

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 06/06/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309</p> <p>Based on observation, interview, and record review, the facility failed to ensure the call lights (an alerting device for nurses to assist a patient when in need) were within the residents' reach for two of 19 sampled residents (Resident 10 and Resident 113). These deficient practices had the potential to result in a delay in care and services and Resident 10 and 113's inability to request assistance.</p> <p>Findings:</p> <p>a. A review of Resident 10's Admission Record (Face Sheet) indicated the facility admitted the resident on 7/13/2017, and readmitted on [DATE], with diagnoses including hemiplegia (an inability to move one side of body) and hemiparesis (an inability to move the arm, leg and sometimes face on one side of the body) following a cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting the right-dominant side.</p> <p>A review of Resident 10's care plan dated 8/7/2023, indicated Resident 10 was at risk for falls and the interventions indicated, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.</p> <p>A review of Resident 10's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 4/16/2024, indicated Resident 10 was dependent on staff for activities of daily living (ADLs - toileting hygiene, shower/bathe, upper and lower body dressing, and personal hygiene).</p> <p>During a concurrent observation and interview on 6/3/2024 at 8:50 AM, with Resident 10 and Licensed Vocational Nurse 1 (LVN 1), in Resident 10's room, the resident was lying on his back in his bed with his call light on the floor of the left side of his bed. LVN 1 stated Resident 10's call light was on the floor, on the left side of the Resident 10's bed. LVN 1 also stated the call light should be within the resident's reach so he can call for help.</p> <p>b. A review of Resident 113's Admission Record indicated the facility admitted the resident on 5/29/2024, with diagnoses including alcohol abuse, stimulant abuse (when you use class of drugs that speed up messages traveling between the brain and body too much), and muscle weakness.</p> <p>A review of Resident 113's Physician's History and Physical (H&P) dated 5/30/2024, indicated the resident had the capacity to understand and make decisions.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview, on 6/3/2024 at 8:42 AM, inside Resident 113's room, Resident 113 was observed lying on her bed. Resident 113's call light was observed hanging from the wall on the other side of her privacy curtains far from her reach. Resident 113 stated, I do not know where my call light is. Certified Nursing Assistant 5 (CNA 5), who was present at the bedside, stated Resident 113's call light was not within the resident's reach. CNA 5 further stated that resident's call light was required to be within reach and stated I do not know why the call light was hanging from the wall far away from Resident 113's reach.</p> <p>During an interview on 6/6/2024 at 2:04 PM, with the facility's Director of Nursing (DON), the DON stated residents' call lights were required to be accessible to the residents at all times. The DON stated the potential outcome of staff not placing the call lights within residents' reach was the inability of residents to call for help when they need it.</p> <p>A review of the facility's policy and procedure titled, Communication-Call System, revised 3/14/2024, indicated the facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathing facilities and call cord will be placed within the resident's reach in the resident's room.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883</p> <p>Based on observation, interview, and record review, the facility failed to revise care plans for two of 19 sampled residents (Resident 20 and Resident 47) investigated for care planning. The facility failed to revise Resident 20's care plan to reflect a discontinuation of antibiotic therapy (medications that are used to treat infection by stopping bacteria from reproducing or destroying them) and failed to revise Resident 47's care plan after discontinuing a urinary indwelling catheter (a tube inserted in the bladder to drain the urine).</p> <p>This deficient practice placed the residents at risk for inconsistent implementation of care plans which may lead to a delay in or lack of delivery of care and services.</p> <p>Findings:</p> <p>a. A review of Resident 20's Admission Record indicated the facility admitted the resident on 9/18/2023 and readmitted him on 10/1/2023, with diagnoses including encephalopathy (brain disease, damage, or malfunction of brain), hydronephrosis (a condition that occurs when a kidney swells and urine cannot drain out from kidney), and generalized muscle weakness.</p> <p>A review of Resident 20's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 4/12/2024, indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and required moderate assistance from staff with toileting, hygiene, showering, mobility, and setup or clean-up assistance with eating, as well as oral and personal hygiene.</p> <p>A review of Resident 20's of History and Physical, dated 4/5/2024 indicated Resident 20 had the capacity to understand and make decisions.</p> <p>A review of the Physician's Order dated 4/5/2024 indicated Resident 20 was to receive Ceftriaxone Sodium Injection Solution (medication used to treat infection) 1 gram (g - unit of measurement) intravenously, once a day for sepsis (a serious condition in which the body responds improperly to an infection) / urinary tract infection (UTI) for ten days.</p> <p>A review of Resident 20's care plan initiated 4/5/2024 indicated the resident was on antibiotic therapy of Ceftriaxone Sodium Injection and the intervention was to administer antibiotic medication as ordered by a physician and monitor for side effects and effectiveness every shift.</p> <p>A review of the Physician's Order dated 5/26/2024 indicated Resident 20 to receive Keflex (medication used to treat infection) 500 milligram (mg - unit of measurement) given by mouth three times a day for UTI for five days.</p> <p>A review of Resident 20's care plan initiated 5/26/2024 indicated the resident was on antibiotic therapy of Keflex and the intervention was to administer antibiotic medication as ordered by a physician and monitor for side effects and effectiveness every shift.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 6/3/2024 at 9:08 AM, Resident 20 was observed in his room and stated that he was no longer receiving antibiotics.</p> <p>During a concurrent interview and record review on 6/6/2023 at 8:08 AM, Resident 20's medical record was reviewed with Minimum Data Set Coordinator 2 (MDSC 2). MDSC 2 verified that Resident 20's care plan indicated Resident 20 was on antibiotic therapy. MDSC 2 verified that Keflex was administered to Resident 20 from 5/26 to 5/31/2024 and administration of Ceftriaxone Sodium injections was finished in April 2024. MDSC 2 stated that Resident 20 was not receiving antibiotics at this time and the licensed nurses were responsible to update the care plans reflecting the change in the antibiotics therapy. MDSC 2 stated the care plan should have been updated to reflect the use of the antibiotics was resolved.</p> <p>During an interview on 6/6/2023 at 9:21 AM, the Director of Nursing (DON) stated antibiotic care plans have to be specific for different antibiotics and have to be resolved after antibiotic therapy was finished to reflect Resident 20's current status.</p> <p>b. A review of the admission record indicated Resident 47 was admitted to the facility on [DATE] with diagnoses including rhabdomyolysis (a serious condition where your muscle fibers break down and leak their harmful contents into your bloodstream that clog up the kidney and lead to kidney failure) and diabetes mellitus (a condition where the body has trouble using sugar for energy, leading to high blood sugar level).</p> <p>A review of the Physician's Order dated 1/23/2024 indicated Resident 47 was to receive indwelling catheter care daily and as needed, report for sudden change of condition.</p> <p>A review of Resident 47's care plan dated 1/24/2024, indicated the resident would be free from catheter related trauma through the review date, 4/23/2024. Resident 47's care plan was not revised on 4/23/2024 and did not indicate that it was discontinued.</p> <p>A review of the Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 4/23/2024 indicated Resident 47 had sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of her environment. The resident usually made herself understood and was usually able to understand others. The MDS indicated Resident 47 required one-person physical assistance with toilet use / personal hygiene and had an indwelling catheter.</p> <p>The Physician's Order dated 5/28/2024 indicted to remove Resident 47's indwelling catheter.</p> <p>During a concurrent observation and interview on 6/3/2024 at 9:11 AM with Resident 47 in her room, the resident was laying on the bed, alert and oriented. There was no tubing or indwelling catheter bag connected to the resident. The resident stated, I had a UTI (an infection in any part of the urinary system) when I got admitted , but it was gone now, and the nurse already removed the catheter couples of days ago.</p> <p>During a concurrent interview and record review on 6/5/2024 at 11:30 AM with Minimum Data Set Coordinator (MDSC) 2, Resident 47's physician's orders and care plans were reviewed. It indicated the MD ordered to remove Resident 47's indwelling catheter on 5/28/2024 and the indwelling catheter care plan was not discontinued. MDSC 2 stated the charge nurse did not revise Resident 47's care plan after removal of the indwelling catheter.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/5/2024 at 11:44 AM with Director of Nursing (DON), she stated the care plan should have been revised after Resident 47's indwelling catheter was removed. The DON stated resident's care plans need to be documented correctly to provide the appropriate care for the resident.</p> <p>A review of the facility's policy and procedure titled, Comprehensive Person -Centered Care Planning, reviewed 3/14/2024, indicated the comprehensive care plan will be periodically reviewed and revised by IDT after each assessment. In addition, the comprehensive care plan will also be reviewed and revised at the following times: Onset of new problems; Change of condition; In preparation for discharge; To address changes in behavior and care; and Other times as appropriate or necessary.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>47883</p> <p>Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one of three sampled residents (Resident 20), by not rotating the site for administration of a subcutaneous injection (an insertion of medication beneath the skin) of Basaglar (a long-acting insulin [hormone that lowers the level of sugar in the blood]).</p> <p>The deficient practice had the potential to result in the resident developing a lipodystrophy (a condition when fat either break down or builds up under the skin, causing interference with insulin abortion).</p> <p>Findings:</p> <p>A review of Resident 20's Admission Record indicated the facility admitted the resident on 9/18/2023 and readmitted him on 10/1/2023 with diagnoses including encephalopathy (brain disease, damage, or malfunction of brain), hydronephrosis (a condition that occurs when a kidney swells and urine cannot drain out from kidney), and Type 1 diabetes (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly).</p> <p>A review of Resident 20's History and Physical, dated 4/5/2024 indicated Resident 20 had the capacity to understand and make decisions.</p> <p>A review of Resident 20's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 4/12/2024, indicated the resident had intact cognition (mental action or process of acquiring knowledge and understanding) and required moderate assistance from staff with toileting, hygiene, showering, mobility, and setup or clean-up assistance with eating, as well as oral and personal hygiene.</p> <p>A review of the Physician's Order Summary Report, dated 6/4/2024, indicated for Resident 20 to receive Basaglar 20 units (volume measurements) to be administered subcutaneously at bedtime. The physician's order further indicated to rotate injection sites.</p> <p>During a concurrent interview and record review, on 6/6/2023 at 8:08 AM, Resident 20's medical record was reviewed with Minimum Data Set Coordinator 2 (MDSC 2). MDSC 2 verified that Basaglar was administered to Resident 20's right arm on 5/3, 5/4, 5/5 and 5/6/2024. MDSC 2 stated the licensed nurses needed to rotate sites for repeated injections of insulin to prevent complications.</p> <p>During an interview on 6/6/2023 at 9:21 AM, the Director of Nursing (DON) stated that for subcutaneous injections administered repeatedly, the licensed nurses had to rotate the medication administration site according to the physician's order, to prevent any skin complications for Resident 20.</p> <p>A review of the facility's policy and procedure titled, Subcutaneous Injection, reviewed 3/14/2024, indicated for subcutaneous injection administered repeatedly, such as insulin, rotate sites.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>48661</p> <p>Based an observation, interview, and record review, the facility failed to post the federally required daily actual hours worked by the staff in an area accessible to the public for four of six days for the month of June 2024. As a result, the total number of staff and the actual hours worked was not readily accessible to residents, family, or visitors.</p> <p>Findings:</p> <p>During an observation in the facility lobby on 6/3/2024 at 8 AM, the Census and Direct Care Service Hours Per Patient Day (DHPPD: Refers to the actual hours of work performed per patient day by a direct caregiver) did not reflect the actual hours worked of staff and reflected the projected working hours of staff for today (6/3/2024).</p> <p>During an observation in the facility lobby on 6/4/2024 at 9:10 AM, the DHPPD did not reflect the actual hours worked of staff and reflected the projected working hours of staff for today (6/4/2024).</p> <p>During an observation in the facility lobby on 6/5/2024 at 8:36 AM, the DHPPD did not reflect the actual hours worked of staff and reflected the projected working hours of staff for today (6/5/2024).</p> <p>During an observation in the facility lobby on 6/6/2024 at 8:50 AM, the DHPPD did not reflect the actual hours worked of staff and reflected the projected working hours of staff for today.</p> <p>During an interview on 6/6/2024 at 12:02 PM, the Director of Staff Development (DSD) stated the DHPPD posted reflected the projected hours and not the actual hours worked by staff. The DSD stated the actual hours for the day were in a separate binder and were not posted. The DSD stated posting the DHPPD was important to ensure the facility had adequate staffing for the current patient census.</p> <p>During a concurrent interview and record review on 6/6/2024 at 12:30 PM with the DSD, the facility's policy, and procedures (P&P) titled, Nursing Department - NHPPD Staffing Audit Guidelines, dated 3/14/2024 was reviewed. The P&P indicated the facility would provide the minimum number of actual nursing hours performed by direct caregivers per patient day. The DSD stated posting the actual nursing hours was important for patient safety to ensure the proper number of staff were in the facility to take care of the residents. The DSD stated if the residents, family, or visitors were not provided the actual number of staff, the residents, family, or visitors could have felt uneasy.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>48661</p> <p>Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 21) was free of unnecessary medication by failing to follow the Physician's Order to discontinue Enoxaparin (a blood thinner given via injection) 40 milligrams (mg - unit of measurement) subcutaneously (SQ - injected under the skin) dated 5/30/2024.</p> <p>This deficient practice resulted in Resident 21 receiving Enoxaparin from 5/30/2024 to 6/5/2024 without a Physician's Order, which placed the resident at risk for internal bleeding, hemorrhage (loss of blood from damaged blood vessels), organ failure, and death.</p> <p>Findings:</p> <p>A review of Resident 21's Admission Record indicated the facility initially admitted the resident on 1/23/2024 and readmitted the resident on 3/13/2024 with diagnoses that included fracture of left femur (broken thigh bone), reduced mobility and abnormalities of gait (abnormal walking pattern).</p> <p>A review of Resident 21's History and Physical (H&P) dated 1/29/2024, indicated the resident had capacity to understand and make decisions.</p> <p>A review of the Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 2/2/2024, indicated Resident 21's cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated Resident 21 required partial/moderate assistance from facility staff with rolling to the left and right side, lying to sitting on the side of the bed, sit to stand, and required substantial/maximal assistance of facility staff with sit to lying. The MDS indicated the resident was taking an anticoagulant (blood thinner used to prevent and treat blood clots).</p> <p>A review of Resident 21's Physician's Order dated 3/13/2024, indicated for the resident to receive Enoxaparin 40 mg SQ one time a day for deep vein thrombosis prophylaxis (treatment designed to counteract the formation of blood clots inside blood vessels).</p> <p>A review of Resident 21's Anticoagulant Therapy care plan developed on 3/16/2024 for the resident's Enoxaparin, the goal was for the resident to be free from discomfort or adverse reactions related to anticoagulant use. The care plan interventions indicated administering Enoxaparin as ordered by the physician, daily skin inspection, and to monitor / document / report adverse reactions.</p> <p>A review of Resident 21's Medication Administration Record (MAR) dated from 5/1 to 5/31/2024, indicated the resident received Enoxaparin every day, except on 5/16/2024 and 5/28/2024 when the resident refused.</p> <p>According to a review of the Pharmacists Note to Attending Physician dated 5/30/2024, the recommendations for the physician was to consider clarifying Resident 21's Enoxaparin therapy by adding a potential stop date, or discontinuing therapy if the resident's condition warrants. The Pharmacists Note to Attending Physician was signed by the physician and had a note indicating to discontinue the order per the Medical Doctor.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of resident 21's MAR dated from 6/1/2024 to 6/5/2024, indicated the resident received Enoxaparin every day.</p> <p>During a concurrent interview and record review, on 6/5/2024 at 9:06 AM with the Director of Nursing (DON), Resident 21's Pharmacists Note to Attending Physician signed 5/30/2024 was reviewed. The DON stated she was responsible for reviewing the Medication Regimen Review recommendations and communicating with the Registered Nurse Supervisor (RNS) and physician the pharmacy recommendations. The DON confirmed by stating she forgot to follow through on the pharmacy MRR recommendation for Resident 21. The DON stated Resident 21 could have experienced side effects such as an increased risk of bleeding if Enoxaparin was not discontinued per the Physician's Order.</p> <p>A review of Resident 21's Progress Note dated 6/6/2024, indicated the nurse notified the physician regarding the resident's excess doses of Enoxaparin after surveyor interviews with facility staff on 6/5/2024.</p> <p>A review of the facility's policy and procedures (P&P) titled, Medication - Administration, dated 3/14/2024, indicated if the Attending Physician increases or changes a medication order, this was an automatic stop or discontinue order for the original order.</p> <p>A review of the facility's P&P titled, Physician Orders, dated 3/14/2024, indicated the telephone order was transcribed onto the Physician's Order form the time the order was taken. A copy of the printed or handwritten telephone order was maintained in the resident's medical record until the signed original order was returned to the facility. The P&P indicated whenever possible, the licensed nurse receiving the order would be responsible for documenting and carrying out the order.</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309</p> <p>Based on observation, interview, and record review, the facility failed to ensure a therapeutic diet (specialized diet designed to address specific medical conditions and improve health outcomes) was served per Physician's Order for one of six sampled residents (Resident 114).</p> <p>This deficient practice had the potential to place Resident 114 at risk for choking and aspiration (inhaling small particles of food or drops of liquid into the lungs).</p> <p>Findings:</p> <p>A review of the Admission Record (Face Sheet) indicated the facility admitted Resident 114 on 5/22/2024, with diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), muscle weakness, and need for assistance with personal care.</p> <p>A review of the Physician's Order dated 5/23/2024, indicated Resident 114 was to receive a no added salt (NAS) diet, mechanical soft texture (foods that are soft and easy to chew) and nectar thick consistency liquid (slightly more body than thin liquids, but still can pour easily).</p> <p>A review of Resident 114's Speech Language Pathologist (SLP-sometimes called speech therapists, assess, and treat people who have speech, language, voice, and fluency disorders) Evaluation and Plan of Treatment form dated 5/29/2024, indicated that during assessment of bedside swallowing of liquids, there were mild signs and symptoms of dysphagia (difficulty or discomfort in swallowing). The SLP evaluation further indicated a recommendation for nectar thick liquid for Resident 114.</p> <p>A review of the Nutritional Risk assessment dated [DATE], indicated Resident 114 was not tolerating thin liquids (liquid that can be taken through a straw or standard cup) and the Speech Therapist (ST- someone whose job is to treat people who have difficulty speaking) evaluated the resident and recommended nectar thick liquids.</p> <p>During a concurrent observation and interview on 6/3/2024 at 8:53 AM, inside Resident 114's room, Resident 114 was observed sitting on his bed with a bedside table in front of him. There was a written sign on top of the resident's bed indicating nectar thick liquid, there was a cup of thickened water on the table, and a cup of coffee with thin consistency half consumed. Resident 114 stated that he drank half of the coffee a few minutes ago and he enjoyed his coffee.</p> <p>During a concurrent observation and interview on 6/3/2024 at 8:55 AM, inside Resident 114's room, Resident 114's cup of coffee was observed by Certified Nursing Assistant (CNA) 1. CNA 1 stated the staff served coffee with thin consistency instead of nectar thick coffee to Resident 114. CNA 1 stated she did not know which staff member served the coffee to Resident 114 and she removed the cup from Resident 114's bedside table.</p> <p>(continued on next page)</p>		

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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.			
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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/5/2024 at 2 PM, the Registered Dietician (RD -a health professional who has special training in diet and nutrition) stated the facility's Speech Therapist evaluated Resident 114 and recommended nectar thick liquid for him because Resident 114 was not tolerating thin liquids. The RD stated there was a Physician's Order for nectar thick liquids for Resident 114 and staff were required to serve nectar thick liquid to the resident. The RD further stated the potential outcome of serving thin liquid to the resident who required to have thickened liquid was at risk of choking and aspiration.</p> <p>During an interview on 6/6/2024 at 2:05 PM, the Director of Nursing (DON) stated staff were required to follow Physician's Orders for therapeutic diets. The DON stated Resident 114 had an order for nectar thick liquid and was required to receive nectar thick coffee. The DON stated the potential outcome of serving thin liquid to Resident 114 was aspiration and choking.</p> <p>A review of facility policy and procedure titled, Therapeutic Diets, revised 3/14/2024, indicated the purpose of this policy was to ensure the facility provided therapeutic diets to residents that meet nutritional guidelines and physician orders. Therapeutic diets were diets that deviate from the regular diet and require a physician's order. Per physician's order, therapeutic diets were planned, prepared, and served in consultation with the Dietician. Therapeutic diets would not be given without a physician's order. The therapeutic diet would be reflected on the resident's tray card.</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>47883</p> <p>Based on observation, interview, and record review, the facility failed to provide a dycem (non-slip mat that anchors items to the trays or tables and prevents cups and plates from slipping off trays or tables) to the resident for one of three sampled residents (Resident 39).</p> <p>This deficient practice had the potential to result in the resident being unable to maintain or improve his ability to eat or drink independently.</p> <p>Findings:</p> <p>A review of the Admission Record indicated the facility admitted Resident 39 on 8/8/2023 with diagnoses including hemiplegia (paralysis that affects only one side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it had to perform everyday activities like eating or dressing), diabetes Type II (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly), and muscle weakness.</p> <p>A review of the History and Physical (H&P) dated 8/9/2023, indicated Resident 39 had the capacity to understand and make decisions.</p> <p>A review of Resident 39's Care Plan, revised on 8/9/2023, indicated Resident 39 needed assistance with eating and the intervention indicated to provide a divided plate and dycem at each meal to improve the self-feeding task.</p> <p>A review of the Physician's Order Summary Report dated 12/14/2023, indicated Resident 39 had an order for adaptive equipment: divided plate and dycem to be provided at each meal to improve the self-feeding task.</p> <p>A review of the Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/7/2024, indicated Resident 39 had intact cognition (undamaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS indicated Resident 39 required setup or clean-up assistance with meals and required two-persons assistance extensive assistance with bed mobility, showering, dressing, toileting, and personal hygiene.</p> <p>According to a review of Resident 39's Medical Administration Record (MAR), dated 5/1 -5/31/2024, there was no charting for adaptive equipment: divided plate and dycem to be provided at each meal to improve the self-feeding task was not being done.</p> <p>During a concurrent observation and interview on 6/5/2024 at 12:45 PM, Resident 39 was observed eating lunch in his room. A divided plate was observed on the tray, but there was no dycem observed on or below the serving tray. Resident 39 stated he had a blue mat before on his table to prevent the food tray from slipping. The resident stated that he did not know where it went, and that it was never replaced.</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/6/2024, at 9:56 AM, the Director of Rehabilitation (DOR) stated the dycem was provided by the rehabilitation center to the kitchen and the kitchen staff had to place the dycem for the resident during the meal set-up.</p> <p>During an interview on 6/6/2024, at 10 AM, the Director of Nursing (DON) stated that it was important to provide adaptive equipment to Resident 39 to improve his ability to eat and drink independently.</p> <p>A review of the facility's policy and procedure titled, Adaptive Equipment -Feeding Devices, reviewed 3/14/2024, indicated adaptive equipment will be provided by the occupational therapist to the dietary department to be included with meal services for the resident daily.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50358</p> <p>Based on observation, interview, and record review, the facility failed to ensure the indwelling catheter bag (a transparent bag where urine was collected and connected to a tubing that was inserted in the body through the bladder) was not touching the floor for one of 19 sampled residents (Resident 29). This failure had the potential for Resident 29 to acquire a urinary tract infection (UTI - an infection caused by bacteria entering the urinary tract).</p> <p>Findings:</p> <p>A review of the admission records indicated Resident 29 was admitted to the facility on [DATE] with diagnoses including UTI, Type II diabetes mellitus (a condition where the body has trouble using sugar for energy, leading to high blood sugar) and paralysis (a loss of muscle motor function) of right side of the body. The resident had more memory or thinking problems than other people their age and required assistance with daily activities such as personal hygiene, showering, toileting, dressing, eating, and transferring from bed to wheelchair.</p> <p>During an observation on 6/5/2024 at 8:32 AM, in the activity room, Resident 29 was sitting on her wheelchair. Resident 29's indwelling catheter bag was hanging from the wheelchair and touching the floor.</p> <p>During an interview on 6/5/2024 at 8:35 AM with Certified Nursing Assistant (CNA) 3, she stated Resident 29's indwelling catheter bag should not be touching the floor because it was an infection control issue.</p> <p>During an interview on 6/5/2024 at 9:57 AM, the Director of Nursing (DON) stated CNA 3 should have made sure Resident 29's indwelling catheter bag was not touching the floor because it could cause an infection in Resident 29.</p> <p>A review of the facility's policy and procedure titled, Catheter - Care Of, dated 3/14/2024, indicated the catheter tubing, bag or spigot would be anchored to not touch the floor.</p>		

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<p>F 0911</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883</p> <p>Based on observation, interview, and record review, the facility failed to ensure that two of 35 rooms (rooms [ROOM NUMBERS]) did not accommodate more than four residents inside. This deficient practice had the potential to result in inadequate usable living space for the residents and working space for the healthcare staff.</p> <p>Findings:</p> <p>A review of the room waiver request letter, dated 6/6/2024, indicated resident rooms [ROOM NUMBERS] did not meet the 4-bedroom regulation. The letter indicated the rooms were in accordance with the special needs of the residents and would not have an adverse effect on the residents' health and safety or impede the ability of any resident in the room to attain his/her highest practical well-being.</p> <p>The room waiver request and Client Accommodation analysis showed the following:</p> <p>Rooms: # Beds: Sq. ft. Sq. ft./bed:</p> <p>3 7 648.9 92.7</p> <p>4 5 422.1 84.42</p> <p>During multiple room observations conducted in rooms [ROOM NUMBERS], from 6/3 to 6/6/2024, between the hours of 7:30 AM - 4 PM, it was observed that nursing staff had adequate space to provide care to the residents, each resident was provided privacy curtains for privacy; and the rooms had two modes of egress, one with direct access to the corridors and another leading to the outside of the building.</p> <p>During an interview on 6/6/2024 at 2:47 PM, Resident 50 and Resident 114 verbalized the rooms afforded them adequate space to accommodate their needs and staff were able to provide care safely and without restrictions.</p> <p>On 6/6/2024 at 9:51 AM, during an interview, Certified Nursing Assistant (CNA) 1 and CNA 5 did not state concerns regarding the lack of space while providing care for the residents.</p> <p>The Department is recommending continuation of the Room Waiver Request.</p>		