

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/26/2024
NAME OF PROVIDER OR SUPPLIER  Providence St Elizabeth Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  10425 Magnolia Blvd North Hollywood, CA 91601	

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 0584</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 safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38552</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, comfortable, and homelike environment to two of four sampled residents (Residents 1 and 2) by failing to ensure Resident 1 and 2 's room temperature was not above 81 degrees Fahrenheit (a unit of measure).</p> <p>This deficient practice had the potential to affect the comfort of residents and placed the residents at risk for dehydration.</p> <p>Findings:</p> <p>a. During a review of Resident 1 ' s Admission Record, the Admidion Record indicated the facility admitted the resident on 8/9/2024 with diagnoses including aftercare following joint replacement and lack of coordination.</p> <p>During a review of Resident 1 ' s History and Physical (H&amp;P), dated 8/10/2024, the H&amp;P indicated the resident has the capacity to understand and make decisions.</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/13/2024, the MDS indicated resident with intact cognitive status and required partial/moderate assistance (helper does less than half the effort) with sit to stand, lying to sitting on the edge of bed, sit to lying, and roll left and right.</p> <p>b. During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility readmitted the resident on 5/2/2023 with diagnoses including metabolic encephalopathy (an alteration in consciousness caused due to brain dysfunction [due to impaired cerebral metabolism]), generalized muscle weakness, and cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area).</p> <p>During a review of Resident 2 ' s History and Physical, dated 7/23/2024, the H&amp;P indicated the resident does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated the resident can make self understood and understand others. The MDS indicated substantial/maximal assistance (helper does more than half the effort) with chair/bed-to-chair transfer, sit to stand, lying to sitting on side of bed, sit to lying, and rolling left to right on back on the bed.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/26/2024
NAME OF PROVIDER OR SUPPLIER  Providence St Elizabeth Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  10425 Magnolia Blvd North Hollywood, CA 91601	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2 ' s ADL plan of care, dated 5/6/2024, it indicated the resident with goals of appropriate assistance during ADL cares while maintaining independence as able with interventions including the resident obtains the needed nutrition and hydration.</p> <p>During an observation on 8/21/2024 at 10:05 a.m., outside of Resident 1 and 2 ' s room, observed Restorative Nursing Assistant 1 (RNA 1) inside the room. Resident 1 asked RNA 1 to open the window. RNA 1 responded to Resident 1 and stated Resident 2 does not want the window open because it is too hot. Resident 2 asked RNA 1 to not open the window. RNA 1 exited room.</p> <p>During an observation on 8/21/2024 at 10:08 a.m., inside Resident 1 and 2 ' s room, observed window partially open and there was a standing fan in the room. Observed RNA 1 bring cups of ice water for Resident 2. Resident 2 was lying in bed, and was observed with sweat on the resident's face.</p> <p>During an interview on 8/21/2024 at 10:10 a.m., with Resident 1, Resident 1 stated stated yesterday (8/20/2024), the room was so hot, it felt like the air conditioning (AC) was not working. Resident 1 stated the fan was on, but it was not helping. When asked about the window being open, Resident 1 stated she prefers the window open all day because she wants the air to circulate and get fresh air from the outside.</p> <p>During an interview on 8/21/2024 at 10:50 a.m., with the Maintenance Supervisor (MS), the MS stated yesterday, 8/20/2024, he noticed the window was wide open and the room temperature was at 82 degrees Fahrenheit (a unit of measure). The MS stated he noticed the roommate, Resident 2, looked a little red and was sweating so he called the nurse to check on the resident. The MS stated he explained to Resident 1 that when the window is wide open the hot air comes in and for the AC to work, the window needed to be closed.</p> <p>During an interview on 8/22/2024 at 7:16 a.m., with Restorative Nursing Aide 1 (RNA 1), RNA 1 stated Resident 1 and 2 ' s room gets hot after 10 a.m. because Resident 1 likes to have the window open. RNA 1 stated yesterday, 8/21/2024, she was in the room assisting Resident 2 and the resident's CNA. Resident 2 told RNA 1 that she feels hot, and she noticed the resident was sweating, and was about to close the window when Resident 1 told RNA 1 to not to close the window. RNA 1 stated she explained to Resident 1 that Resident 2 felt hot and the window needed to be closed. RNA 1 stated Resident 1 started screaming profanity at RNA 1 and Resident 2 asked RNA 1 to not close the window. RNA 1 stated she told Resident 2 she will be back and would bring her cup of ice water to help her cool down. RNA 1 stated there was a fan in the room, but the room remains hot when the windows are open.</p> <p>During an interview on 8/23/2024 at 11:45 a.m. with the Director of Nursing (DON), the DON stated she encouraged Resident 1 to close the window to keep the room cool. The DON stated the facility should ensure the residents are hydrated and maintenance personnel should check the room temperatures. The DON stated when the room is not within, 71 degrees Fahrenheit to 81 degrees Fahrenheit, the residents could potentially get dehydrated and have increased body temperatures.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, SNF Homelike Environment, last revised 8/2024, the P&amp;P indicated that it is the facility ' s policy to provide residents with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings and include characteristics of comfortable temperatures.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/26/2024
NAME OF PROVIDER OR SUPPLIER  Providence St Elizabeth Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  10425 Magnolia Blvd North Hollywood, CA 91601	
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 0585</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 voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>38552</p> <p>Based on interview and record review, the facility failed to maintain written grievance documentation and outcome of investigation/course of action taken for one of three sampled residents (Resident 1) by failing to address Resident 1 ' s grievances related to room being hot and increased noise levels at night.</p> <p>This deficient practice had the potential for Resident 1 ' s grievances to go unnoticed causing frustration and distress to the resident; and had the potential to result in a delay of care and services.</p> <p>Findings:</p> <p>During review of Resident 1 ' s Admission Record, indicated the facility admitted the resident on 8/9/2024 with diagnoses including aftercare following joint replacement and lack of coordination.</p> <p>During a review of Resident 1 ' s History and Physical (H&amp;P), dated 8/10/2024, the H&amp;P indicated resident has the capacity to understand and make decisions.</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS), a standardized assessment and care screening tool), dated 8/13/2024, the MDS indicated the resident with intact cognitive status and required partial/moderate assistance (helper does less than half the effort) with sit to stand, lying to sitting on the edge of bed, sit to lying, and roll left and right.</p> <p>During an interview on 8/21/2024 at 10:10 a.m., with Resident 1, the resident stated yesterday, 8/20/2024, the room was so hot, it felt like the AC was not working The resident stated the fan was on, but it was not helping. Resident 1 stated she prefers the window open all day because she wants the air to circulate and get fresh air from the outside. Resident 1 further stated she has filed a grievance against the facility related to residents yelling and screaming and increased noise levels at night. Resident 1 stated the Director of Nursing (DON) and the Administrator (ADM) are aware of the resident ' s concerns and was told her concerns had been addressed but the resident stated her concerns remain unresolved.</p> <p>During an interview on 8/21/2024 at 10:50 a.m., with the Maintenance Supervisor (MS), the MS stated yesterday, 8/20/2024, he noticed the window was wide open and the room temperature was at 82 degrees Fahrenheit (a unit of measure). The MS stated he noticed the roommate, Resident 2, looked a little red on the face and was sweating so he called the nurse to check on the resident. The MS stated he explained to Resident 1 that when the window is wide open the hot air comes in and for the AC to work, the window needed to be closed.</p> <p>During a concurrent interview and record review on 8/21/2024 at 1:45 p.m., with the Social Services Designee (SSD), the facility ' s grievance log was reviewed. The SSD stated the last grievance on file was on 1/8/2024 and there were no grievances reported or filed in 7/2024 and 8/2024. The SSD stated she does not fill out the grievance log.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/26/2024
NAME OF PROVIDER OR SUPPLIER  Providence St Elizabeth Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  10425 Magnolia Blvd North Hollywood, CA 91601	
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/22/2024 at 7:11 a.m. with Licensed Vocational Nurse 2 (LVN 2) stated at night Resident 1 complained to him about Resident 2 talking to herself. LVN 2 stated they had offered headphones, but the resident refuses to wear one.</p> <p>During an interview on 8/23/2024 at 10:49 a.m., the DON stated she was not aware of Resident 1 ' s concerns of noise about her roommate.</p> <p>During a concurrent interview and record review on 8/23/2024 at 10:40 a.m., with the DON, facility ' s grievance log was reviewed. The DON stated the Grievance/Concern form is filled out by any staff when a resident files for a grievance and once the form is completed it is submitted to SSD. The DON stated the SSD will then forward the form to the appropriate department to address the residents ' concerns. The DON stated a response action should be taken immediately and resolved in five working days.</p> <p>During an interview on 8/23/2024 at 11:50 a.m., with the DON, the DON stated it is important that the resident ' s concerns are addressed and receive timely resolution.</p> <p>A review of the facility ' s policy and procedure titled, Resident Grievance Policy, last revised 7/2022, indicated the purpose of this policy is to ensure the prompt resolution of all resident grievances. The policy defined grievance as verbal or written expression of a problem, concern or dissatisfaction with service delivery or the quality of care furnished. The policy indicated the Grievance Official with whom a grievance can be filed is with Social Services/Admissions Coordinator. The policy indicated that all written grievance decisions must include:</p> <ul style="list-style-type: none"> <li>- The date the grievance was received;</li> <li>- A summary statement of the resident ' s grievance;</li> <li>- The steps taken to investigate the grievance;</li> <li>- A summary of the pertinent findings or conclusions regarding the resident ' s concerns;</li> <li>- A statement as to whether the grievance was confirmed or not confirmed;</li> <li>- Any corrective action taken or to be taken by the facility as a result of the grievance; and</li> <li>- The date the written decision was issued.</li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/26/2024
NAME OF PROVIDER OR SUPPLIER  Providence St Elizabeth Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  10425 Magnolia Blvd North Hollywood, CA 91601	
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 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>38552</p> <p>Based on observation, interview, and record review, the facility failed to obtain a physician order for oxygen therapy for one of three sampled residents (Resident 1), who was receiving oxygen therapy.</p> <p>This deficient practice placed the resident at risk for adverse effects due to unnecessary oxygen administration.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted the resident on 8/9/2024 with diagnoses including aftercare following joint replacement and lack of coordination.</p> <p>During a review of Resident 1 ' s History and Physical (H&amp;P), dated 8/10/2024, the H&amp;P indicated the resident has the capacity to understand and make decisions.</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/13/2024, the MDS indicated the resident with intact cognitive status and required partial/moderate assistance (helper does less than half the effort) with sit to stand, lying to sitting on the edge of bed, sit to lying, and roll left and right.</p> <p>During an observation on 8/21/2024 at 10:10 a.m., at Resident 1 ' s bedside, observed Resident 1 receiving oxygen at 5 liters per minute (LPM) via nasal cannula (a device that provides additional oxygen through the nose). Resident 1 stated she told the nurses she needed oxygen because sometimes she feels out of breath and the oxygen helped.</p> <p>During a concurrent interview and record review on 8/23/2024 at 10:16 a.m., with Licensed Vocational Nurse 1 (LVN 1), Resident 1 ' s physician orders were reviewed. LVN 1 stated Resident 1 has been on oxygen therapy since the resident's initial admission and readmission but the resident did not have a physician's order for oxygen therapy.</p> <p>During an interview on 8/23/2024 at 10:29 a.m., with LVN 2, LVN 2 stated Resident 1 likes to have the oxygen on for sense of security. LVN 2 stated she has spoken to Resident 1 ' s physician this morning and received an order for oxygen therapy.</p> <p>During an interview on 8/23/2024 at 11:13 a.m., with the Director of Nursing (DON), the DON stated there should be a physician's order and care plan for administration and monitoring of oxygen use before before a resident is placed on oxygen therapy to ensure the resident does not experience adverse effects from oxygen use.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/26/2024
NAME OF PROVIDER OR SUPPLIER  Providence St Elizabeth Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  10425 Magnolia Blvd North Hollywood, CA 91601	

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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Physician Orders, last approved 9/2021, the P&amp;P indicated the purpose of this policy to assure that care, treatment and services administered by facility licensed nurses are in conformance with the orders of the physician, ensure accuracy of physician ' s orders when taken verbally, define the required elements of an order, ensure adequate and timely documentation of physician orders.</p>