STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055192	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence St Elizabeth Care Center	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)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on interview and record review, the facility failed to implement its policies and procedures related to residents and or responsible party notification rights for one of four sampled residents (Resident 1). The facility received a Notice of Medicare Non-Coverage ([NOMNC] a form from the Centers of Medicare & Medicaid services that skilled nursing facilities must provide to residents informing them Medicare-covered services are ending, and the right to appeal or contest the decision) notice for Resident 1, which included the process of how to file an appeal, but Resident 1 nor the responsible party(s) of Resident 1 were not provided the notice. This deficient practice denied Resident 1 and the responsible party the rights to make informed decisions related to Resident 1's care, the rights to stay in the facility, and discussion and implementation of safe discharge planning needs. Cross reference F627. Findings: During a review of Resident 1's admission Record, undated, the admission Record indicated the facility originally admitted Resident 1 on 12/1/2025 with diagnoses including periprosthetic fracture around internal prosthetic left knee joint (a broken bone in the leg or knee near an artificial joint, often caused from a fall), type 2 diabetes mellitus (a chronic condition leading to high blood sugar due to insulin resistance), history of falling, difficulty in walking, and retention of urine (the inability to empty urine from the body). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), date unreadable, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/6/2025, the MDS indicated Resident 1's cognitive functioning (the ability to think, learn, remember, use judgment, and make decisions) was with moderate impairment. The MDS also indicated Resident 1 needed substantial/maximal assistance (helper does more than half the effort) for toileting needs, showering or bathing, and assistance when dressing items below the waist including footwear. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the following physician's order: - 12/25/2025: Discharge Destination: Home with home health services During a review of Resident 1's Notice of Medicare Non-Coverage (NOMNC) letter, dated 12/22/2025, the notice indicated Resident 1's Medicare coverage of current skilled nursing facility ended on 12/24/2025, with a discharge date scheduled for 12/25/2025. The notice included a contact number and the instructions on how to ask for an immediate appeal:Ask for the appeal as soon as possible. You must ask for a timely appeal no later than noon of the day before the above date. The form also indicated the facility did not physically provide the notice to Resident 1 or the responsible party(s) of Resident 1 as the signature section read, Temporarily incapacitated. During a phone interview on 1/7/2026 at 2:20 p.m. with Resident 1's Responsible Party 3 (RP 3), RP 3 stated I kept telling them my mother is not ready for discharge. RP 3 also stated, We felt the discharge was incompetent, the most unorganized discharge, I have never seen a more unorganized, unsafe discharge in my life. She (Resident 1) was discharged home with an intravenous ([IV] an access point for administering medication directly into the bloodstream) port on her arm. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	They didn't give discharge instructions to anybody. RP 3 also stated, I did not receive any information on how to appeal the case. During a concurrent interview and record review on 1/8/2026 at 1:18 p.m. with Admissions Coordinator 1 (AC 1), Resident 1's progress note titled Administrative Note, dated 12/22/2025 at 10:25 a.m. inputted by AC 1, was reviewed. AC 1 stated Resident 1 wanted to have her responsible party(s) to make decisions on Resident 1's behalf. Resident 1's progress note titled Administrative Note, dated 12/22/2025 at 10:25 a.m. inputted by AC 1 indicated a phone conversation with RP 3 indicating, The insurance is issuing a last cover day of date 12/24/2025 with a discharge (DC) date 12/25/2025. Explained options: Like DC home, care giver resources and the right to appeal if felt that she wasn't ready to DC to a lower level. Stated that she will appeal. The note also indicated, Patient was given a copy of NOMNC that was left on bedside and the number to appeal. During further interview with AC 1, AC 1 stated, On the note, the family wanted to file an appeal. We failed to obtain a signature from the family that they received the NOMNC notice. During an interview with Admissions Director (AD 1) on 1/9/2026 at 2:11 p.m., AD 1 stated, They (resident/responsible party) have to sign that they received a copy, because it is acknowledging that they received the NOMNC. The NOMNC has the information including multiple languages and explains that they have the right to appeal, which is the right to appeal the day before the last cover day, normally by noon. AD 1 also stated, We cannot file the appeal on the resident or the family's behalf, it has to be from the resident or responsible party. If someone was never given the NOMNC, you can't file an appeal, because you wouldn't know what phone number to call. They would also request a Medicare identification number. If it cannot be provided, then the appeal cannot be started. AD 1 stated, The failure was not obtaining a signature from the resident (Resident 1) or from the responsible party, which prevents them to file an appeal or extending the resident's stay with this facility. AD 1 also stated, I am not too familiar with the 30-day notice. I have never heard of the 30-day notice, and I have worked on admission since 2017. During a review of the facility provided policy and procedure (P & P) titled, Resident Rights with last reviewed date of 6/2025 indicated, It is the policy of this facility that all resident rights be followed per state and federal guidelines as well as other regulative agencies. The P & P also indicated The Resident has the right:To be encouraged and assisted throughout his or her stay in the center.To receive appropriate advanced notice (usually thirty days written notice) or any involuntary transfer or discharge from the Nursing Center as required by law.During a review of the facility provided P & P titled Medicare Notice of Non-Coverage (NOMNC) with last revised date of 11/30/2023 indicated, Medicare providers are responsible for the delivery of the NOMNC. Providers may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all the requirements of valid notice delivery apply to designated agents. The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to account for and update the personal belongings for one of four sampled residents (Resident 1). This deficient practice increased Resident 1's risk for loss of personal belongings while residing in the facility. Findings:During a review of Resident 1's admission Record, undated, the admission Record indicated the facility originally admitted Resident 1 on 12/1/2025 with diagnoses including periprosthetic fracture around internal prosthetic left knee joint (a broken bone in the leg or knee near an artificial joint, often caused from a fall), type 2 diabetes mellitus (a chronic condition leading to high blood sugar due to insulin resistance), history of falling, difficulty in walking, and retention of urine (the inability to empty urine from the body). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), date unreadable, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/6/2025, the MDS indicated Resident 1's cognitive functioning (the ability to think, learn, remember, use judgment, and make decisions) was with moderate impairment. The MDS also indicated Resident 1 needed substantial/maximal assistance (helper does more than half the effort) for toileting needs, showering or bathing, and assistance when dressing items below the waist including footwear. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the following physician's order: - 12/25/2025: Discharge Destination: Home with home health services During an interview and concurrent record review with the Director of Nursing (DON) on 1/12/2026 at 3:22 p.m., the DON stated, On discharge, the resident/responsible party gets a copy of the discharge summary, the list of medications, any follow up order, and the inventory. The importance of the inventory shows if there were any items missing or important items to make sure it goes home with resident (Resident 1) and family. During a concurrent record review with DON of Resident 1's document titled, Inventory of Personal Effects, the DON stated, The resident's (Resident 1) inventory is not complete. Why, because upon admission, it was not signed by a facility representative upon admission on [DATE]. Now, upon discharge, it is also not completed as it was not signed by the resident or family representative. The resident (Resident 1) was discharged [DATE], but the signature on facility representative (unknown signer) says 12/26/2025. For the inventory, we failed to have the facility representative and the resident or representative sign the form to certify the belongings were present and that they were received or taken home upon discharge.During a review of a facility provided policy and procedure (P & P) titled, Personal Effects, Inventory of, with last revised date of 6/2025, the P & P indicated, It is the policy of the facility to take responsible steps to protect the personal property of the residents. Procedures:On AdmissionWhen a resident is admitted to the facility, an inventory of the resident's personal effects shall be done by a staff member of the facility. The inventory should include the recording of all personal clothing, valuable articles, etc. which are brought into the facility with the resident and retained by the resident. These personal effects shall be recorded on the Inventory of Personal Effects form.Following completion of the inventory, the indicated form shall be signed by the resident and responsible party and by the staff member.The original copy shall be retained in the resident's health record and a photocopy given to the resident or his/her responsible party. On DischargeUpon discharge of a resident from the facility, the resident or responsible party shall date and sign the Certificate of Receipt on Discharge section of the form in conjunction with a staff nurse in order to certify that the resident's personal effects were received.A photocopy of this completed original form shall then be given to the resident or (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible party.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policies and procedures related to discharge planning for one of four sampled residents (Resident 1). The facility received a Notice of Medicare Non-Coverage ([NOMNC] a form from the Centers of Medicare & Medicaid services that skilled nursing facilities must provide to residents informing them Medicare-covered services are ending, and the right to appeal or contest the decision). The facility failed:1.To provide the NOMNC notice to Resident 1 or responsible party, which included the process of how to file an appeal.2. To provide discharge instructions or teachings to Resident 1 or responsible party.3. To develop an individualized care plan specifically covering the needs of Resident 1 with the inclusion of responsible parties.4. To ensure Resident 1 was not discharged to home with an intravenous ([IV] an access point for administering medication directly into the bloodstream) still intact.These deficient practices posed a serious risk for infection related to Resident 1's intact IV, the possibility of worsening health conditions, lack of care at home, or the potential need for rehospitalization of Resident 1. Cross reference F551. Findings:During a review of Resident 1's admission Record, undated, the admission Record indicated the facility originally admitted Resident 1 on 12/1/2025 with diagnoses including periprosthetic fracture around internal prosthetic left knee joint (a broken bone in the leg or knee near an artificial joint, often caused from a fall), type 2 diabetes mellitus (a chronic condition leading to high blood sugar due to insulin resistance), history of falling, difficulty in walking, and retention of urine (the inability to empty urine from the body). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), date unreadable, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/6/2025, the MDS indicated Resident 1's cognitive functioning (the ability to think, learn, remember, use judgment, and make decisions) was with moderate impairment. The MDS also indicated Resident 1 needed substantial/maximal assistance (helper does more than half the effort) for toileting needs, showering or bathing, and assistance when dressing items below the waist including footwear.During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the following physician's order:- 12/25/2025: Discharge Destination: Home with home health servicesDuring a review of Resident 1's Notice of Medicare Non-Coverage (NOMNC) letter, dated 12/22/2025, the notice indicated Resident 1's Medicare coverage of current skilled nursing facility ended on 12/24/2025, with a discharge date scheduled for 12/25/2025. The notice included a contact number and the instructions on how to ask for an immediate appeal:Ask for the appeal as soon as possible. You must ask for a timely appeal no later than noon of the day before the above date.The form also indicated the facility did not physically provide the notice to Resident 1 or the responsible party(s) of Resident 1 as the signature section had a note which read, Temporarily incapacitated.During an interview on 1/7/2026 at 1:54 p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 remembered discharging Resident 1 with an IV. LVN 1 stated, For someone being discharged with an IV, I would assume its for more treatment. The access site can lead to an infection, or possible bleeding. If uncontrolled bleeding, it can result in the need for emergency care.During a phone interview on 1/7/2026 at 2:20 p.m. with Resident 1's Responsible Party 3 (RP 3), RP 3 stated I kept telling them my mother is not ready for discharge. RP 3 also stated, We felt the discharge was incompetent, the most unorganized discharge, I have never seen a more unorganized, unsafe discharge in my life. She (Resident 1) was discharged home with an intravenous ([IV] an access point for administering medication directly into the bloodstream) port on her (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	arm. They didn't give discharge instructions to anybody. RP 3 also stated, I did not receive any information on how to appeal the case.During a concurrent interview and record review on 1/8/2026 at 1:18 p.m. with Admissions Coordinator 1 (AC 1), Resident 1's progress note titled, Administrative Note, dated 12/22/2025 at 10:25 a.m., inputted by AC 1, was reviewed. AC 1 stated Resident 1 wanted to have her responsible party(s) to make decisions on Resident 1's behalf. During a concurrent progress note titled, Administrative Note, dated 12/22/2025 at 10:25 a.m. inputted by AC 1, indicated a phone conversation with RP 3 indicating, The insurance is issuing a last cover day of date 12/24/2025 with a discharge (DC) date 12/25/2025. Explained options: Like DC home, care giver resources and the right to appeal if felt that she wasn't ready to DC to a lower level. Stated that she will appeal. The note also indicated, Patient was given a copy of NOMNC that was left on bedside and the number to appeal. During further interview with AC 1, AC 1 stated, On the note, the family wanted to file an appeal. We failed to obtain a signature form the family that they received the NOMNC notice.During an interview with Admissions Director (AD 1) on 1/9/2026 at 2:11 p.m., AD 1 stated, They (resident/responsible party) have to sign that they received a copy, because it is acknowledging that they received the NOMNC. The NOMNC has the information including multiple languages and explains that they have the right to appeal, which is the right to appeal the day before the last cover day, normally by noon. AD 1 also stated, We cannot file the appeal on the resident or the family's behalf, it has to be from the resident or responsible party. If someone was never given the NOMNC, you can't file an appeal, because you wouldn't know what phone number to call. They would also request a Medicare identification number. If it cannot be provided, then the appeal cannot be started. AD 1 stated, The failure was not obtaining a signature from the resident (Resident 1) or from the responsible party, which prevents them to file an appeal or extending the resident's stay with this facility. AD 1 also stated, I am not too familiar with the 30 day notice. I have never heard of the 30 day notice, and I have worked on admission since 2017.During an interview and concurrent record review with the Assistant Director of Nursing (ADON) on 1/12/2026 at 12:36 p.m., ADON stated Resident 1 was discharged to home on [DATE]. On the NOMNC dated 12/22/2025 and per progress note dated 12/22/2025 at 10:25am, it stated that after providing instructions, the family member stated they would appeal. It also stated, Patient (Resident 1) was given a copy of the NOMNC that was left on bedside and the number to appeal. A review of the NOMNC indicated the resident did not sign because the documentation indicated the resident was Temporarily Incapacitated. The ADON stated, The failure was that there were no other steps taken to prove the NOMNC was given to the resident or family, because we don't have a signed copy that the resident (Resident 1) or family acknowledged receiving the NOMNC. The NOMNC offers the resident and family the right to appeal as it contains the phone number to file the appeal and the instructions. Because they were not provided with a copy of the NOMNC that shows how to file an appeal, the failure was that the resident (Resident 1) and family were not given a copy of the NOMNC, so they wouldn't know how to file an appeal. ADON stated, For the discharge planning process, per policy, the discharge planning process shall: Provide and document sufficient preparation and orientation to residents, in a form and manner that the resident can understand, to ensure safe and orderly transfer or discharge from the facility. For the foley catheter (a thin tube inserted into the bladder to continuously drain urine into an external bag, used when retaining urine), it only discusses teaching done on the date of discharge, there was no documentation on the IV, it does not discuss the resident (Resident 1), or family understood the teaching. It should have been documented if the resident (Resident 1) or family understood the teaching, if the teaching was provided. It is a lot of information on the date of discharge, but it was common practice. The failure of the discharge order (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	also does not include the resident (Resident 1) being discharged with an IV to home and also the foley catheter. The standard practice is the resident/or family is (provided the) discharged order summary which includes all the orders while the resident was residing at the facility. The transfer discharge report does not include any foley catheter or the relevant information or about the IV. For the policy of discharge planning process, we have no documentation that considers caregiver/support person availability and capacity to perform required care, there is no documentation to prove return demonstration and understanding. ADON stated, For the NOMNC policy provided, the provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate they received the notice and understands that the termination decision can be disputed. The failure was, since the family never received the NOMNC letter, they pretty much cannot dispute the decision to possibly extend the Resident's stay here in the facility and extend the insurance coverage. The ADON stated, For care plans, a person-centered care plan would be specific to the resident and their needs. The resident's (Resident 1) care plan on Foley Catheter removal did not disclose resident (Resident 1) or family teaching on interventions. The foley catheter was reinserted on 12/18/2025 and there was a care plan for the foley catheter. It includes the intervention of monitoring for signs and symptoms of UTI, but it does not talk about catheter care. So, the failure includes not involving the family in how to care for the foley catheter. ADON stated, For the discharge care plan, the wish to return to home does not discuss education to the family or involvement of the family so that they would be better prepared for the discharge. The ADON stated going to Resident 1's home on [DATE] around 3 p.m. (note: facility discharged Resident 1 on 12/25/2026) to give instructions with the foley catheter, to remove the IV, and the Responsible Party 1 (RP 1) asking the ADON to assist in cleaning Resident 1. The ADON stated assisting RP 1 in providing hygiene care to Resident 1 at home. The ADON stated, This is not the standard of practice to do this after the discharge from the facility. The failure here was the resident (Resident 1) and family were not provided enough instructions to prepare them for the discharge. For staff competency in general, we would need to provide thorough in-services training on how to properly discharge a resident.During a review of the facility provided policy and procedure (P & P) titled, Resident Rights with last reviewed date of 6/2025 indicated, It is the policy of this facility that all resident rights be followed per state and federal guidelines as well as other regulative agencies. The P & P also indicated The Resident has the right:To be encouraged and assisted throughout his or her stay in the center.To receive appropriate advanced notice (usually thirty days written notice) or any involuntary transfer or discharge from the Nursing Center as required by law.During a review of the facility provided P & P titled Medicare Notice of Non-Coverage (NOMNC) with last revised date of 11/30/2023 indicated, Medicare providers are responsible for the delivery of the NOMNC. Providers may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all the requirements of valid notice delivery apply to designated agents. The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed.During a review of the facility provided P & P titled Comprehensive Resident Centered Care Plan with last revision date of 4/2025 indicated, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The P & P also stated, The facility will provide the resident and resident representative, if applicable, advance notice of care planning conference to encourage resident and/or resident representative (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	participation. Care conference may be in the form of face-to-face meeting, conference calls or video conferencing. If practicable, the reason will be documented in the medical record.During a review of the facility provided P & P titled Discharge Planning Process with last revised date on 4/2025, indicated, It is the policy of this Facility that the discharge planning process focuses on the resident's discharge goals, involving the residents as active partners. The discharge process should effectively transition them to post discharge care and minimize clinical or other factors which are related to the possibility of a readmission. The policy also indicated the procedure:The Facility's discharge planning process shall:Provide and document sufficient preparation and orientation to residents, in a form and manner the resident can understand, to ensure safe and orderly transfer or discharge from the facility.Ensure that the discharge needs of each resident are identified on admission, and that a discharge plan for each resident is developed and implemented in a timely manner.Include regular reevaluation of residents to identify changes that require modifications of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.Address the resident's goals and treatment preferencesDocument that a resident has been asked about their interest in receiving information regarding returning to the community.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policies and procedures related to comprehensive care planning for one of four sampled residents (Resident 1) by: 1.Failing to provide an individualized care plan related to discharge which specifically covered the needs of Resident 1's care, with the inclusion of Resident 1's responsible party. 2. Failing to provide discharge instructions or teachings to Resident 1 or responsible party prior to discharge. 3. Failing to ensure Resident 1 was not discharged to home with an intravenous ([IV] an access point for administering medication directly into the bloodstream) still intact. Resident 1 was discharged to home on [DATE]. On 12/26/2026, the Assistant Director of Nursing (ADON) went to the home of Resident 1 to provide teaching and remove Resident 1's IV needle and dressing. These deficient practices denied Resident 1 and responsible party the preparation, training, and interventions needed for a safe discharge back to Resident 1's home setting. Cross reference F627 & F726Findings:During a review of Resident 1's admission Record, undated, the admission Record indicated the facility originally admitted Resident 1 on 12/1/2025 with diagnoses including periprosthetic fracture around internal prosthetic left knee joint (a broken bone in the leg or knee near an artificial joint, often caused from a fall), type 2 diabetes mellitus (a chronic condition leading to high blood sugar due to insulin resistance), history of falling, difficulty in walking, and retention of urine (the inability to empty urine from the body). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), date unreadable, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/6/2025, the MDS indicated Resident 1's cognitive functioning (the ability to think, learn, remember, use judgment, and make decisions) was with moderate impairment. The MDS also indicated Resident 1 needed substantial/maximal assistance (helper does more than half the effort) for toileting needs, showering or bathing, and assistance when dressing items below the waist including footwear.During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the following physician's order:- 12/25/2025: Discharge Destination: Home with home health servicesDuring an interview on 1/7/2026 at 1:54 p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 remembered discharging Resident 1 with an IV. LVN 1 stated, For someone being discharged with an IV, I would assume it's for more treatment. The access site can lead to an infection, or possible bleeding. If uncontrolled bleeding, it can result in the need for emergency care.During a phone interview on 1/7/2026 at 2:20 p.m. with Resident 1's Responsible Party 3 (RP 3), RP 3 stated I kept telling them my mother is not ready for discharge. RP 3 also stated, We felt the discharge was incompetent, the most unorganized discharge, I have never seen a more unorganized, unsafe discharge in my life. She (Resident 1) was discharged home with an intravenous port on her arm. They didn't give discharge instructions to anybody.During an interview and concurrent record review with the Assistant Director of Nursing (ADON) on 1/12/2026 at 12:36 p.m., the ADON stated Resident 1 was discharged to home on [DATE]. The ADON stated, For the discharge planning process, per policy, the discharge planning process shall: Provide and document sufficient preparation and orientation to residents, in a form and manner that the resident can understand, to ensure safe and orderly transfer or discharge from the facility. For the foley catheter (a thin tube inserted into the bladder to continuously drain urine into an external bag, used when retaining urine), it only discusses teaching done on the date of discharge, there was no documentation on the IV, it does not discuss the resident (Resident 1), or family understood the teaching. It should have been documented if the resident (Resident 1) or family (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055192	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence St Elizabeth Care Center	10425 Magnolia Blvd North Hollywood, CA 91601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	understood the teaching, if the teaching was provided. It is a lot of information on the date of discharge, but it was common practice. The failure of the discharge order also does not include the resident (Resident 1) being discharged with an IV to home and also the foley catheter. The standard practice is the resident/or family is discharged order summary which includes all the orders while the resident was residing at the facility. The transfer discharge report does not include any foley catheter or the relevant information or about the IV. For the policy of discharge planning process, we have no documentation that considers caregiver/support person availability and capacity to perform required care, there is no documentation to prove return demonstration and understanding. The ADON stated, For care plans, a person-centered care plan would be specific to the resident and their needs. The resident's (Resident 1) care plan on foley catheter removal did not disclose resident or family teaching on interventions. The foley catheter was reinserted on 12/18/2025 and there was a care plan for the foley catheter. It included the intervention of monitor for signs and symptoms of urinary tract infection (UTI), but it does not talk about catheter care. So, the failure includes not involving the family in how to care for the foley catheter. ADON stated, For the discharge care plan, the wish to return to home does not discuss education to the family or involvement of the family so that they would be better prepared for the discharge. The ADON stated going to Resident 1's home on [DATE] around 3 p.m. to give instructions with the foley catheter, to remove the IV, and the Responsible Party 1 (RP 1) asking the ADON to assist in cleaning Resident 1. ADON stated assisting RP 1 in providing hygiene care to Resident 1 at home. ADON stated, This is not the standard of practice to do this after the discharge from the facility. The failure here was the resident (Resident 1) and family were not provided enough instructions to prepare them for the discharge. For staff competency in general, we would need to provide thorough in-services training on how to properly discharge a resident.During an interview with the Director of Nursing (DON) on 1/12/2026 at 3:22 p.m., the DON stated a comprehensive person-centered care plan includes individual focus, the goals, and the interventions. The DON stated, for Resident 1's discharge care plan, We failed to conduct a comprehensive care plan as it was not specific or did not specify the goals needed to have the resident ready for discharge. For the interventions, it does not show family involvement or types of education needed in order for the resident (Resident 1) and family to discharge the resident to home. Per policy on Comprehensive Resident centered care plan, the objectives we had were not measurable.During a review of the facility provided policy & procedure (P & P) titled, Comprehensive Resident Centered Care Plan, with last revision date of 4/2025, the P & P indicated, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The P & P also stated, The facility will provide the resident and resident representative, if applicable, advance notice of care planning conference to encourage resident and/or resident representative participation. Care conference may be in the form of face-to-face meeting, conference calls or video conferencing. If practicable, the reason will be documented in the medical record.During a review of the facility provided P & P titled, Discharge Planning Process, with last revised date of 4/2025, the P & P indicated, It is the policy of this Facility that the discharge planning process focuses on the resident's discharge goals, involving the residents as active partners. The discharge process should effectively transition them to post discharge care and minimize clinical or other factors which are related to the possibility of a readmission. The policy also indicated the procedure:The Facility's discharge planning process shall: Provide and document sufficient preparation and orientation to residents, in a form (continued on next page)

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	055192	A. Building B. Wing	01/12/2026

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Providence St Elizabeth Care Center	10425 Magnolia Blvd North Hollywood, CA 91601

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and manner the resident can understand, to ensure safe and orderly transfer or discharge from the facility.Ensure that the discharge needs of each resident are identified on admission, and that a discharge plan for each resident is developed and implemented in a timely manner.Include regular reevaluation of residents to identify changes that require modifications of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.Address the resident's goals and treatment preferencesDocument that a resident has been asked about their interest in receiving information regarding returning to the community.

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	055192	A. Building B. Wing	01/12/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policies and procedures related to nursing staff competency for one of four sampled residents (Resident 1), by:1.Failing to provide an individualized care plan related to discharge which specifically covered the needs of Resident 1' care, with the inclusion of responsible party.2. Failing to provide discharge instructions and teachings to Resident 1 or responsible party prior to discharge.3. Failing to ensure Resident 1 was not discharged to home with an intravenous ([IV] an access point for administering medication directly into the bloodstream) still intact.Resident 1 was discharged home on [DATE]. On 12/26/2026, the Assistant Director of Nursing (ADON) went to Resident 1's home to provide teaching and remove Resident 1's IV needle.These deficient practices denied Resident 1 and responsible party the preparation needed for a safe transition in returning home.Cross reference F551 & F627 Findings:During a review of Resident 1's admission Record, undated, the admission Record indicated the facility originally admitted Resident 1 on 12/1/2025 with diagnoses including periprosthetic fracture around internal prosthetic left knee joint (a broken bone in the leg or knee near an artificial joint, often caused from a fall), type 2 diabetes mellitus (a chronic condition leading to high blood sugar due to insulin resistance), history of falling, difficulty in walking, and retention of urine (the inability to empty urine from the body). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), date unreadable, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/6/2025, the MDS indicated Resident 1's cognitive functioning (the ability to think, learn, remember, use judgment, and make decisions) was with moderate impairment. The MDS also indicated Resident 1 needed substantial/maximal assistance (helper does more than half the effort) for toileting needs, showering or bathing, and assistance when dressing items below the waist including footwear.During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the following physician's order:- 12/25/2025: Discharge Destination: Home with home health servicesDuring an interview on 1/7/2026 at 1:54 p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 remembered discharging Resident 1 with an IV. LVN 1 stated, For someone being discharged with an IV, I would assume it's for more treatment. The access site can lead to an infection, or possible bleeding. If uncontrolled bleeding, it can result in the need for emergency care.During a phone interview on 1/7/2026 at 2:20 p.m. with Resident 1's Responsible Party 3 (RP 3), RP 3 stated I kept telling them my mother is not ready for discharge. RP 3 also stated, We felt the discharge was incompetent, the most unorganized discharge, I have never seen a more unorganized, unsafe discharge in my life. She (Resident 1) was discharged home with an intravenous port on her arm. They didn't give discharge instructions to anybody. RP 3 also stated, I did not receive any information on how to appeal the case.During an interview and concurrent record review with the Assistant Director of Nursing (ADON) on 1/12/2026 at 12:36 p.m., the ADON stated Resident 1 was discharged to home on [DATE]. The ADON stated, For the discharge planning process, per policy, the discharge planning process shall: Provide and document sufficient preparation and orientation to residents, in a form and manner that the resident can understand, to ensure safe and orderly transfer or discharge from the facility. For the foley catheter (a thin tube inserted into the bladder to continuously drain urine into an external bag, used when retaining urine), it only discusses teaching done on the date of discharge, there was no documentation on the IV, it does not discuss the resident (Resident 1), or family understood the teaching. It should have been documented if the resident (Resident 1) (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or family understood the teaching, if the teaching was provided. It is a lot of information on the date of discharge, but it was common practice. The failure of the discharge order also does not include the resident (Resident 1) being discharged with an IV to home and also the foley catheter. The standard practice is the resident/or family is discharged order summary which includes all the orders while the resident was residing at the facility. The transfer discharge report does not include any foley catheter or the relevant information or about the IV. For the policy of discharge planning process, we have no documentation that considers caregiver/support person availability and capacity to perform required care, there is no documentation to prove return demonstration and understanding. The ADON stated, For care plans, a person-centered care plan would be specific to the resident and their needs. The resident's (Resident 1) care plan on Foley Catheter removal did not disclose resident or family teaching on interventions. The foley catheter was reinserted on 12/18/2025 and there was a care plan for the foley catheter. It included the intervention of monitor for signs and symptoms of urinary tract infection (UTI), but it does not talk about catheter care. So, the failure includes not involving the family in how to care for the foley catheter. The ADON stated, For the discharge care plan, the wish to return to home does not discuss education to the family or involvement of the family so that they would be better prepared for the discharge. ADON stated going to Resident 1's home on [DATE] around 3 p.m. to give instructions with the foley catheter, to remove the IV, and the Responsible Party 1 (RP 1) asking the ADON to assist in cleaning Resident 1. The ADON stated assisted RP 1 in providing hygiene care to Resident 1 at home. The ADON stated, This is not the standard of practice to do this after the discharge from the facility. The failure here was the resident (Resident 1) and family were not provided enough instructions to prepare them for the discharge. For staff competency in general, we would need to provide thorough in-services training on how to properly discharge a resident.During an interview with the Director of Nursing (DON) on 1/12/2026 at 3:22 p.m., For competency, for nursing staff competency, based on our policy, we failed in communication with the resident (Resident 1) and family for the resident's needs. On 12/26/2025, the ADON went to the home to provide teaching on the foley catheter and to remove the IV line. So, the failure was to adequately educate family on training and return demonstration of understanding and the clarification with the physician of discharging the resident with an IV.During a review of the facility provided policy & procedure (P & P) titled, Comprehensive Resident Centered Care Plan with last revision date of 4/2025, the P & P indicated, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The P & P also stated, The facility will provide the resident and resident representative, if applicable, advance notice of care planning conference to encourage resident and/or resident representative participation. Care conference may be in the form of face-to-face meeting, conference calls or video conferencing. If practicable, the reason will be documented in the medical record.During a review of the facility provided P & P titled, Discharge Planning Process, with last revised date of 4/2025, the P & P indicated, It is the policy of this Facility that the discharge planning process focuses on the resident's discharge goals, involving the residents as active partners. The discharge process should effectively transition them to post discharge care and minimize clinical or other factors which are related to the possibility of a readmission. The policy also indicated the procedure:The Facility's discharge planning process shall:Provide and document sufficient preparation and orientation to residents, in a form and manner the resident can understand, to ensure safe and orderly transfer or discharge from the facility.Ensure that (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the discharge needs of each resident are identified on admission, and that a discharge plan for each resident is developed and implemented in a timely manner.Include regular reevaluation of residents to identify changes that require modifications of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.Address the resident's goals and treatment preferencesDocument that a resident has been asked about their interest in receiving information regarding returning to the community.During a review of the P & P titled Nursing Staff Competency with last revised date of 6/2025, the P & P indicated, It is the policy of this facility to have sufficient nursing staff with the appropriate competencies and skills set to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The P & P also indicated, The competency in skills and techniques necessary to care for residents' needs include but not limited to:Resident RightsPerson Centered CareCommunication

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	055192	A. Building B. Wing	01/12/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policies and procedures related to documentation for one of four sampled residents (Resident 1). Resident 1 was discharged home on [DATE]. On 1/6/2026, while onsite at the facility, the State Survey Agency (SSA) identified newly added documentation on Resident 1's files added on same date, 1/6/2026.This deficient practice resulted to inaccurate account of Resident's 1 records. Cross reference F726. Findings:During a review of Resident 1's admission Record, undated, the admission Record indicated the facility originally admitted Resident 1 on 12/1/2025 with diagnoses including periprosthetic fracture around internal prosthetic left knee joint (a broken bone in the leg or knee near an artificial joint, often caused from a fall), type 2 diabetes mellitus (a chronic condition leading to high blood sugar due to insulin resistance), history of falling, difficulty in walking, and retention of urine (the inability to empty urine from the body). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), date unreadable, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/6/2025, the MDS indicated Resident 1's cognitive functioning (the ability to think, learn, remember, use judgment, and make decisions) was with moderate impairment. The MDS also indicated Resident 1 needed substantial/maximal assistance (helper does more than half the effort) for toileting needs, showering or bathing, and assistance when dressing items below the waist including footwear.During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the following physician's order:- 12/25/2025: Discharge Destination: Home with home health servicesDuring a phone interview with Responsible Party 2 (RP 2) on 1/7/2026 at 2:20 p.m., RP 2 stated Resident 1 was not ready to be discharged home. RP 2 stated, There was a lot of stuff we didn't know, and we were not prepared for. It was unsafe, having an IV ([IV] an access point for administering medication directly into the bloodstream) and not knowing what we do with the catheter (a thin tube inserted into the bladder to continuously drain urine into an external bag, used when retaining urine).During an interview and concurrent record review with Social Worker (SW) on 1/8/2026 at 2:21 p.m., SW stated, I input a note on 1/6/2026 at 1:20 p.m. This was for the effective date of 12/22/2025 at 12:51 p.m. The resident (Resident 1) was discharged on Christmas day, 12/25/2025. It is not our standard of practice to document weeks later after a discharge of the resident (Resident 1). I failed to document when it happened, I should have documented it within 72 hours. I don't believe this is believable because the creation date of the note was when you (State Survey Agency) started the investigation. During a concurrent record review with SW indicated a Progress Note created on 1/6/2026 at 1:20 p.m. with the effective date 12/22/2025 at 12:51 p.m. indicating, Family expressed concerns regarding the patient's readiness for discharge. SSD (SW) discussed alternative placement and care options, including remaining at the facility under private pay status or transitioning to a boarding care. The family declined options and decided to proceed with home discharge.During an interview and concurrent record review with the Assistant Director of Nursing (ADON) on 1/12/2026 at 12:36 p.m., the ADON stated, Per policy, any pertinent entry or missed or not written in a timely manner, a late entry should be used to record. Identify the late entry as a Late entry. Enter the current date and time, do not try to give the appearance that the entry was made on a previous date or an earlier time. The more time that passes, the less reliable the entry becomes. The ADON stated, For the discharge summary and post discharge plan of care, when I went to the home on [DATE], the family was not provided the documentation on 12/25/2025 (date of Resident (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1's discharge), it was given to them when I visited on 12/26/2025. The failure there was that it provides information on the home health agency, ombudsman's (an advocate for residents of nursing homes) number, and it shows a history of the resident (Resident 1) during their time in the facility. For the documentation, I did not place this as a late entry. I documented it on 1/6/2026. The ADON indicated the investigation start date was on 1/6/2026. ADON stated, The failure here was me not documenting on the day I went to the home.During an interview and concurrent record review with the Director of Nursing (DON) on 1/12/2026 at 3:22 p.m., the DON stated, The failure was the staff failed to timely document communication to resident (Resident 1) and family.A review of the facility provided policy & procedure (P & P) titled, Guidelines for Handling Corrections, Errors, Omissions, and Other Documentation Problems/Documentation in a Long-Term Care Record with last revised date of 11/2024, indicated, Occasionally, documentation issues or errors arise, necessitating changes or clarifications. It is essential to follow the correct procedures when addressing these situations. The P & P indicated:Making a Late EntryWhen a pertinent entry was missed or not written in a timely manner, a late entry should be used to record the information in the health record.Identify the new entry as a late entryEnter the current date and time - do not try to give the appearance that the entry was made on a previous date or an earlier time.Identify or refer to the date and incident for which late entry was writtenIf the late entry is used to document an omission, validate the source of additional information as much as possible (where did you get information to write late entry). For example, use of supporting documentation on other facility worksheets or forms.When using late entries document as soon as possible. There is not a time limit to writing a late entry, however, the more time that passes the less reliable the entry becomes.Entering an AddendumAn addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry. With this type of correction, a previous note has been made and the addendum provides additional information to address a specific situation or incident. With an addendum, additional information is provided, but would not be used to document information that was forgotten or written in error. When making an addendum-Document the current date and timeWrite addendum and state the reason for the addendum referring back to the original entry.Identify any sources of information used to support the addendumWhen writing an addendum, complete it as soon after the original note as possible.