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	04/02/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect in full recognition of their individuality for one of three sampled residents (Resident 2) when on 4/1/2026 at 8:22 a.m., Resident 2 was observed in the facility's Rehab Room with a urinary catheter (also known as an indwelling catheter, a hollow tube inserted into the bladder to drain or collect urine) that was not covered with a dignity cover (a fabric, cloth, or vinyl sleeve designed to cover the external urine collection bag).This deficient practice had the potential to negatively affect the resident's psychosocial wellbeing (a person's overall mental and social health, combining how they feel inside [emotions] with how they relate to others and their environment) and loss of dignity. Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 3/21/2026 with diagnoses including retention of urine, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dependency on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).During a review of Resident 2's Order Summary Report (ORS), dated 3/21/2026, the OSR indicated:- Change indwelling catheter soiled, clogged, leaking, dislodged as needed.- Indwelling catheter 16 French (16 Fr - a standard size, for urinary catheter) with 10 milliliters (ml - unit of measurement) to closed drainage system due to urinary retention. - Indwelling catheter care every shift.During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 3/27/2026, the MDS indicated Resident 2 had the ability to understand and be understood. The MDS indicated that Resident 2 had an indwelling catheter.During an observation on 4/2/2026 at 8:22 a.m. in the facility's Rehab Room, observed Resident 2 sitting up in his (Resident 2) wheelchair. Resident 2 was observed with a urinary catheter with red tinted urine and no observation of a dignity cover. During a concurrent observation and interview on 4/2/2026 at 8:24 a.m. of Resident 2 with the Director of Staff Development (DSD), the DSD stated Resident 2 did not have dignity cover on his (Resident 2) urinary catheter.During an interview on 4/2/2026 at 3:15 p.m. with the DSD, the DSD stated Resident 2 did not have a dignity cover on his (Resident 2) urinary catheter. The DSD stated Resident 2 should have a dignity cover, the dignity cover is for the resident's privacy and dignity. The DSD stated if the residents do not have dignity cover, they will not have any privacy, and it will affect their dignity. During an interview on 4/2/2026 at 3:47 p.m. with the Director of Nursing (DON), the DON stated Resident 2 should have been provided with a dignity cover. The DON stated as far as she (DON) is aware, Resident 2 had not refused to have a dignity cover for his (Resident 2) urinary catheter. The DON stated if residents are not provided with a dignity cover for their urinary catheter, there is potential for dignity and privacy issues with Resident 2. The DON stated Resident 2 may not feel comfortable showing what is in his (Resident 2) urinary catheter bag.During a review of the facility's policy and procedures (P&P) titled, Resident Rights, Dignity and Privacy, last reviewed on 3/19/2026, the P&P indicated it is the policy of this facility that all residents be treated with kindness, dignity and respect. 4. Privacy of a Resident's body shall be maintained during toileting, bathing and other activities of personal hygiene, except when staff assistance is needed for Resident's safety.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview and record review, the facility failed to provide care in accordance with professional standards of care for one of three sampled residents (Resident 1) when the facility failed to:1. Implement the Registered Dietitian's (RD - a credentialed food and nutrition expert who uses evidence-based science to help people improve their health, manage diseases, and create personalized meal plans) recommendations and doctors' orders after Resident 1 was noted with a Change of Condition (COC), on 3/9/2026, of 4 pounds (lbs. - a unit of measurement) in one (1) month.2. Obtain weekly weights for Resident 1 after Resident 1 was noted with a COC, dated 3/9/2026, of a 4 lbs. weight loss in 1 month.These deficient practices had the potential for Resident 1 to experience weight variance (fluctuation). Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 12/2/2024 with diagnoses including dysphagia (difficulty swallowing), hypothyroidism (a common condition where the butterfly-shaped thyroid gland in the neck is underactive and does not produce enough thyroid hormones), and muscle weakness (generalized). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/10/2026, the MDS indicated Resident 1 had the ability to understand and be understood. The MDS indicated that Resident 1 required partial assistance (helper does less than half the effort) with toileting, showering, required supervision (helper providers verbal cues and or touching, stead and or contact guard assistance) oral hygiene, upper and lower body dressing, putting on and taking off footwear, and personal hygiene and required setup or clean-up assistance (helper sets up or cleans up, resident completes activity) with eating. During a review of Resident 1's Weight and Vitals Summary, from 1/1/2026 to 4/30/2026, the Weight Vital Summary indicated:- 1/7/2026: 137 lbs.- 2/3/2026: 133 lbs. - 3/4/2026: 129 lbs. - 4/2/2026: 129 lbs. During a review of Resident 1's care plan (CP), created on 8/22/2025 and revised on 12/5/2025, the CP for Resident 1 indicated risk for nutritional compromise related to dysphagia, chronic disease and metabolic demands, with increased risk for malnutrition, aspiration, weight loss, and poor healing if not managed properly. The CP interventions included diet as ordered by the physician and Resident 1 prefers to use sippy cup at bedside. During a review of Resident 1's Order Summary Report (OSR), dated 9/16/2025, the OSR indicated Consistent Carbohydrate (CCHO - a structured eating plan designed to manage blood sugar levels, primarily for people with diabetes [DM-a disorder characterized by difficulty in blood sugar control and poor wound healing] or prediabetes) diet regular level 7 texture (Easy to chew [EC] - soft, tender foods that require minimal effort to chew and swallow), thin liquids, add fortified (are everyday foods that have extra vitamins and minerals added to them during manufacturing to make them more nutritious) cereal in the morning, add fortified soup for lunch and dinner for diabetes.During a review of Resident 1's RD Note, dated 3/4/2026, at 6:44 p.m., the RD indicated Resident 1's weight at 129 lbs. decreased 7.1 % in three months and four lbs. in one month. Resident 1 is on CCHC level 7 diet with fortified cereal breakfast, fortified soup for lunch and dinner with variable intake. Recommended weekly weight for two weeks. During a review of Resident 1's Nutrition Interdisciplinary Team (IDT - a regular, collaborative gathering where professionals from different fields [such as doctors, nurses, social workers, and therapists] meet to discuss a resident's care) Review, dated 3/6/2026, at 3:18 p.m., the Nutrition IDT Review indicated Resident 1's weight at 129 lbs., decreased 7.1% in three months, 4 lbs. in one month. The review indicated Resident 1 was on CCHO, level 7 diet with fortified cereal for breakfast, fortified soups for lunch and dinner with variable intake and recommended weekly weights for two weeks.During a review of Resident 1's Nursing Notes, dated 3/6/2026, at 4:06 p.m., the Nursing Notes indicated Resident 1 was seen by the RD with new recommendations that included weekly weights for two weeks, doctor made aware and in agreement, noted and carried out. During a review of Resident 1's COC, dated 3/9/2026, at 2:08 p.m., the COC indicated Resident 1 had weight loss. The COC Summarized observation, evaluation, and recommendation indicated Resident 1 was noted with weight loss of four pounds in one month. The (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	COC indicated Resident 1's oral intake was variable from 25 to 100 % of meals. The COC indicated the doctor was notified on 3/9/2026 at 3 p.m. with the recommendation for an RD consultation.During a review of Resident 1's CP, created on 3/9/2026, the CP indicated Resident 1 has weight loss of four pounds in one month related to diuretic (a medication that helps your body get rid of excess water and salt [sodium] by increasing the amount of urine produced by the kidneys) use and variable oral intake. The CP indicated interventions including monitor and evaluate any weight loss, and RD consult. During an interview on 4/2/2026 at 1:12 p.m. with Restorative Nursing Assistant (RNA) 1, RNA 1 stated she (RNA 1) is the one that does the weekly and monthly weights for the residents. RNA 1 stated, for Resident 1, she (Resident 1) obtains the monthly weights and the Director of Nursing (DON) is the one who inputs the weight in the computer. During a concurrent interview and record review on 4/2/2026 at 4:22 p.m. with the DON, Resident 1's Nurses Notes were reviewed. The DON stated when the RD comes out, they make recommendations, then the nurse will contact the doctor to ensure they are okay with recommendations. The DON reviewed Resident 1's Nursing Notes, dated 3/6/2026, at 4 :06 p.m., and the DON stated the doctor was agreeable to plan. The DON stated the nurse should have input an order for weekly weights then communicate with the RNA to ensure weights were done weekly. The DON stated this was not done. The DON stated monitoring and interventions would be missed because there was no order input for weekly weights. The DON stated weekly weights are performed to ensure weights are stable. The DON stated if there was a COC for weight loss, the facility will implement interventions. The DON stated there is potential for weight variance for Resident 1 if the facility did not follow the RD's and doctors' recommendations. During a review of the facility's Policy and Procedures (P&P) titled, Nutrition Status Management, last reviewed on 3/19/2026, the P&P indicated it is the policy of this facility to assess each resident's nutritional status and needs, including medications and medical conditions to ensure that all residents maintain acceptable parameters of nutritional status, such as body weight and other available data, unless the resident's clinical condition demonstrates that this is not possible.2. Dietary Evaluation:b. If there is a significant change in the residents' condition related to weight or nutrition, the RD will make recommendations to offer additional nutrition to those residents including all high-risk residents. c. The IDT and or RD will monitor and evaluate the resident's response or lack of response to the interventions; and revising or discontinuing the approaches or justifying the continuation of current approaches. 3. Clinical Evaluation:b. Any resident weight that varies from the previous reporting period by more than 5% in 30 days, 7.5% in 90 days and 10% in 180 days will be evaluated by the IDT to determine the cause of weight loss/gain and intervention required.c. The nurse will notify physicians, family and or resident of weight loss and or resident of weight loss and or gain with interventions.d. Any resident meeting the criteria for weight loss and any resident at risk will be weighted weekly with the weight entered into POC/PCC (Point of Care/Point Click Care - a type of electronic medical record). Weekly weights will be reviewed by the RD/designee.