

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2024
NAME OF PROVIDER OR SUPPLIER  Montecito Heights Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 4585 N. Figueroa St. Los Angeles, CA 90065	

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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36395</p> <p>Based on interview and record review the facility failed to ensure residents and their family member/next of kin were given the opportunity to discuss and review the documents the residents signed for two of two sampled residents (Resident 1 and Resident 2). For Resident 1 and Resident 2, the facility failed to ensure the Assisted Living Waiver (ALW, program that provides specified benefits to eligible residents to remain in their community as an alternative to residing in a licensed health facility) forms and consents signed by Resident 1 and Resident 2 on 7/26/24 were in the language Resident 1 and Resident 2 could understand.</p> <p>These deficient practices resulted in Resident 1, Resident 2 and their families not being aware of what forms and consents Resident 1 and Resident 2 signed.</p> <p>Findings:</p> <p>1. During a review of the Admission Record indicated the facility originally admitted Resident 1 on 9/1/21 and was readmitted on [DATE] with diagnoses including Parkinson ' s Disease (brain condition that causes problems with movement, mental health, sleep, pain, and other health issues), muscle weakness and difficulty in walking.</p> <p>During a review of the Minimum Data Set (MDS, standardized care and health screening tool) dated 8/6/24, indicated Resident 1 was cognitively intact. Resident 1 needed substantial assistance (helper does more than half the effort) with personal hygiene, putting on/taking off footwear, lower body dressing, partial assistance (helper does less than half the effort) with upper body dressing, shower/bathe, and set-up (helper sets up, resident completes activity) with oral hygiene, eating and toileting hygiene. The same MDS indicated Resident 1 preferred his own language and Resident 1 needed or wanted an interpreter to communicate with a doctor or health care staff.</p> <p>During a review of the ALW Forms and Consents, indicated Resident 1 signed the forms on 7/26/24. The Forms and Consents were written in English.</p> <p>2. During a review of the Admission Record indicated the facility originally admitted Resident 2 on 1/31/2017 and readmitted on [DATE] with diagnoses including diabetes (group of disease that affect how the body uses blood sugar [glucose]), reduced mobility, and difficulty in walking.</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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the MDS dated [DATE] indicated Resident 2 was cognitively intact. Resident 2 needed supervision (helper provides cues or cleans up) with oral hygiene and set up assistance (helper sets up, resident completes activity) with personal hygiene, putting on/off footwear, lower/upper body dressing, shower/bathe, toileting hygiene and eating. The same MDS indicated Resident 1 preferred her own language and Resident 2 needed or wanted an interpreter to communicate with a doctor or health care staff.</p> <p>During a review of the ALW Forms and Consents, indicated Resident 2 signed the forms on 7/26/24. The Forms and Consents were written in English.</p> <p>During an interview on 9/5/24 at 9:36 a.m. with Resident 1, medical record director (MRD) interpreting, Resident 1 stated he signed documents and does not remember what he signed. Resident 1 stated he does not have a copy of the documents he signed.</p> <p>During an interview on 9/5/24 at 10:09 a.m., Resident 2 and certified nursing assistant (CNA 1) interpreting, Resident 2 stated she signed documents but does not remember what she signed. Resident 2 also stated she does not have a copy of the documents she signed.</p> <p>During an interview on 9/5/24 at 11:30 a.m., with Resident 1 and Resident 1 ' s family member (FM 1), FM 1 stated Resident 1 signed some documents. FM 1 and Resident 1 stated they do not know what Resident 1 signed. FM 1 stated the facility did not provide FM1 and Resident 1 a copy of the document that Resident 1 had signed.</p> <p>During an interview on 9/5/24 at 12:36 p.m., with the administrator (ADM) and the director of nursing (DON), the ADM stated he speaks the language of Resident 1 and Resident 2. ADM stated when the ALW application were filled out, ADM was present and interpreted the ALW Forms and Consents that was written in English for Resident 1 and Resident 2. DON stated, moving forward the documents should be in a language Resident 1 and Resident 2 can understand.</p> <p>During a telephone interview on 9/5/24 at 1:04 p.m., Resident 2 ' s FM 2 (FM 3 interpreting) stated she does not know what Resident 2 signed. FM 2 stated she did not receive a copy of the forms Resident 2 had signed.</p> <p>During a review of the facility's Policy and Procedures (P&amp;P) titled Resident Rights reviewed on 3/19/24, indicated, the facility will promote and protect resident rights. Residents have freedom of choice, as much as possible about how they wish to live their everyday lives and receive care, subject to the facility ' s rules and regulations and applicable state and federal laws governing the protection of resident health and safety. The same Policy indicated the resident have the right that included the right to participate in decisions and care planning.</p> <p>During a review of the facility's P&amp;P titled Translation and Interpretation Services revised on 6/27/24, indicated, upon admission, facility staff will assess the resident ' s language skills. Facility staff will inform the residents, in a language they can understand or their right to obtain competent translation services free of charge. The same policy indicated translation and interpretation are provided in a way that is culturally and appropriate to the limited English proficient individual.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36395</p> <p>Based on interview and record review the facility failed to provide a Notice of Proposed Transfer and Discharge to one of two sampled residents (Resident 2). For Resident 2, the facility failed to provide the Notice on 8/29/24 when Resident 2 had a planned discharged to a lower level of care on 9/4/24.</p> <p>This deficient practice had the potential for Resident 2 not be given her right to know in writing the date and reasons for her discharge.</p> <p>Findings:</p> <p>During a review of the Admission Record indicated the facility originally admitted Resident 2 on 1/31/2017 and was readmitted on [DATE] with diagnoses including diabetes (group of disease that affect how the body uses blood sugar [glucose]), reduced mobility, and difficulty in walking.</p> <p>During a review of the Minimum Dat Set (MDS, standardized care and health screening tool) dated 6/24/24, indicated Resident 2 was cognitively intact. Resident 2 needed supervision (helper provides cues or cleans up) with oral hygiene and set up assistance (helper sets up, resident completes activity) with personal hygiene, putting on/off footwear, lower/upper body dressing, shower/bathe, toileting hygiene and eating.</p> <p>During a review of the Social Services Progress Notes dated 8/29/24 at 1:38 p.m., indicated the interdisciplinary team (IDT) met with Resident 2 and Resident 2 ' s family member (FM 2). The Notes indicated Resident 2 will be discharged to a lower level of care on 9/4/24.</p> <p>During concurrent interview and record review on 9/5/24 at 12:36 p.m., the social services progress notes dated 8/29/24 was reviewed with the director of nursing (DON). The DON stated Resident 2 was not given the Notice of Proposed Transfer and</p> <p>Discharge and should have been given to Resident 2 as soon as the facility knew that Resident 2 had a date of discharge. DON stated the Notice should have been given to Resident 2 on 8/29/24.</p> <p>During a review of the facility's Policy and Procedures titled Discharge and Transfer of Residents reviewed on 3/14/24, indicated, the resident/resident representative will be provided with a Notice of Proposed Transfer and Discharge 30 days prior to discharge or as soon as practicable. The same Policy indicated prior to discharge the social service staff or nursing will provide the resident/resident representative with the Notice of Proposed transfer and discharge document. Social service/designee will keep a copy of the Notice that was provided to the resident/representative. This will be placed in the medical record.</p>		