> <p>The KM 1 confirmed that food items were not labeled with use by date and there was one food item labeled with use by date that was not legibly written.</p> <p>During a concurrent observation in the walk- in refrigerator (milk room - where milk products are stored) and dry storage area 1 located at the first floor and interview on [DATE] at 7:59 AM with KM 1, the milk room door was open. KM 1 stated there were no staff inside or outside the milk room and the milk room door should be always closed when facility staff is not inside and not restocking to maintain the desired temperature in the milk room. KM 1 stated there were 3 loaves of bread that were not labeled with expiration dates.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on [DATE] at 8:11 AM with KM 1 in the walk -in freezer located at the first floor, the following were observed:</p> <ul style="list-style-type: none"> One pack of frozen meat and was not labeled with use by date. One pack of meatballs resealed with no label of open date or use by date. One pack of chicken nuggets, not labeled with use by date. One container of mustard, labeled with preparation date of [DATE], and no label of use by date. One block of cheese, labeled with product date of [DATE], and no label of use by date. One metal pan with frozen meat, not labeled. One Ziploc bag containing sausage, labeled with use by date ,d+[DATE]. One resealed frozen pack of unknown item, not labeled. One resealed pack resembling tater tots, not labeled. <p>KM 1 confirmed several food items were expired, not labeled completely, and cannot be identified should be discarded. Residents and staff could become ill or sick if served with expired food.</p> <p>During a concurrent interview and record review on [DATE] at 10:55 AM with the Food Services Manager (FSM), the Policies and Procedures titled, Food Safety Management System- Food Safety Product Labeling and Dating Guidelines revised [DATE], indicated:</p> <p>Date Marking Time Control for Food Safety: ready-to-eat, time/temperature control for safety (TCS - foods that require special handling to prevent the growth of harmful bacteria. TCS foods are also known as potentially hazardous foods) food prepared in a food establishment and held longer than the subsequent meal period must be marked to indicate the date or day by which the food is to be consumed or discarded. These time/temperature parameters are intended to help control for growth of Listeria monocytogenes (species of pathogenic [disease-causing] bacteria that can be found in moist environments, soil, water and can even grow under refrigeration and other food preservation measures).</p> <p>Date Marking Non Time Control for Food Safety: once a product has a documented use by date, the Food and Drug Administration (FDA, responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation.) Food Code and Vendor 1 Policy requires the product to be consumed or discarded` by that date. It is important to date food properly to avoid unnecessary disposal of safe food.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>FSM stated food items such as juice or milk, when delivered, a received date sticker should be applied on the carton, and once opened, it should be labeled with the item name, opened date and the use by date. FSM stated, labeling with preparation date was not enough and it should be discarded if there was no use by date indicated. FSM stated fresh cut fruits must also be labeled with item name, prepared date and use by date. In addition, FSM stated, ice cream scooped into small serving bowls and placed back in the freezer must be individually covered and must also be labeled with the prepared and use by dates. FSM also stated a big container of juice or juice concentrate should be labeled with date opened and use by date and once opened, manufacturer's expiration date is not followed, the use by date should be followed. FSM stated it was important to follow the opened and use by dates, if there were no labels of date opened, use by date and/or expiration date, staff would not know how old the food item was and if served to the residents and staff, they could get sick and could affect multiple residents and staff.</p> <p>During a review of the Facility's Policy and Procedure (P&P) for Food Safety Management System titled Food Product Shelf-Life Guidelines, revised [DATE], indicated food manufacturer/supplier code dates, use by dates, use thru dates, or expires on dates should always be considered the first level of control.</p> <p>2. During a concurrent observation in the dry storage area 2 and interview on [DATE] at 8:05 AM with KM 1, the following were observed:</p> <p>One dented can of tomato ketchup and one dented can of corn.</p> <p>One peanut butter jar with visible crack on the lid, with contents seeping out, transparent tape applied around the lid with oily substance seeping out, unlabeled with date opened, and product expiration date faded and unreadable.</p> <p>One opened box with a thick layer of dust on top of the half-closed box, inside was granulated sugar in a plastic bag. Thick layer of dust also observed on the plastic bag of sugar and was not sealed. Patches of black round shaped material were observed under the adhesive tape stuck on top of the half- opened box.</p> <p>One plastic container with blue lid containing lima beans, labeled with date of [DATE], and the use by date was left blank. The blue lid was covered with thick layer of dust and 1 dead fly observed on top of the lid.</p> <p>KM 1 stated that dented canned goods should not be placed in the storage room and they should have been set aside to return to the company it was ordered from for disposal. KM 1 also stated the peanut butter jar that is leaking and the open plastic bag of sugar that was covered with dust should have been discarded. KM 1 added, it is not acceptable that the container of lima beans was covered with thick layer of dust and a dead fly.</p> <p>During an interview on [DATE] at 11:05 AM, FSM stated, staff designated for the Dry storage room was responsible for checking for any dented canned goods and set them aside to be given back to the supplier for disposal. The same staff was also responsible for maintaining cleanliness of the storage room, making sure there were no pests or insects. FSM stated dusty containers and a dead fly were not acceptable those can be source of food contamination which could cause sickness to the residents they served.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the Facility's P&P titled Canned Food Safety, undated, indicated, if a can containing food has a sharp dent on the top, bottom, or side seam, it can damage the seam and allow bacteria to enter the can. Discard any can with a sharp dent on any seam.</p> <p>3. During a concurrent observation in the facility's kitchen and interview on [DATE] at 7:42 AM with the KM 1, the following were observed in the Refrigerator #2 and #4, and Freezer #3:</p> <p>In Refrigerator #2, one chocolate syrup, preparation date of [DATE] and use by date on [DATE].</p> <p>In Freezer #3, one wrapped meat labeled vegiburgers and use by date of [DATE].</p> <p>In Refrigerator #4, one container of pesto sauce, labeled with use by date on [DATE].</p> <p>KM 1 stated there were food items that were already past the use by dates and should have been discarded.</p> <p>During a concurrent observation and interview on [DATE] at 8:11 AM with KM 1 in the walk -in freezer located at the first floor, the following were observed:</p> <p>One pack of unknown frozen item, resealed and labeled with use by date on [DATE].</p> <p>One container of basil pesto, product expiration date of [DATE].</p> <p>KM 1 confirmed several food items were expired and should have been discarded, residents and staff could become ill or sick if served with the expired food.</p> <p>4. During a concurrent observation in the facility's kitchen and interview on [DATE] at 7:42 AM with the KM 1, Refrigerator #4 temperature log had missing temperature readings and initials (the staff checking):</p> <p>[DATE], [DATE] and [DATE] were missing afternoon temperature readings and initials.</p> <p>[DATE], [DATE], and [DATE] were missing morning temperature readings and initials.</p> <p>[DATE], [DATE] and [DATE] were missing morning temperature readings and initials.</p> <p>[DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] were missing morning temperature readings and initials.</p> <p>KM 1 stated the refrigerator's temperature should be monitored and documented in the temperature log daily, every morning and afternoon shift and staff responsible on checking the temperature should put their initials.</p> <p>During a concurrent observation and interview on [DATE] at 8:05 AM with KM 1 at the dry storage area 2 the following were observed the temperature log were missing temperature readings and staff's initials for [DATE] afternoon shift, [DATE] morning and afternoon shifts, and on [DATE] morning shift.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a follow up observation on [DATE] at 9:53 AM at the Milk Room, temperature logs did not have temperature readings and staff's initials for [DATE] and [DATE] for both morning and afternoon shifts.</p> <p>During an interview on [DATE] at 11:05 AM with the FSM, FSM stated the cooks were responsible for checking and recording the temperatures for all the refrigerators and freezer in the kitchen and the first floor walk in freezer and refrigerators when the shift starts at 6:00 AM. FSM stated kitchen supervisor checked the logs daily. FSM also stated it was important to check and record the temperatures of the refrigerators and freezer so staff would know that food items were being stored safely. FSM also stated, FSM cannot find in their P&Ps regarding monitoring temperature readings and documenting it daily every start of morning and afternoon shift. FSM stated it should be included in their P&P that the refrigerators, milk room and dry storage area temperature readings are monitored and documented in the facility's temperature log.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>49537</p> <p>Based on observation, interview, and record review, the facility failed to dispose garbage (mostly decomposable food waste or yard waste) and keep 11 of 11 garbage bin/plastic dumpster/refuse (dry material such as glass, paper, cloth, or wood that does not readily decompose) containers covered and/or not overfilled with trash as indicated on the facility policy.</p> <p>These deficient practices had the potential to attract vermin (animals that are believed to be harmful, carry diseases such as rodents, parasitic worms, or insects), pests (any living thing that has a negative effect on humans), and wildlife (undomesticated animal species) that could potentially infiltrate the facility, affect the resident care areas and pose a disease threat to the residents and staff of the facility.</p> <p>Findings:</p> <p>During an observation of the first-floor hallway of the kitchen on 10/22/2024 at 7:59 AM, a garbage bin without a cover was seen next to a metal cart with a plate, two used uncovered pitchers, a washcloth, roll of unused trash bags, and two open boxes of plastic aprons. There was also a rolling cart with used meal trays observed beside the uncovered garbage bin.</p> <p>During a concurrent observation of the dumpster area (outside the facility building) and interview on 10/22/2024 at 8:21 AM with Food Services Manager (FSM), FSM stated this area is for kitchen garbage. The area was observed to be covered with a roof and with partial walls. The following were observed:</p> <ol style="list-style-type: none"> One rectangular plastic dumpster (large trash container designed to be emptied into a truck) overfilled with boxes with its lid open. One round uncovered plastic garbage bin overfilled with boxes from food deliveries. Five (5) round uncovered plastic garbage bins with garbage from the kitchen. One partially closed black garbage bin, also filled with garbage from the kitchen. <p>FSM stated all garbage bins should have covers even if not full. FSM also stated Facilities (Maintenance department) oversaw garbage pick-up and disposal. FSM stated the Facilities were in charge of the garbage pickup schedule was twice a day every day except Sundays when garbage pickup was only once.</p> <p>During a concurrent observation of another dumpster area (outside the facility building behind the Assisted Living [housing for elderly or disabled people that provides nursing care, housekeeping, and prepared meals as needed] building) and interview with FSM on 10/22/2024 at 8:23 AM, two uncovered rectangular plastic dumpsters filled with garbage were observed.</p> <p>During an observation on 10/24/2024 at 9:50 AM at the kitchen dumpster area, the following were observed:</p> <p>(continued on next page)</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. One rectangular plastic dumpster overfilled with boxes.</p> <p>b. Three used boxes on the floor</p> <p>c. Two (2) overfilled and uncovered garbage bins.</p> <p>d. One trash bag on the floor next to the dumpster</p> <p>e. Three (3) trash bags were on the floor.</p> <p>f. One overfilled garbage bin with lid open.</p> <p>During an interview on 10/24/2024 at 1:40 PM with FSM, FSM stated trash bins should be covered whether full or not. FSM stated, No trash should be on the floor or ground, even if in a closed trash bag. FSM stated the trash could attract pests and wildlife that could cause problems and residents could get sick.</p> <p>During an interview on 10/25/2024 at 11:30 AM with Engineer Assistant (EA 1), EA 1 stated the garbage bins should be covered and trash bags should not be left on the floor/ground. EA 1 stated garbage bin and dumpster should not be overfilled. EA 1 stated this was important because it could attract vermin or animals in the area, and this can bring diseases put the residents and staff at risk. EA 1 also stated the trash were normally picked up daily in the mornings however the trash had been picked up late on 10/22/2024 that resulted to the dumpsters being overfilled.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Garbage/Refuse Disposal, Sanitation & Infection Control, revised 5/2023, the P&P indicated:</p> <ol style="list-style-type: none"> 1. all items shall be disposed of in appropriate dumpster, food/medical waste versus recyclable materials. 2. Dumpster lids shall be closed at all times. 3. Area around dumpsters shall be free of waste products including food, medical, paper trash and other waste to prevent harborage and feeding of pests. 4. All departments utilizing the dumpsters for waste and/or recycling purposes are responsible for maintaining the area and ensuring that the dumpster lids are closed and the area around the dumpster is free of waste. 		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087</p> <p>Based on observation, interview, and record review, the facility failed to observe infection control measures as indicated on the facility policy when facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure staff wear Personal Protective Equipment (PPE, protective clothing such as gown, gloves, goggles, mask) before administering medication to Resident 35 via gastrostomy tube (G-tube, a surgically inserted tube that provides a way to deliver nutrition, fluids, and medications directly to the stomach) on 10/24/2024. <p>This deficient practice had the potential to result in Resident 35 developing an infection and spread of infection among staff and residents.</p> <ol style="list-style-type: none"> 2. Ensure the Legionella (a type of bacteria spread through small droplets of water that can cause legionellosis [Legionnaires' Disease, a serious and potentially deadly lung infection]) Water Management Program policy and procedure was implemented when Facility lost water supply due to water main break outside the facility on 10/23/2024. <p>This deficient practice had the potential to result in the infection (a process when a microorganism, such as bacteria, fungi, or a virus, enters a person's body and causes harm) and spread of waterborne illness in the facility.</p> <ol style="list-style-type: none"> 3. Ensure infection control prevention was maintained when Minimum Data Set Nurse (MDSN), Certified Nurse Assistant (CNA 5), and Restorative Nurse Assistant (RNA 1) did not perform hand hygiene (washing hands with soap and water for at least 20 seconds [time measurement] or using an alcohol-based hand sanitizer [substance used to make something clean and hygienic]) while assisting Resident 8 and Resident 24, Resident 40 and Resident 46, and Resident 10 and Resident 11 respectively with feeding. <p>This deficient practice had the potential to result in spread of infection between residents that could compromise the health of the residents, visitors, and staff.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 35's Admission Record, the Admission Record indicated Resident 35 was originally admitted to the facility on [DATE]. Resident 35's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a medical condition that causes weakness or an inability to move on one side of the body) affecting left side, and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for residents with swallowing problems). <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of Resident 35's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/17/2024, the MDS indicated Resident 35's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 35 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/taking off footwear and personal hygiene. It also indicated a nutritional approach of feeding tube while in the facility.</p> <p>During a review of Resident 35's order summary report, dated 10/24/2024, indicated the following:</p> <p>Gastrostomy tube, ordered on 10/03/2024.</p> <p>Restorative Nurse Assistant (RNA) to apply left hand splint in the morning, ordered on 9/30/2021.</p> <p>During a concurrent observation on 10/23/2024 at 9:18 AM, in Resident 35's room, and interview with RNA 2, Resident 35 was sitting in wheelchair while RNA 2 was applying splint to Resident 35's left hand. RNA 2 stated she only need to wear gloves during splint application and did not need to wear gown. RNA 2 stated Resident 35's left hand need to be held while placing the splint.</p> <p>During a concurrent observation and interview with Licensed Vocational Nurse 1 (LVN 1) on 10/24/2024 at 9:21 AM, LVN 1 was not wearing gown while obtaining Resident 35's blood pressure and prior to medication administration via Resident 35's G-tube. LVN 1 stated she had to held Resident 35's arm to place the blood pressure cuff when obtaining blood pressure. LVN 1 stated Resident 35 receives all medication through his G-tube. LVN 1 was stopped by surveyor before LVN 1 attempts to access Resident 35's G-tube. LVN 1 stated there was no signage outside Resident 35's room to alert staff and visitors regarding Resident 35's isolation precaution.</p> <p>During a concurrent observation and interview with Infection Preventionist (IP) on 10/24/2024 at 10:20 AM, IP stated Resident 35 has a G-tube and enhanced barrier precaution (EBP, an infection control practice that involves wearing gowns and gloves during high-contact activities with residents in nursing homes) should be applied during high contact activities such as splint application and medication administration. IP nurse verified there was no EBP signage outside Resident 35's room to alert staff and visitors to wear appropriate PPE while rendering close contact care to Resident 35.</p> <p>During a follow up interview on 10/24/2024 at 10:34 AM with LVN 1 and concurrent record review of Resident 35's active orders, LVN 1 verified that Resident 35 has no order for EBP. LVN 1 stated that Resident 35 has G-tube for a while now.</p> <p>During an interview on 10/25/2024 at 10:57 AM with Assistant Director of Nursing (ADON), she stated the facility does adhere EBP, wherein PPE, such as wearing gown, gloves, and mask, is needed during physical contact care to residents with G-tube. ADON stated Resident 35 has a G-tube and PPE should have been used when RNA applied left hand splint because it required a physical contact with Resident 35. ADON stated LVN 1 should have worn a gown when obtaining blood pressure and administering medication because the activity required close contact with Resident 35. ADON verified Resident 35 did not have an order for EBP. ADON stated EBP is important for Resident 35, so he won't catch a virus and infection because he have an external device which is the G-tube that is a quick portal entry of bacteria and virus.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of Facility's Policy and Procedure titled Enhanced Barrier Precautions, revised on March 2024, indicated EBP involve gown and glove use during high-contact resident care activities to those increased risk of multidrug-resistant organism (MDRO, a bacteria that does not respond to antibiotics) acquisition (example, resident with wounds or indwelling medical devices [a medical device that is left inside the body]). It indicated a physician order is obtained for EBP for residents with indwelling medical devices even if the resident is not known to be infected or colonized with EBP. It also indicated EBP should be followed when performing transfers and assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. High-contact resident activities included the following:</p> <p>Dressing</p> <p>Providing hygiene</p> <p>Device care or use of feeding tube</p> <p>2. During an interview on 10/23/2024 at 6:30 AM with Director of Nursing, she stated there was a main water line repair affecting water supply to the entire facility. DON stated there will be no water in faucets and toilets.</p> <p>During an interview on 10/25/2024 at 8:54 AM with Engineer Assistant (EA), he stated that on 10/23/2024 around 5AM, facility did not have water supply running to the facility pipes because of a main water line break outside the facility. EA stated that during that time, there was water stagnation in facility's water pipes, and there was a water pressure and temperature change when water supply came back on 10/23/2024 at 10:46 AM. EA stated that facility uses a third-party company for their water management. EA stated facility had an annual check for legionella last October 2023. EA stated the main water line incident on 10/23/2024, where in the facility did not have a running water for few hours (almost 6 hours) was a major issue and third-party company should have been called to check facility's water lines and supply to make sure it was not contaminated and for safety.</p> <p>During an interview on 10/25/2024 at 9:14 AM with IP, she stated Facility did not have water supply for few hours due to water main break outside the facility on 10/23/2024. She stated water should have been tested when water supply came back on 10/23/2024 to make sure there is no presence of legionella in the water that is supplying the facility and residents. IP stated water stagnation and change in water temperature is an indicative to check water for legionella. IP stated presence of legionella in the water is harmful to the residents. IP stated residents might get sick, develop pneumonia, fever, cough or get hospitalized if they consumed anything that is contaminated with legionella.</p> <p>During an interview on 10/25/2024 at 11:50 AM with Director of Nursing (DON), she stated that Facility has a water management team that consist of different department heads and IP. DON stated that anyone of them should have thought and called the third company in accordance with the water management program policy when Facility had a water incident on 10/23/2024.</p> <p>During a review of Facility's Policy and Procedure (P&P) titled, Water Management Program, revised 1/2023, the P&P indicated the identification of situations that can lead to Legionella growth, such as</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>construction</p> <p>water main breaks</p> <p>water temperature fluctuations</p> <p>water pressure changes</p> <p>water stagnation</p> <p>The water management program will be reviewed at least once a year or sooner if any of the following occur:</p> <p>There is a major maintenance or water service change.</p> <p>49537</p> <p>3a. During a review of Resident 24's Admission Record, the Admission Record indicated the facility admitted Resident 24 on 11/16/2023 with diagnoses that included dementia (a progressive state of decline in mental abilities), protein-calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition and function), hypokalemia (electrolyte imbalance that occurs when potassium [a mineral that the body needs to work properly] levels in the blood are lower than normal), and hypo-osmolality (condition where the levels of electrolytes, proteins, and nutrients in the blood are lower than normal) and hyponatremia (a condition where the plasma sodium [essential mineral the body needs in small amounts to maintain fluid balance] concentration is lower than normal).</p> <p>During a review of Resident 24's History and Physical (H&P-formal document that physicians produce through resident interview, physical exam and the summary of the testing either obtained or pending) dated 10/7/2024, the H&P indicated Resident 24 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 24's MDS dated [DATE], the MDS indicated Resident 24 had severe cognitive impairment. The MDS also indicated Resident 24 needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating.</p> <p>During a review of Resident 24's Care Plan focused on ADL (Activities of Daily Living-a measure of a person's ability to care for themselves without assistance) related to advanced age, multiple health comorbidities, required assistance with ADL, initiated on 8/23/2024, indicated interventions for Eating: set up assist if resident is in the mood, if falling asleep and not feeding herself: Total feeder.</p> <p>During a review of Resident 8's Admission Record, the Admission Record indicated the facility admitted Resident 8 on 2/5/2020 with diagnoses that included dementia, muscle weakness (loss of muscle strength due to aging and underlying health conditions), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and pulmonary fibrosis (lung disease that occurs when lung tissue becomes damaged and scarred causing difficulty in breathing).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of Resident 8's H&P dated 4/15/2023, the H&P indicated Resident 8's aspiration (accidentally inhaling food, liquid, or other material into the lungs) risk was high and had severe altered mental status (AMS-change in mental function that stems from illnesses, disorders and injuries affecting the brain).</p> <p>During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8 had severe cognitive impairment and was dependent with eating.</p> <p>During an observation on 10/23/2024 at 7:48 AM at the [NAME] Dining Room, MDSN was observed assisting Resident 24 and Resident 8 with eating breakfast. MDSN was holding a glass of juice to Resident 24's mouth and held Resident's 24's utensils to feed resident. MDSN used both of her hands feeding Resident 24. MDSN then helped Resident 8, holding a cup of juice to Resident 8's mouth and held Resident 8's utensil to feed resident. MDSN did not perform hand hygiene in between helping both Resident 24 and Resident 8.</p> <p>3b. During a review of Resident 46's Admission Record, the Admission Record indicated the facility admitted Resident 46 on 5/19/2023 with diagnoses that included cerebral infarction (a serious medical condition that occurs when the brain's blood supply is disrupted), dysphagia (difficulty swallowing), severe protein calorie malnutrition, adult failure to thrive (a syndrome of weight loss, decreased appetite and poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, and impaired immune function), and alzheimer's disease (a disease characterized by a progressive decline in mental abilities).</p> <p>During a review of Resident 46's MDS dated [DATE], the MDS indicated Resident 46 had severe cognitive impairment and was dependent with eating.</p> <p>During a review of Resident 40's Admission Record, the Admission Record indicated the facility admitted Resident 40 on 1/13/2020 with diagnoses that included alzheimer's disease, dementia, muscle weakness, and major depressive disorder (a mental health condition that can impact how a person feels, thinks, and behaves).</p> <p>During a review of Resident 40's H&P dated 4/9/2024, the H&P indicated Resident 40 did not have the capacity to understand ad make decisions.</p> <p>During a review of Resident 40's MDS dated [DATE], the MDS indicated Resident 40 had severely impaired cognitive skills for daily decision making and was dependent with eating.</p> <p>During an observation on 10/23/2024 at 7:52 AM at the [NAME] Dining Room, CNA 5 was observed assisting Resident 40 and Resident 46 with eating breakfast. CNA 5 held Resident 46's glass to assist Resident 40 to drink from the glass and held Resident 46's utensils with both hands to assist resident with feeding. CNA 5 then turned to assist Resident 40 with the resident's breakfast without performing hand hygiene.</p> <p>3c. During a review of Resident 10's Admission Record, the Admission Record indicated the facility admitted Resident 10 on 3/8/2023 with diagnoses that included alzheimer's disease, dementia, dysphagia, anorexia (an eating disorder that causes people to weigh less that is considered healthy for their age and height, usually by excessive weight loss), and abnormal weight loss (losing weight without trying or unintentionally).</p> <p>(continued on next page)</p>		

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 10/25/2024
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.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10 has moderately impaired cognitive skills for daily decision making and was dependent with eating.</p> <p>During a review of Resident 11's Admission Record, the Admission Record indicated the facility admitted Resident 11 on 12/26/2023 with diagnoses that included dementia, dysphagia, cerebral infarction, and hemiplegia and hemiparesis of the left non dominant side.</p> <p>During a review of Resident 11's H&P dated 12/29/2023, the H&P indicated Resident 11 did not have the capacity to understand or make decisions.</p> <p>During a review of Resident 11's MDS dated [DATE], the MDS indicated Resident 11 had severe cognitive impairment and required set up or clean up assistance with eating.</p> <p>During an observation on 10/24/2024 at 7:43 AM in the RNA Room, RNA 1 was observed feeding Resident 10, touching, and holding Resident 10's utensils, cup, plate, and glass consecutively using both of her hands. RNA 1 then moved her chair closer to Resident 11 and started feeding resident, touching utensils, cup, plate, and glass. RNA 1 did not perform hand hygiene before assisting Resident 11. At 7:45 AM, RNA 1 moved her chair closer to Resident 10 and resumed feeding Resident 11, without performing hand hygiene.</p> <p>During an observation on 10/24/24 at 7:49 AM, RNA 1 left the RNA room to get Resident 11 a cup of coffee at the main dining room. RNA 1 was not observed performing hand hygiene before leaving the room. RNA 1 came back and opened a drawer in the counter, got sugar and spoon to mix in the coffee, and gave it to Resident 11. RNA 1 was further observed going to Resident 10's table, mixed the resident's food, touched Resident 10's hair and face and RNA 1 did not perform hand hygiene in between the tasks.</p> <p>During a concurrent observation and interview on 10/24/2024 at 7:52 AM, RNA 1 moved her chair closer to Resident 11's table, held Resident 11's water glass and utensils, RNA 1 moved her chair back closer to Resident 10's table, touched resident's wheelchair, and resumed feeding Resident 10, without performing hand hygiene before moving from Resident 11 to Resident 10. When RNA 1 was asked what step was missed when she was helping Resident 10 and Resident 11 with feeding, RNA 1 stated she did not perform hand hygiene.</p> <p>During an interview on 10/25/2024 at 9:10 AM with RNA 1, RNA 1 stated, if helping two (2) residents with feeding, setting up of trays were done one at time, perform hand hygiene before and after setting up Tray 1, then set up Tray 2. RNA 1 confirmed she did not perform hand hygiene after helping Resident 10 and before helping Resident 11 and every time she moved from helping both residents during breakfast on 10/24/2024. RNA 1 stated germs (microscopic bacteria, viruses, fungi that can cause disease) can be spread from one resident to another if hand hygiene was not performed and residents could get sick.</p> <p>(continued on next page)</p>		

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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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a concurrent interview and record review on 10/25/2024 at 9:25 AM with the DON, the facility's P&P titled Feeding the Resident, dated 1/2020 was reviewed. The DON stated according to their policy, staff can be assigned to help two (2) or more residents who need feeding assistance simultaneously but cannot cross meaning if staff's left hand was used to help feed Resident A on staff's left-hand side, left hand cannot be used to help Resident B who was on staff's right-hand side. If both hands were used to help Resident A, hand hygiene must be performed before helping Resident B, alcohol rub is acceptable but if hands got soiled with food, hand washing needed to be done.</p> <p>During the same interview on 10/25/2024 at 9:25 AM, the DON stated it was important to follow the facility's hand hygiene policy to mitigate the spread of pathogens (bacteria, virus, or other microorganism that can cause disease) from resident to resident.</p> <p>During a review of the facility's P&P titled Feeding the Resident revised 1/2020, the P&P indicated one (1) staff may be assigned to two (2) or more residents who need feeding assistance. The P&P also indicated to observe universal precautions (a set of hygienic practices that healthcare workers use to prevent the spread of infectious diseases and originally developed for patients with known bloodborne diseases), wash hands before assisting resident.</p> <p>During a review of the facility's P&P titled Standard Precautions, revised 12/2023, the P&P indicated standard precautions (a set of infection control practices that healthcare providers use to prevent the spread of diseases, are used in all healthcare settings and apply to all patients) will be used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. The P&P also indicated standard precautions included hand hygiene which referred to handwashing with soap (anti-microbial or non-antimicrobial) or using alcohol-based hand rubs (gels, foams, rinses) that do not require access to water.</p>		