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	10/04/2024

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 38552 Based on observation, interview, and record review, the facility failed to promote the resident rights to examine the results of the most recent survey (a survey to determine compliance with state and federal regulations) of the facility by failing to: 1. Ensure three of three (Residents 20, 26, and 24) residents knew where to locate the most recent survey results. 2. Post the most recent survey results in a place that are prominent and accessible (a place where individuals wishing to examine surveys results do not have to ask staff to see them) to residents, family members, and legal representatives of residents. These deficient practices had the potential to impede the resident's rights. Findings: During an interview on 10/1/2024 at 2:50 p.m., three of three resident council group attendees (Residents 20, 26, and 24), stated they do not know where to find the state inspection results. During an observation on 10/2/2024 at 10:43 a.m., observed a survey binder posted on a wall-mounted holder by the information board. During a concurrent interview and record review on 10/2/2024 at 10:48 a.m., with the Minimum Data Nurse (MDSN), the facility's survey binder was reviewed. The MDSN stated the most recent survey results in 2023 were not posted. The MDSN stated the survey results information is posted for public view, so the public have information on what is going on in the facility and what the findings were during the inspection visit. During an interview on 10/4/2024 at 4:09 p.m., with the Administrator (ADM), the ADM stated the purpose of posting the survey results is to make the public aware of the facility's operations clinically and to alert the public of any complaints related to the care provided to the residents so they can look out for their loved ones. The ADM stated survey results during the three preceding years should be available for any one to review upon request. (continued on next page)

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Resident Rights, last approved 7/2024, indicated the residents have the right to examine facility survey results.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43418 Based on interview and record review, the facility failed to inform and provide written information to residents concerning their right to accept or refuse medical or surgical treatment and formulate an advance directive (AD, a written instruction, such as a living will or durable power of attorney for health care, recognized under State law [whether statutory or as recognized by the courts of the State], relating to the provision of health care when the individual is incapacitated) for three of five sampled residents (Resident 3, 11, and 1) reviewed under the advance directive care area when the facility failed to provide Residents 3, 11, and 1 and their responsible persons information regarding creation of an advance healthcare directive and maintained a current copy of Resident 1's AD in the clinical record. These deficient practices had the potential for the residents and their responsible persons to not be informed of their right to formulate an advance directive and not honor the resident's wishes regarding end-of-life care. Findings: a. During a review of Resident 3's Record of Admission, the record of admission indicated the facility originally admitted Resident 3 on 3/11/2015 and readmitted the resident on 5/1/2024 with diagnoses including, but not limited to, acute respiratory failure with hypoxia (a condition when the body does not have enough oxygen in the tissues in the body) and generalized muscle weakness. During a review of Resident 3's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/14/2024, the MDS indicated Resident 3 did not have the capacity to understand and make decisions and required maximal assistance to setup assistance with activities of daily living such as eating, hygiene, showering/bathing herself, dressing, and surface-to-surface transfers. During a review of Resident 3's History and Physical (H&P), dated 5/11/2024, the H&P indicated Resident 3 does not have the capacity to understand and make decisions. During a concurrent interview and record review with the Social Services Director (SSD), on 10/3/2024, at 1:23 p.m., Resident 3's Consent to Treatment, undated, was reviewed and the SSD confirmed the resident, or the responsible party did not sign the form. The consent to treatment form indicated following admission, the facility encourages the resident to provide the facility with an advance health care directive specifying the wishes of the resident as to the care and services the resident wants to receive in certain circumstances. The consent to treatment form indicated if the resident does not know how to prepare and advance directive and wishes to prepare one, the facility will help the resident find someone to assist in doing so. The SSD stated it is important to have the residents or their responsible persons sign the consent to treatment form to provide information about advance directives. The SSD further stated if residents are not provided the opportunity to create an advance directive, there is a potential that the resident's wishes will not be respected. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 11's Record of Admission, the record of admission indicated the facility originally admitted Resident 11 on 8/13/2020, and readmitted the resident on 9/13/2024, with diagnoses including, but not limited to, polyneuropathy (the simultaneous malfunction of many peripheral nerves throughout the body) and generalized muscle weakness. During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11 had difficulty understanding and making decisions, and had impairment on both upper and lower extremities. During a concurrent interview and record review with the SSD, on 10/3/2024, at 1:23 p.m., Resident 11's medical record, current as of 10/3/2024, was reviewed and the SSD confirmed Resident 11's Consent to Treatment form was not signed by the resident's responsible person. The SSD stated she sent an email on 9/25/2024 to Resident 11's responsible person and attached Resident 11's Consent to Treatment form and did not receive a returned signed form from Resident 11's responsible person. The SSD stated she did not follow up with Resident 11's responsible person. The SSD stated it is important to have the residents or their responsible persons sign the consent to treatment form to provide information about advance directives. The SSD further stated if residents are not provided the opportunity to create an advance directive, there is a potential that the resident's wishes will not be respected. During an interview with the Administrator (ADM), on 10/4/2024, at 3:47 p.m., the ADM stated the Consent to Treatment form should be a part of the admission packet and offer information on how to form an advance directive to carry the residents' right to a dignified existence and honor their wishes regarding medical treatment. During a review of the facility's policy and procedure (P&P) titled, SNF (Skilled Nursing Facility)/AL (Assisted Living) Advance Directives, last revised 1/2022, the P&P indicated to determine on admission whether the resident has an advance directive and, if not, determine whether the resident wishes to formulate one. 44244 c. During a review of Resident 1's Record of Admission, the Record of Admission indicated the facility admitted the resident on 5/22/2014 and most recently readmitted the resident on 10/19/2023. During a review of Resident 1's Client Diagnosis Report, undated, the Client Diagnosis Report indicated diagnoses that included unspecified dementia (a progressive state of decline in mental abilities), spinal stenosis (a narrowing of the spinal canal in your lower back that may cause pain or numbness in your legs) cervical region (the neck), encounter for gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and acquired absence of unspecified parts of the digestive tract. During a review of Resident 1's H&P, dated 11/8/2023, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 1's MDS, dated [DATE], the MDS indicated the resident was usually able to understand others and sometimes was able to make herself understood. The MDS further indicated the resident was dependent on staff for oral hygiene, toileting, dressing, and mobility. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life), dated 5/16/2022, the POLST form indicated the resident had a legally recognized decisionmaker that the AD was discussed with. The POLST check boxes (a small box on a form in which to place a check mark to make a selection) were not completed for the following: -AD dated__, and available and reviewed, Health Care Agent if named in AD__. -AD not available -No AD During an interview on 10/3/2024 at 11:06 a.m., with the SSD, the SSD stated Resident 1 had an AD, but it was not located in the resident's chart. The SSD stated every time a resident is readmitted a new chart is created, and the old chart is filed as a closed chart. The AD stated when the new chart is created an AD should be removed from the closed chart and placed in the new chart, but that was not done for Resident 1's AD. The SSD stated the Family Member 1 was made aware the AD was not available, and FM 1 stated they would look to see if they could find a copy to provide the facility. The SSD stated the importance of maintaining the AD in the resident's chart is so that it is accessible for staff to be aware and able to follow the resident's medical wishes. The AD stated when a resident has an AD and it is not available, then there is the potential that the resident's wishes would not be followed. During an interview and record review on 10/4/2024 at 8:12 a.m., with the Minimum Data Set Nurse (MDSN) reviewed Resident 1's admission documents. The MDSN stated there was no documented evidence that the AD was discussed during the resident's admission to the facility. During an interview on 10/4/2024 at 11:06 a.m., with FM 1, FM 1 stated she completed an AD at the facility a very long time ago. FM 1 stated she was looking for a copy of the AD to provide to the facility, but she was not sure if she would be able to find it. During an interview on 10/4/2024 at 11:34 a.m., with the MDSN, the MDSN stated the AD includes the resident's health care wishes and their assigned decision maker, in the event that they would not be able to make decisions for themselves. The MDSN stated the AD must be offered at admission and education provided regarding the formulation of an AD. The MDSN stated if an AD is formulated it must be maintained in the legal section of the resident's chart for staff to refer to in the event of an emergency. The MDSN stated if an AD was formulated and not available then there was a potential to not know what the resident's wishes are. During an interview on 10/4/2024 at 3:50 p.m., with the ADM, the ADM stated the AD is part of the admission packet. The ADM stated if a resident has an AD, it should be in the chart. The ADM stated the importance of maintaining the AD in the chart was to be able to provide and carry out the resident's right to a dignified existence and to be able to honor their wishes with regard to medical treatment. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, SNF/AL Advanced Directives, last reviewed 1/2022, the P&P indicated the purpose of the policy was to establish a standard for determining and carrying out residents' or resident representatives' health care decision-making including participation in experimental research. AD is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law, relating to the provision of health care when the individual is incapacitated. Skilled Nursing Facility residents have the right to request, refuse and / or discontinue treatment, to participate in or decline to participate in experimental research and to formulate an AD. Determine on admission whether the resident has an AD and, if not, determine whether the resident wishes to formulate one. Obtain a copy of the resident's active / current AD and maintain the copy for all care team members to access in the resident's medical record. During a review of the facility's P&P titled, Resident Rights, last reviewed 7/2024, the P&P indicated procedures are implemented to ensure that the rights of the resident are protected and promoted and not violated. Residents have the right to refuse any treatment or procedure and to be treated with consideration, respect, and full recognition of dignity and individuality.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 43418 Based on interview and record review, the facility failed to inform the beneficiary (resident) about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services for one of three sampled residents (Resident 3) investigated during the beneficiary notification task when Resident 3 or Resident 3' representative did not receive the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN, form that provides information to beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility). This deficient practice had the potential for a delay in care related to coverage and medical needs. Findings: During a review of Resident 3's Record of Admission, the Record of Admission indicated the facility originally admitted Resident 3 on 3/11/2015 and readmitted the resident on 5/1/2024 with diagnoses including, but not limited to, acute respiratory failure with hypoxia (a condition when the body does not have enough oxygen in the tissues in the body) and generalized muscle weakness. During a review of Resident 3's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/14/2024, the MDS indicated Resident 3 did not have the capacity to understand and make decisions and required maximal assistance to setup assistance with activities of daily living such as eating, hygiene, showering/bathing herself, dressing, and surface-to-surface transfers. During a review of Resident 3's History and Physical (H&P), dated 5/11/2024, the H&P indicated Resident 3 does not have the capacity to understand and make decisions. During a review of Resident 3's SNFABN, dated 7/19/2024, the SNFABN indicated beginning on 7/24/2024, Resident 3 may have to pay out of pocket for care if the resident does not have other insurance that may cover the cost. The SNFABN indicated the following options: -Option 1: [The resident wants] the care listed above. [The resident wants] Medicare to be billed for an official decision on payment, which will be sent to [the resident] on a Medicare Summary Notice (MSN). [The resident understands] that if Medicare [does not] pay, [the resident] is responsible for paying, but can appeal to Medicare by following the directions on the MSN. -Option 2: [The resident wants] the care listed above, but [do not] bill Medicare. [The resident understands] that [the resident] may be billed now because [the resident is] responsible for payment of the care. [The resident] cannot appeal because Medicare [will not] be billed. -Option 3: [The resident does not] want the care listed. [The resident understands] that [the resident is] not responsible for paying, and [the resident cannot] appeal to see if Medicare would pay. (continued on next page)

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	The SNFABN does not indicate which option Resident 3 chose. The SNFABN further indicated no signature of the resident or authorized representative. During a concurrent interview and record review with the Social Services Director (SSD), on 10/3/2024, at 12:50 p.m., Resident 3's SNFABN, dated 7/19/2024, was reviewed and the SSD confirmed the Resident 3's SNFABN was not signed, and an option was not indicated. The SSD stated Resident 3's family member was notified regarding the form over the phone. The SSD stated Resident 3's family visits at least two to three times a week and it was possible for the resident's family to sign the form. The SSD further stated if the SNFABN is not signed or if the resident or family did not receive the form, the resident and/or the family would not be aware they are responsible for payment and what their options are. During an interview with the Administrator, on 10/4/2024, at 3:47 p.m., the Administrator stated the SNFABN should be given 48 hours prior to non-coverage so that residents have the right to appeal. The Administrator stated after the resident is made aware, the facility should have proof that the resident was made aware. The Administrator further stated if the resident is not made aware, there can be gaps in care, specifically in coverage and medical needs. During a review of the facility's policy and procedure (P&P) titled, Notice of Medicare Non Coverage, last approved 10/2024, the P&P indicated to provide verbal and written notice to residents or their legal representatives whenever furnished services are non-covered and that no claim for Medicare reimbursement will be submitted.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 38552 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 97) was provided a homelike environment by failing to: 1. Properly secure the ceiling light's screen, leaving the screen not fully clipped in place. 2. Ensure that a chain/cord is attached to the wall light to enable Resident 97 to turn the light on and off. These deficient practices had the potential to violate the resident's right to living in a safe, comfortable, and homelike environment. Findings: During a review of Resident 97's Record of Admission, the Record of Admission indicated the facility admitted the resident on 9/17/2024 with diagnoses including left hand acute (sudden onset) osteomyelitis (inflammation of bone or bone marrow, usually due to infection) and cellulitis (a skin infection that causes swelling and redness) of left finger. During a review of Resident 97's History and Physical (H&P) dated 9/21/2024, the H&P, indicated the resident has the capacity to understand and make decisions. During a review of Resident 97's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/27/2024, indicated the resident intact cognition. The MDS indicated the resident required supervision or touching assistance with walking. During a concurrent observation and interview on 10/1/2024 at 8:19 a.m., at Resident 97's bedside, observed the resident's ceiling light screen not properly secure and there was no cord or chain attached to the wall light located at the head of the bed. Resident 97 stated she is afraid the screen might fall off onto her. Resident 97 stated she could not turn the light on and off without a chain or cord. During a concurrent observation and interview on 10/1/2024 at 11:26 a.m., at Resident 97's bedside with the Maintenance Supervisor (MS), the MS stated the ceiling light screen was not clipped in place. Observed the MS used a ladder to access the ceiling light and secured the screen i n place by adjusting the screen to fully cover the ceiling light. The MS stated the ceiling light screen is to prevent dust from accumulating and in case the bulb blows out, the cover would prevent the glass from falling. The MS stated the chain, or the cord is missing from the resident's overhead light. The MS stated a chain or cord should be attached to the light so the resident can turn the light on and off. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/4/2024 at 4:12 p.m., with the Director of Nursing (DON), the resident should be able to turn the light on and off and would need a chain to access the wall light. The DON stated if the ceiling light screen is not fully clipped it can fall. The DON stated allowing the resident to control when to turn the light on and off promotes resident safety and provides the resident with a dignified existence. During a review of the facility's policy and procedure (P&P) titled, SNF Homelike Environment, last approved 8/2024, the P&P indicated it is the facility's policy to provide a homelike environment that promotes comfort, dignity and well-being for all residents. The P&P indicated comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable, and homelike environment. The P&P indicated the lighting design emphasizes sufficient general lighting in resident-use areas.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 43418 Based on interview and record review, the facility failed to send a copy of the notification of discharge to the ombudsman (a long-term care resident advocate) for one of three sampled residents reviewed under closed record review (Resident 46). This deficient practice had the potential for Resident 46 to have an unsafe discharge. Cross-reference F625 and F641 Findings: During a review of Resident 46's Record of Admission, the Record of Admission indicated the facility admitted the resident on 8/15/2024 with diagnoses including, but not limited to, encounter for orthopedic (relating to the branch of medicine dealing with the correction of deformities of bones or muscles) after care and generalized weakness and was discharged to the hospital on 8/18/2024. During a review of Resident 46's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/18/2024, the MDS indicated Resident 46 was able to understand and make decisions, was independent with eating and required supervision to maximal assistance with activities of daily living including hygiene, showering/bathing, dressing, and surface-to-surface transfers. During a review of Resident 46's Internal Medicine Initial Evaluation, dated 8/16/2024, the Internal Medicine Initial Evaluation indicated Resident 46 had the capacity to understand and make decisions. During a review of Resident 46's Progress Note, dated 8/18/2024, the Progress Note indicated ambulance services took Resident 46 and family member to the GACH for further evaluation related to altered mental status condition. During a review of Resident 46's Physician Orders, dated 8/18/2024, the Physician Orders indicated an order to transfer Resident 46 to the GACH for altered mental status. During a review of Resident 46's Notice of Transfer/Discharge, dated 8/18/2024, the Notice of Transfer/Discharge indicated Resident 46 was transferred/discharged to the general acute care hospital (GACH) for the resident's welfare and the resident's needs cannot be met in the facility. The notice of transfer/discharge did not indicate if a copy was sent to the state long term care ombudsman office. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the Social Services Director (SSD), on 10/3/2024, at 1:29 p.m., Resident 46's Notice of Transfer/Discharge, dated 8/18/2024, was reviewed and the SSD confirmed the checkbox to send to the ombudsman was left unchecked and a fax transmittal was not attached to the notice. The SSD stated Resident 46 was discharged on a weekend and the licensed vocational nurses (LVN) or the registered nurses (RN) are responsible for sending the notification on the weekends. The SSD stated if the notice was sent to the ombudsman's office, the fax transmittal would be attached to the form to indicate when the notice was sent. The SSD stated the checkbox for notifying the ombudsman should be checked after faxing the notice. The SSD stated it is important to send the notice of transfer/discharge to the ombudsman to inform the ombudsman that the resident is no longer under the facility's care. The SSD further stated if the ombudsman was not notified of the resident's transfer/discharge, the ombudsman would not know if the discharge was appropriate or not. During an interview with the Administrator, on 10/4/2024, at 3:47 p.m., the Administrator stated upon discharge or discharge, the facility should notify the ombudsman that the resident was discharged home, the community, or the hospital. The Administrator further stated if the ombudsman is not made aware, the resident's rights would not be protected regarding a safe discharge. During a review of the facility's policy and procedure (P&P) titled, SNF Transfer or Discharge and Ombudsman Notification, last revised 1/2022, the P&P indicated ombudsman notification should occur during unplanned hospitalization s and sent when practical, but not less than monthly.

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	055192	A. Building B. Wing	10/04/2024

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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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 43418 Based on interview and record review, the facility failed to ensure residents were made aware of the facility's bed-hold policy upon transfer to a general acute care hospital (GACH) for one of three sampled residents (Resident 46) investigated during closed record review when the facility failed to complete and provide the seven (7) day bed hold agreement to Resident 46. This deficient practice had the potential for the resident and/or the resident's resident representatives to not know if the resident have a room to return to after going to the GACH. Cross-reference F623 and F641. Findings: During a review of Resident 46's Record of Admission, the Record of Admission indicated the facility admitted the resident on 8/15/2024 with diagnoses including, but not limited to, encounter for orthopedic (relating to the branch of medicine dealing with the correction of deformities of bones or muscles) after care and generalized weakness and was discharged to the hospital on 8/18/2024. During a review of Resident 46's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/18/2024, the MDS indicated Resident 46 was able to understand and make decisions, was independent with eating and required supervision to maximal assistance with activities of daily living including hygiene, showering/bathing, dressing, and surface-to-surface transfers. During a review of Resident 46's Internal Medicine Initial Evaluation, dated 8/16/2024, the Internal Medicine Initial Evaluation indicated Resident 46 had the capacity to understand and make decisions. During a review of Resident 46's Progress Note, dated 8/18/2024, the Progress Note indicated ambulance services took Resident 46 and family member to the GACH for further evaluation related to altered mental status condition. During a review of Resident 46's Physician Orders, dated 8/18/2024, the physician orders indicated an order to transfer Resident 46 to the GACH for altered mental status. During a review of Resident 46's Notice of Transfer/Discharge, dated 8/18/2024, the Notice of Transfer/Discharge indicated Resident 46 was transferred/discharged to the GACH for the resident's welfare and the resident's needs cannot be met in the facility. During a concurrent interview and record review with the Medical Record Director (MRD), on 10/3/2024, at 11:37 a.m., Resident 46's medical record, current as of 10/3/2024, was reviewed and the MRD confirmed Resident 46's Bed Hold Agreement was not in the medical record. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the Social Services Director (SSD), on 10/3/2024, at 12:29 p.m., Resident 46's medical record, current as of 10/3/2024, was reviewed and the SSD confirmed Resident 46's medical record did not have a bed hold agreement and stated Resident 46 should have a bed hold agreement from her admission to the facility and when she was transferred to the GACH. The SSD stated the facility's process for bed hold agreements is that the resident and/or responsible party is informed of the bed hold agreement upon admission to the facility. The SSD stated the bed hold agreement has two sections with the first part completed upon admission and the second part is completed when the resident is transferred out of the facility. The SSD stated the bed hold agreement form should be completed to indicate if the resident wants or does not want a bed hold. The SSD further stated if a bed hold is not offered to a resident or the resident's responsible party, the resident might think they might not have a place to return to after their stay in the GACH and could potentially make the resident and responsible party feel frustrated from not know if they have a place to return to. During an interview with the Administrator, on 10/4/2024, at 3:47 p.m., the Administrator stated upon admission, the facility discusses with the resident about their right a bed hold, which is typically seven days, and confirm receipt of the bed hold by signing the form. The Administrator stated the second part of the bed hold is used when a resident is transferred and to inform them of their option to have a bed hold. The Administrator stated if a bed hold is not provided, the resident can potentially lose their bed in the facility. The Administrator stated a bed hold safeguards the resident's rights to their home. The Administrator further stated not providing a bed hold for residents can cause possible distress from not knowing if residents have a place to return to. During a review of the facility's policy and procedure (P&P) titled, SNF (Skilled Nursing Facility) Bed Hold and Return To Facility, last revised 2/2022, the P&P indicated residents and their representatives, regardless of payer will be provided with bed hold and return information at admission and before a hospital transfer or therapeutic leave.

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	055192	A. Building B. Wing	10/04/2024

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43418 Based on interview and record review, the facility failed to ensure residents receive an accurate assessment for one of three sampled residents (Resident 46) investigated during closed record review when Resident 46's Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 46 was discharged to home or the community when the resident was discharged to the hospital. This deficient practice resulted in inaccurate tracking of Resident 46 and create a communication error between the facility and the Centers for Medicare and Medicaid Services (CMS). Cross-reference F623 and F625. Findings: During a review of Resident 46's Record of Admission, the record of admission indicated the facility admitted the resident on 8/15/2024 with diagnoses including, but not limited to, encounter for orthopedic (relating to the branch of medicine dealing with the correction of deformities of bones or muscles) after care and generalized weakness and was discharged to the hospital on 8/18/2024. During a review of Resident 46's MDS, dated [DATE], the MDS indicated Resident 46 was able to understand and make decisions, was independent with eating and required supervision to maximal assistance with activities of daily living including hygiene, showering/bathing, dressing, and surface-to-surface transfers. The MDS further indicated Resident 46's discharge status was to home or the community. During a review of Resident 46's Internal Medicine Initial Evaluation, dated 8/16/2024, the Internal Medicine Initial Evaluation indicated Resident 46 had the capacity to understand and make decisions. During a review of Resident 46's Progress Note, dated 8/18/2024, the Progress Note indicated ambulance services took Resident 46 and family member to the GACH for further evaluation related to altered mental status condition. During a review of Resident 46's Physician Orders, dated 8/18/2024, the physician orders indicated an order to transfer Resident 46 to the GACH for altered mental status. During a review of Resident 46's Notice of Transfer/Discharge, dated 8/18/2024, the Notice of Transfer/Discharge indicated Resident 46 was transferred/discharged to the GACH for the resident's welfare and the resident's needs cannot be met in the facility. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During a concurrent interview and record review with the MDS Nurse (MDSN), on 10/3/2024, at 3:19 p.m., Resident 46's MDS, dated [DATE], was reviewed and the MDSN confirmed the MDS indicated Resident 46 was discharged home or to the community. The MDSN stated Resident 46 was discharged to the GACH on 8/18/2024 and Resident 46's MDS should have indicated the resident was discharged to the GACH. The MDSN further stated it is important to have an accurate assessment to know what is going on with the resident and to make sure the facility knows where the resident went and the status of the resident. During an interview with the Administrator, on 10/4/2024, at 3:47 p.m., the Administrator stated the importance of an accurate MDS is for accurate importing to CMS and for tracking. The Administrator stated home, and community are very different discharge settings from acute care. The Administrator further stated when the facility inputs an error in the MDS, the error can create a communication error between the facility and CMS. During a review of the facility's policy and procedure (P&P) titled, SNF (Skilled Nursing Facility) MDS Accuracy, last revised 10/2024, the P&P indicated to ensure that all residents receive an accurate assessment, reflective of the resident's status at the time of assessment, by staff qualified to assess relevant care areas especially entry tracking, accurate capture of current diagnosis and activities preferences.

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	055192	A. Building B. Wing	10/04/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43418 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of five sampled residents (Resident 3) investigated under the unnecessary medication care area and one of one sampled residents (Resident 148) investigated under the urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) or Urinary Tract Infection (UTI, an infection in the bladder/urinary tract) care area when: 1. The facility failed to develop a care plan for Resident 3's use of Eliquis (also known as apixaban, an anticoagulant medication used to prevent blood clots). 2. The facility failed to implement Resident 148's care plan for the resident's urinary catheter. These deficient practices had the potential cause a delay in care. Cross-reference F757 and F880. Findings: 1. During a review of Resident 3's Record of Admission, the Record of Admission indicated the facility originally admitted Resident 3 on 3/11/2015 and readmitted the resident on 5/1/2024 with diagnoses including, but not limited to, acute respiratory failure with hypoxia (a condition when the body does not have enough oxygen in the tissues in the body) and generalized muscle weakness. During a review of Resident 3's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/14/2024, the MDS indicated Resident 3 did not have the capacity to understand and make decisions, required maximal assistance to setup assistance with activities of daily living such as eating, hygiene, showering/bathing herself, dressing, and surface-to-surface transfers, and is taking anticoagulant medication. During a review of Resident 3's History and Physical (H&P), dated 5/11/2024, the H&P indicated Resident 3 does not have the capacity to understand and make decisions. During a review of Resident 3's Physician Orders, dated 5/1/2024, the physician orders indicated Resident 3 was ordered Eliquis five milligrams (mg, a unit of measure for mass), one tablet by mouth twice a day for anticoagulant. During a concurrent interview and record review with the MDS Nurse (MDSN), on 10/4/2024, at 10:27 a.m., Resident 3's care plans, current as of 10/4/2024, were reviewed and the MDSN confirmed the facility did not create a care plan for Resident 3's order for Eliquis. The MDSN stated the facility should have developed a care plan for Eliquis to provide the staff interventions and things to observe for signs of significant changes of condition and adverse side effects of medications. The MDSN further stated if care plans were not in place, the facility staff would not know what to do for the resident and what interventions to perform for the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator, on 10/4/2204, at 3:47 p.m., the Administrator stated the importance of care plans is to guide the resident's healthcare team and to look for signs and symptoms for the team to catch. The Administrator stated care plans are a way of communication and can be used to improve interventions for the resident. 2. During a review of Resident 148's Record of Admission, the Record of Admission indicated the facility admitted Resident 148 on 9/20/2024 with diagnoses including, but not limited to, fusion of spine (surgery to connect two or more bones in any part of the spine), cervical (relating to the neck) region, generalized muscle weakness, and history of falling. During a review of Resident 148's Internal Medicine Initial Evaluation, dated 9/23/2024, the Internal Medicine Initial Evaluation indicated Resident 148 has the capacity to understand and make decisions. During a review of Resident 148's Physician Order, dated 9/27/2024, the Physician Order indicated an order for bladder scan (a noninvasive procedure that uses ultrasound to measure the volume of urine in the bladder) every six hours and if urinary retention (a condition that makes it difficult to empty the bladder, either partially or completely) is more than 350 milliliters (ml, a unit of measure for volume) for two consecutive six hours (two shifts), reinsert urinary catheter 16 French (Fr, a unit of measure for the diameter of a catheter tube) with 10 ml and contact the physician for further orders. During a review of Resident 148's Care Plan, dated 9/20/2024, the care plan indicated Resident 148 had a urinary catheter related to urinary retention with a goal for the resident to not develop infection or injury related to catheter use. The care plan further indicated interventions included following the standard of care and/or policy for catheter care and documentation. During a concurrent observation and interview with Resident 148, on 10/1/2024, at 8:57 a.m., inside Resident 148's room, Resident 148 was lying down in bed with a urinary catheter bag hanging at the side of the foot of the bed. Resident 148's urinary catheter bag was touching the floor. Resident 148 confirmed his urinary catheter bag was touching the floor and stated he has a urinary catheter due to having urinary retention. During a concurrent observation and interview with the Director of Staff Development (DSD), on 10/1/2024, at 9:13 a.m., inside Resident 148's room, the DSD confirmed Resident 148's urinary catheter bag was hanging at the side of the foot of the bed and was touching the floor. The DSD stated Resident 148's urinary catheter bag should not be touching the floor due to infection control. During an interview with the Administrator, on 10/4/2024, at 3:47 p.m., the Administrator stated Resident 148's care plan should be implemented so that proper care is rendered to the resident. During a review of the facility's policy and procedure (P&P) titled, Resident Care Plan, last approved 4/2024, the P&P indicated resident care plans are a communication tool for staff, providing consistency and continuity in resident care and effective appropriate nursing care based on resident needs, values, and preferences.

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	055192	A. Building B. Wing	10/04/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 38552 Based on interview and record review, the facility failed to revise one of three sampled residents investigated under the nutrition care area when Resident 34's care plan was not updated to reflect current nutritional interventions addressing the resident's risk for further weight loss. This deficient practice had the potential to result in inconsistent implementation of the care plan that may lead to a delay in or lack of delivery of care and services. Cross reference F692 Findings: During a review of Resident 34's Record of Admission, the Record of Admission indicated the facility admitted the resident on 8/20/2024 with diagnoses including unilateral primary osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) and gastro-esophageal reflux disease (GERD - a common condition in which the stomach contents move up into the esophagus). During a review of Resident 34's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/30/2024, the MDS indicated the resident made self-understood and understood others. The MDS indicated the resident is independent with eating and had a weight loss of 5 percent (% - a unit of measure), was not on a physician-prescribed weight-loss program. During a review of Resident 34's History and Physical (H&P), dated 8/30/2024, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 34's Physician Orders, the Physician Orders indicated the following diet order: Regular Diet Texture: Regular Bland Diet; liquid consistency; give health shake 4 ounce (oz - a unit of measure) with lunch and dinner, snack twice a day 10 a.m. and 2 p.m., dated 9/16/2024. During a review of Resident 34's nutrition care plan (CP), dated 9/13/2024, the CP indicated a goal of the resident will be gaining one to two pounds (lbs - a unit of measure) per month with interventions including adhere to food preferences, weekly weights as ordered, and registered dietitian consult as needed. During a review of Resident 34's Nutrition/Dietary RD Note: Weight Review, dated 9/23/2024, the Nutrition/Dietary RD Note indicated the following: - Provide soup with lunch and dinner per preference. - Reminded resident of her ability to have family/friends bring in food. - Snack options updated (cottage cheese/fruit plate or yogurt and graham crackers) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Prune juice with breakfast. - Healthshake 4 ounces (oz - a unit of measure) - Medications: B-12 (vitamin), D3 (vitamin), Marinol (appetite stimulant), Escitalopram (antidepressant), Ferrous Sulfate (supplement), Folic Acid (supplement), Linzess (increases fluid in the intestine which may help move stool), Magnesium Oxide (supplement), multivitamins (vitamin), potassium chloride (supplement), and sucralfate (forms a barrier over the stomach ulcer). During an observation on 10/1/2024 at 12:32 p.m., observed Resident 34's lunch meal tray on the overbed table, with regular chopped potatoes, chicken, and green beans. Observed Resident 34 eating by herself. During a concurrent observation and interview on 10/1/2024 at 12:55 p.m., observed Resident 34 in bed, did not eat lunch, meal plate untouched. Resident 34 stated she tried her lunch, and she did not like it and she does not want anything else. During a concurrent observation and interview on 10/2/2024 at 1:28 p.m., at Resident 34's bedside, Certified Nursing Assistant 1 (CNA 1) stated Resident 34 did not like her food, so she offered milk and soup, and sandwich but she declined the sandwich. Resident 34 stated resident ate 40% and only ate the pasta on the plate. During a concurrent observation and interview on 10/3/2024 at 1:26 p.m., at Resident 34's bedside, observed lunch meal tray untouched. Resident 34 stated she does not want her lunch. Resident 34 stated she has soup, but she only likes to drink the broth. During a concurrent interview and record review of Resident 34's nutrition care plan on 10/3/2024 at 4:32 p.m., with the MDSN, the MDSN stated the care plan does not reflect the current interventions recommended by the RD on 9/23/2024. The MDSN stated not revising the resident's care plan with the RD's recommended interventions placed the resident at risk for further weight loss. The MDSN stated the family should have been contacted and relayed the resident's food preferences to resident's MD and resident representatives and included them (food preferences) in the plan of care. During an interview on 10/4/2024 at 4:21 p.m., the Director of Nursing (DON) stated Resident 34's care plan should have been revised to reflect the current interventions recommended by the RD on 9/23/2024. The DON stated the resident's weight loss of 8 lbs. in one week on 8/28/2024 and 20 lbs. in approximately one month, on 9/17/2024 were significant and the IDT care plan team should have had a meeting to discuss the residents' weight loss. During a review of the facility's policy and procedure titled, Weight Change Protocol, 2023, indicated the following criteria define significant or insidious weight changes: 3 LB weight loss in one week 5 lbs. or 5% weight loss in one month. The protocol indicated interventions to correct the identified problem such as allowing for food preferences (cultural, customary) using selections, foods from home, weekly weights, or more often, and referral to social services or IDT to meet with resident and decision maker to discuss resident's weight and general decline. The protocol indicated the care plan must be revised as the goals and interventions change and is reviewed in all areas and changes made, as needed. (continued on next page)

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	055192	A. Building B. Wing	10/04/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Resident Care Plan Review, last approved 7/2024, indicated the nursing staff initiate, review, and update the resident care plans on admission and as needed.

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	055192	A. Building B. Wing	10/04/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44244 Based on observation, interview, and record review, the facility failed to provide an environment free from accidents and hazards for one of one sampled residents (Resident 10) reviewed under the Accidents care area by failing to ensure Resident 10 did not have a bottle of Refresh eyedrops (a medication to relieve dry, burning, irritated eyes) and a bottle of clindamycin phosphate topical solution (an antibiotic, a medication that stops the growth of bacteria) readily available for self-administration and accessible by other residents while in the dining room. This deficient practice had the potential to result in resident's self-administering medications without staff knowledge potentially resulting in resident illness. Findings: During a review of Resident 10's Record of Admission, the Record of Admission indicated the facility admitted the resident on 5/24/2022 and most recently readmitted the resident on 6/16/2022. During a review of Resident 10's Client Diagnosis Report, undated, the Client Diagnosis Report indicated diagnoses that included sepsis (a life-threatening blood infection), metabolic encephalopathy (a general term that describes brain disease, damage, or malfunction usually related to inflammation within the body), dysphagia (difficulty swallowing), anxiety disorder (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear), and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 10's History and Physical, dated 3/1/2024, the History and Physical indicated the resident had the capacity to understand and make decisions. During a review of Resident 10's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/23/2023, indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident required partial / moderate staff assistance with bathing, dressing, and mobility; and required substantial staff assistance for toileting and putting on / taking off footwear. During a review of Resident 10's Physician's Orders, the Physician's Orders indicated an order for Refresh solution, one drop ophthalmic every four hours for prevention of dryness, dated 7/2/2024. During a review of Resident 10's Care Plan titled, Non-Alzheimer's Dementia ., initiated 5/24/2023, indicated (Resident 10) has periods of confusion, disorientation, and is at risk for decline in cognition and decision making. During a concurrent observation and interview on 10/1/2024 at 9 a.m., Resident 10 sat in the main activities room and no staff were present. Observe a bottle of Refresh eyedrops and a bottle of clindamycin phosphate topical solution on the table in front of the resident. Resident 10 stated both medications were his and he takes them himself. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/1/2024 at 9:15 a.m., with the Minimum Data Set Nurse (MDSN), observed Resident 10 in the activities room and stated the resident had two medications on the table in the dining room. Observed the MDSN walk into the activities room to speak with Resident 10. During an observation on 10/1/2024 at 9:20 a.m., observe Resident 10 in the activities room and the bottle of Refresh eye drops and bottle of clindamycin remained on the table in front of the resident. During a concurrent observation, interview, and record review on 10/2/2024 at 12:54 p.m., with the MDSN, reviewed Resident 10's Self-Administration Assessment form dated 6/16/2022 and physician orders. The MDSN stated Resident 10 was assessed as not capable to self-administer medications. The MDSN stated the resident had an order for the eye drops but not the clindamycin. The MDSN stated a staff member should have noticed the medication on the table and taken the medications because residents should not have medications on the table in the activities room. The MDSN stated she tried to remove the residents eye drops and bottle of clindamycin, but he refused to give them to her. The MDSN stated she told the Director of Nursing (DON) that the resident had medication and refused to give it to her. The MDSN stated she did not follow up with the DON and she is not sure what happened to the medication. During a concurrent observation and interview on 10/2/2024 at 12:54 p.m., with the DON, the DON stated the MDSN told her that Resident 10 had medications in the activities room, but she did not follow up. The DON stated she would follow up now. Observed the DON state to the MDNS to please follow up. During a concurrent observation and interview on 10/2/2024 at 12:56 p.m., observed the MDSN enter Resident 10's room. Observed the Refresh eye drops and bottle of clindamycin on the resident's rolling bedside table. During an interview on 10/2/2024 at 1:04 p.m., with the MDSN, the MDSN stated it was a safety issue when the resident had medications. The MDSN stated the resident may overuse the medication causing skin issues. The MDSN stated there was also a risk that other residents would get the medication and use it which could possibly result in an adverse reaction. During an interview on 10/3/2024 at 7:32 a.m., with the DON, the DON stated medications should not be left unattended with residents in the activities room because there was a risk that other residents would gain access to them. The DON stated the medications should have been removed by the MDSN from the resident on the day it was discovered, but they were not. The DON stated when medications are left with a resident it could potentially lead to improper handling and other resident's ingesting medication not meant for ingestion causing gastrointestinal distress. (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	10/04/2024

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility policy and procedure titled, Self-Administration of Medications effective 4/2008, the policy indicated residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility, during the care planning process. The results of the interdisciplinary teams are recorded in the resident's medical record. All nurses and aides are required to report to the charge nurse on duty any medications found that are not authorized.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on observation, interview, and record review, the facility failed to provide nutritional care and services consistent with resident's nutritional assessment and care plan for one of three sampled residents (Resident 34) by: 1. Failing to continue obtaining the resident's weight weekly as ordered by the physician. 2. Failing to revise the resident's care plan to address the resident's weight loss. 3. Failing to complete an SBAR (Situation, Background, Assessment, Recommendation - an assessment used to facilitate prompt and appropriate communication) form for weight loss on 8/28/2024 and 9/17/2024. 4. Failing to ensure the Interdisciplinary (IDT-group of experts from various disciplines working together to treat ailment, injury, or chronic health conditions) care plan meeting was done to address the resident's weight loss. These deficient practices had the potential to result in further risk of weight loss for Resident 34. Findings: During a review of Resident 34's Record of Admission, the Record of Admission indicated the facility admitted the resident on 8/20/2024 with diagnoses including unilateral primary osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) and gastroesophageal reflux disease (GERD - a common condition in which the stomach contents move up into the esophagus [hollow, muscular tube that carries food and liquid from your throat to your stomach]). During a review of Resident 34's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/30/2024, the MDS indicated the resident had severe impaired cognition (the ability to maintain a relatively high level of mental functioning, including thinking, learning, memory, and perception). The MDS indicated the resident was able to make self understood and understood others. The MDS indicated the resident was independent with eating and required partial/moderate assistance (helper lifts, holds trunk or limbs, but provides less than half the effort) with lying to sitting on side of bed and rolling left and right on the bed. During a review of Resident 34's History and Physical dated 8/30/2024, the History and Physical indicated the resident has the capacity to understand and make decisions. During a review of Resident 34's Physician Orders, the Physician Orders indicated the following: - Diet: Regular Bland Diet; liquid consistency; give health shake 4 ounce (oz - a unit of measure) with lunch and dinner, snack twice a day 10 a.m. and 2 p.m., order dated 9/16/2024. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Weight: Document weight difference during day shift on Tuesdays for four weeks. Restorative Nursing Aide (RNA) to document weights in Point of Care (POC - electronic health record), order date 9/24/2024, discontinue date 10/28/2024. - Weight: Document weight difference during day shift on Tuesdays for four weeks. RNA to document weights in POC, order date 8/20/2024, discontinue date 9/24/2024. During a review of Resident 34's nutrition care plan dated 9/13/2024, the nutrition care plan indicated the resident goals of gaining one to two pounds (lbs - a unit of measure) per month. The interventions included: adhere to food preferences, weekly weights as ordered, and registered dietitian (RD) consult as needed. During a review of Resident 34's Vital Signs: Weights, the Vital Signs: Weights indicated the following: 8/22/2024 - 163 lbs 8/28/2024 - 155 lbs 9/3/2024 - 156 lbs 9/9/2024 - 156 lbs 9/10/2024 - 152 lbs 9/17/2024 - 143 lbs During a review of Resident 34's POC History Report, the POC History Report indicated the following: - 10/1/2024 = Breakfast Amount: 25 % (out of 100 percentage of meals consumed) - 10/1/2024 = Lunch Amount: 45 % - 10/2/2024 = Lunch Amount: 40 % - 10/3/2024 =Lunch Amount: 30 % During an observation in Resident 34's room on 10/1/2024 at 8:15 a.m., observed Resident 34 asleep with the breakfast plate untouched. During an observation in Resident 34's room on 10/1/2024 at 12:32 p.m., observed the resident's lunch meal tray on the overbed table with regular chopped potatoes, chicken, and green beans. Observed Resident 34 was able to feed self. During a concurrent observation and interview on 10/1/2024 at 12:55 p.m., observed Resident 34 in bed, with lunch meal plate untouched. Resident 34 stated she tried her lunch but she did not like it and she did not want anything else. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/2/2024 at 1:28 p.m., at Resident 34's bedside, Certified Nursing Assistant 1 (CNA 1) stated Resident 34 did not like her (Resident 34) food, so she (CNA 1) offered milk, soup, and sandwich but the resident declined the sandwich. Resident 34 stated resident ate 40%. During a concurrent interview and record review of Resident 34's clinical records on 10/3/2024 at 11:22 a.m., with the MDS Nurse (MDSN), Resident 34's weight was not recorded for the week of 9/23/2024. The MDSN stated she does not know Resident 34's weight was not recorded, but if there was a physician's order, the resident should have been weighed. During an observation on 10/3/2024 at 12:47 p.m., observed CNA 1 brought soup for Resident 34. During a concurrent observation and interview on 10/3/2024 at 1:26 p.m., at Resident 34's bedside, observed lunch meal tray untouched. Resident 34 stated she did not want her lunch. Resident 34 stated she has soup, but she only likes to drink the broth. During a concurrent observation and interview on 10/3/2024 at 1:35 p.m., at Resident 34's bedside, with CNA 2, CNA 2 stated she is the regular CNA for Resident 34. CNA 2 stated the resident only drank the broth of the soup and currently was eating cheesecake. CNA 2 stated the resident did not drink her (Resident 34's) milkshake that morning and did not drink the health shake (nutritional supplement) for lunch. CNA 2 stated the resident does refuse lunch sometimes when she (Resident 34) eats breakfast. During an interview 10/3/2024 at 4 p.m., the Dietary Supervisor (DS) stated he and the MDSN attend the weight variance meetings and if there were any changes, they would relay it to the RD. The DS stated Resident 34 did have a weight loss, but because Resident 34 was within her ideal body weight, they did not think this was significant change and continued the plan of care and monitored the resident. During a concurrent interview and record review of Resident 34's nutrition care plan on 10/3/2024 at 4:32 p. m., with the MDSN, the MDSN stated the care plan did not reflect the current interventions recommended by the RD. The MDSN stated not revising the resident's care plan with the RD's recommended interventions placed the resident at risk for further weight loss. The MDSN stated the family should have been contacted and relayed the resident's food preferences to the resident's physician and resident representatives and should have included them in the plan of care. During a concurrent interview and record review of Resident 34's Nutrition/Dietary RD Note: Weight Review dated 9/23/2024, on 10/4/2024 at 9:52 a.m., the RD stated the Nutrition/Dietary RD Note: Weight Review indicated the resident's food preference included of soup, lobster, and Chinese food. The RD stated catering to Chinese food is a difficult request. The RD stated there are Asian recipes that are available and within reason to offer and liberalize (making it less restrictive and allowing a wider variety of foods) their diet. The RD stated they can attempt to offer Chinese food and talk to resident's family to bring food from home. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/4/2024 at 4:21 p.m., the Director of Nursing (DON) stated the weight protocol is implemented by checking the resident's weight upon admission and weekly for four weeks, and if the resident's weight is stable, they would check the weight at least monthly. The DON stated if there was a change in the resident's weekly weights, they will need to notify the resident's physician. The DON stated weight variance meetings are done weekly. The DON stated the SBAR was not done when Resident 34 had an eight-lb weight loss in one week on 8/28/2024 and a 20-lb weight loss in about 30 days on 9/17/2024. The DON stated they should have contacted the resident's physician and the RD. The DON stated the care plans should have been revised to reflect the current interventions. The DON stated the 8/28/2024 and 9/17/2024 weight loss are significant change and the IDT care plan team should have reconvened. During an interview on 10/4/2024 at 4:24 p.m., the DON stated the purpose of doing the SBAR was a way of communicating to the physician to make sure immediate care can be rendered to the resident. The DON stated conducting the IDT meeting allows an oversight of care from the IDT at a more expert level and allows discussion for interventions for the resident. The DON stated revision of the care plan is done to prevent the further deterioration of the resident. During an interview on 10/4/2024 at 4:30 p.m., the DON stated the purpose of following the physician's order was to ensure continuous care for the resident. The DON stated Resident 34 had weight fluctuations and they would not know if she (Resident 34) improved or not which was why they check the resident's weight weekly and they determine the variance. The DON stated the nursing staff would communicate the outcome of the weight variance meetings to the RD. During a review of the facility's policy and procedure (P&P) titled, Weight Change Protocol, dated 2023, the P&P indicated the following criteria define significant or insidious (gradual and often unnoticed weight loss) weight changes: 3 lb weight loss in one week, 5 lb or 5% weight loss in one month, the protocol indicated the facility RD will assess, nutritionally diagnosed , suggest interventions, monitor, and evaluate the success of the interventions. The protocol indicated interventions to correct the identified problem included allowing for food preferences (cultural, customary) using selections, foods from home, weekly weights, or more often, and referral to social services or IDT to meet with resident and decision maker to discuss resident's weight and general decline. The protocol indicated the care plan must be revised as the goals and interventions change and is reviewed in all areas and changes made, as needed. During a review of the facility's P&P titled, Providence St [NAME] Care Center (PSECC) Weight and Nutrition Monitoring, last approved in 12/2023, the P&P indicated the purpose of the policy is to monitor and maintain the optimal nutritional status of residents, preventing malnutrition and addressing weight-related concerns promptly. The P&P indicated the medical team to collaborate with dining services staff (like the Dietitian) to adjust nutritional interventions based on resident's changing needs and involve residents and resident representatives to provide information on residents' dietary preferences, cultural considerations, and specific needs. The P&P indicated the facility maintains and updates records of residents' weights, nutritional assessments, dietary plans, and modifications made to address their nutritional needs.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 44244 Based on observation, interview, and record review, the facility failed to ensure residents who need respiratory care are provided care consistent with professional standards of practice for one of one sampled residents (Resident 26) reviewed under the respiratory care area by failing to ensure supplemental oxygen (O2) was administered per physicians orders, was documented in the Medication Record (MAR, - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), and was monitored while in use. This deficient practice had the potential to result in undetected changes in the resident's respiratory status resulting in a delay in care and services. Findings: During a review of Resident 26's Record of Admission, the Record of Admission indicated the facility admitted the resident on 8/13/2024. During a review of Resident 26's Client Diagnosis Report, undated, the Client Diagnosis Report indicated diagnoses that included heart failure (HF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), emphysema (also called chronic obstructive pulmonary disease, COPD - a chronic lung disease that damages the air sacs in the lungs, making it difficult to breathe), and anxiety disorder (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear. During a review of Resident 26's History and Physical, dated 8/16/2024, the History and Physical indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 26's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/21/2024, indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated the resident required partial / moderate staff assistance for toileting, bathing, dressing, and mobility. During a review of Resident 26's Physician's Orders for October, the Physician's Orders indicated: As needed (PRN) oxygen, monitor SpO2 (oxygen saturation level, O2 sat - a measurement of how much oxygen the blood is carrying as a percentage) and administer oxygen at 2 to 4 liters per minute (a unit of measurement) via NC during each shift as needed for O2 sat less than 92 %, dated 8/13/2024. During a review of Resident 26's Care Plan titled, Oxygen - (Resident 26) is on oxygen therapy of 2-4 LPM via NC as needed for oxygen saturation below 92%, initiated 8/14/2024, indicated assess oxygen saturation every shift and as needed, administer oxygen as ordered, observe for alteration in breathing patterns, and call the physician for any change of condition. During a review of the Medication Record for 9/2024 and 10/2024, the MAR indicated no documentation that O2 was administered to Resident 26. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 10/1/2024 at 10:35 a.m., observed Resident 26 sitting up in bed and was on O2 via NC at 3 LPM. The resident stated she uses the oxygen on and off. During a concurrent observation and interview on 10/1/2024 at 10:40 a.m., Certified Nursing Assistant 3 (CNA 3) entered Resident 26's room and stated the resident was using O2 via NC. During a concurrent observation, interview, and record review on 10/2/2024 at 1:08 p.m., the Minimum Data Set Nurse (MDSN) reviewed Resident 26's physician orders and MAR. The MDSN observed Resident 26 in the Dining Room and stated the resident was currently administered O2 via NC at 2 LPM. The MDSN stated the resident is not always administered O2, but she had seen her wearing the NC at least a couple of times. The MDSN reviewed Resident 26's physician orders and stated the resident had an order for as needed O2 for an O2 Sat less than 92%. The MDSN reviewed the MAR and stated there was no documentation that O2 was administered to the resident. The MDSN stated oxygen is considered a medication that is used for respiratory enhancement for problems with breathing. The MDSN stated the MAR is used for the documentation of medication and should show the frequency of the usage and need for O2 by Resident 26. The MDSN reviewed Resident 26's O2 Sats Report for 9/2024 and 10/2024, and MAR for 9/2024 and 10/2024, and noted the resident was documented as receiving O2 via NC with no documented evidence of administration in the MAR and no documented evidence of monitoring on the following date and times: -On 9/2/2024 at 1:34 p.m., Resident 26 was on 2 LPM O2 via NC. -On 9/3/2024 at 1:24 a.m., Resident 26 was on 2 LPM O2 via NC. -On 9/6/2024 at 9:48 a.m., Resident 26 was on 2 LPM O2 via NC. -On 9/7/2024 at 6:48 a.m., Resident 26 was on 2 LPM O2 via NC. -On 9/7/2024 at 8:45 p.m., Resident 26 was on 2 LPM O2 via NC. -On 9/8/2024 at 6:21 a.m., Resident 26 was on 2 LPM O2 via NC. -On 9/8/2024 at 9:27 a.m., Resident 26 was on 2 LPM O2 via NC. -On 9/11/2024 at 1:47 a.m., Resident 26 was on 2 LPM O2 via NC. -On 9/13/2024 at 11:11 a.m., Resident 26 was on 2 LPM O2 via NC. -On 9/13/2024 at 8:12 a.m., Resident 26 was on 2 LPM O2 via NC. -On 9/14/2024 at 2:13 a.m., Resident 26 was on 2 LPM O2 via NC. -On 9/14/2024 at 8:32 a.m., Resident 26 was on 2 LPM O2 via NC. -On 9/15/2024 at 6:21 a.m., Resident 26 was on 2 LPM O2 via NC. -On 9/16/2024 at 3:08 a.m., Resident 26 was on 2 LPM O2 via NC. (continued on next page)

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	055192	A. Building B. Wing	10/04/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 9/20/2024 at 9:06 a.m., Resident 26 was on 2 LPM O2 via NC. -On 9/20/2024 at 10:08 p.m., Resident 26 was on 2 LPM O2 via NC. -On 9/21/2024 at 9:08 a.m., Resident 26 was on 2 LPM O2 via NC. -On 9/21/2024 at 11:46 p.m., Resident 26 was on 2 LPM O2 via NC. -On 9/22/2024 at 2:35 p.m., Resident 26 was on 2 LPM O2 via NC. -On 9/24/2024 at 10:33 a.m., Resident 26 was on 2 LPM O2 via NC. -On 9/26/2024 at 10:09 p.m., Resident 26 was on 2 LPM O2 via NC. -On 9/27/2024 at 4:47 p.m., Resident 26 was on 2 LPM O2 via NC. -On 9/28/2024 at 8:45 a.m., Resident 26 was on 2 LPM O2 via NC. -On 9/29/2024 at 10:16 p.m., Resident 26 was on 2 LPM O2 via NC. -On 9/30/2024 at 11 a.m., Resident 26 was on 2 LPM O2 via NC. -On 10/1/2024 at 10:27 a.m., Resident 26 was on room air. -On 10/1/2024 at 9:53 p.m., Resident 26 was on 2 LPM O2 via NC. During an interview on 10/2/2024 at 2:09 p.m., the Director of Staff Development (DSD) stated he was caring for Resident 26 during the day shift on 10/1/2024 and the resident was administered O2 via NC. The DSD stated he did not remember documenting the resident's administration of O2 in the MAR. The DSD stated O2 use should be documented in the MAR. The DSD stated he thought the resident was on continuous O2, not as needed. The DSD stated he should have checked the resident's orders and documented the usage of the O2 in the MAR, but he did not. The DSD stated when Resident 26's O2 use was not documented in the MAR, it could lead to a delay in care for the resident. During an interview on 10/3/2024 at 7:32 a.m. with the Director of Nursing (DON), the DON stated when oxygen is used as needed it should be documented and monitored to assess the resident's need for oxygen. The DON stated if the resident needs O2 all the time, then staff can request for an order for the continuous use of oxygen that includes an indication for the need. The DON stated it was important to document the use of oxygen in the MAR based on the physician's order. The DON stated when O2 use is not documented in the MAR, it could potentially lead to a change of condition and delay in care for the resident. During a review of the facility policy and procedure titled, Oxygen Therapy, last approved 9/2024, the policy indicated the objective of the policy was to administer oxygen in conditions in which insufficient oxygen is carried by the blood to the tissues. Record oxygen therapy on the designated form, rate of flow, concentration, and tolerance. Chart pertinent observations. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility policy and procedure titled, Chart Documentation, last approved 10/2024, indicated charting will be completed as applicable on all residents to maintain a complete and accurate medical record. Documenting information on the resident in the medical record provides: 1.A means of communication between the physician and other professionals contributing to the resident's care. 2.A basis for planning an interdisciplinary plan of care for the resident. 3. A way to record the care the resident received while at the facility. Record care given, including but not limited to, medications and treatments. Document responses to medications and treatments. Example: if a resident complains of shortness of breath, document the assessment and the treatment given and the results of the treatment.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 38552 Based on observation, interview, and record review, the facility failed to post the total number and the actual hours worked by the licensed nurses (including registered nurses and licensed vocational nurses) and Certified Nursing Assistants directly responsible for resident care per shift on 10/1/2024 to 10/2/2024 at the nursing station. This deficient practice had the potential to keep residents and visitors unaware of the total number of staff and the actual hours worked by staff in the facility. During an observation on 10/1/2024 at 8:05 a.m., observed posting titled Census and Direct Care Service Hours Per Patient Day (DHPPD - a form which indicates the calculated total hours of the scheduled and total actual hours of work performed by a direct caregiver) outside the nursing station dated 10/1/2024, indicated a census 45 but did not indicate the hours worked by the Registered Nurses, Licensed Vocational Nurses and Certified Nursing Assistants (CNA) per shift. During an interview on 10/2/2024 at 11:05 AM, the DSD stated the nurse staffing information posted on 10/1/2024 and 10/2/2024 did not indicate the total number and the actual hours worked by licensed nurses (RN and LVNs) and CNAs per shift. The DSD stated the nursing station is the only place in the facility where the staffing information is posted. During an interview on 10/4/2024 at 4:18 p.m., the Administrator (ADM), the ADM stated the daily nurse staffing posting should include the total number and the actual hours worked by the licensed nurses and CNAs per shift in addition to the census, so the facility staff, family, and residents are aware of the facility's staffing. The ADM stated it is important to post nurse staffing information maintain safe staffing and alert the public what the facility's staffing is. The ADM stated the nurse staffing information provides the resident and family information on the number of staff that they can reach out to meet the residents' needs. During a review of the facility's policy and procedure (P&P) titled , Daily Nurse Staffing, last approved 9/2022, indicated the purpose of this facility in accordance with health and safety code regulations, skilled nursing facilities and nursing facilities are required to post daily, for each shift, the number of licensed and certified nursing staff directly responsible for resident care in the facility. The P&P indicated this information should be displayed in a place where residents and public can easily view it.

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	055192	A. Building B. Wing	10/04/2024

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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review, the facility failed to: 1. Reorder medications five (5) days in advance of need to assure an adequate supply was on hand (current availability) as per facility policy for two (2) of four (4) sampled residents (Resident 5 and 31) observed during the Medication Administration facility task. 2. Follow-up for delivery and availability of medications for two (2) of four (4) sampled residents (Resident 5 and 31) observed during the Medication Administration facility task. 3. Remove and destroy and not use another resident's medication (Resident 18, a discharged resident) to provide Eliquis (a medication used for cerebrovascular accidents [CVA, also known as stroke, a loss of blood flow to part of the brain, which damages brain tissue]) to Resident 31 from [DATE] to [DATE]. These deficient practices resulted in: 1. Resident 5 not receiving two (2) doses on [DATE] at 9 a.m. and 5 p.m. of metoprolol (a medication used to treat hypertension [a condition in which the blood vessels have persistently raised pressure]) and one (1) dose on [DATE] at 8 a.m. of bumetanide (a medication used to treat edema [swelling of feet, ankles, legs, and other parts of the body, such as the face, hands, and abdomen caused by fluid retention]) on [DATE], increasing the potential to cause Resident 5 serious harm, serious impairment, and serious complications, potentially resulting in elevated blood pressure, hospitalization , and/or death. 2. Resident 31 not receiving two (2) doses on [DATE] at 9 a.m. and 5 p.m. of Eliquis, two (2) doses on [DATE] at 9 a.m. and 5 p.m. of brimonidine (a medication used for glaucoma [a condition of increased pressure in the eyeball]), one (1) dose on [DATE] at 9 a.m. of finasteride (a medication used for benign prostatic hyperplasia [BPH] - a condition in men where the prostate gland - a small gland located inside the groin - is enlarged]), one (1) dose on [DATE] at 9 a.m. of folic acid (a medication used for anemia [a condition with lower-than-normal number of red blood cells]), and one (1) dose on [DATE] at 9 a.m. of tamsulosin (a medication used for BPH) increasing the potential to cause Resident 31 serious harm, serious impairment, and serious complications, potentially resulting in blood clots, blindness, stroke, hospitalization , and/or death. 3. Resident 31 receiving 60 doses of Eliquis between [DATE] and [DATE] from Resident 18's medication supply. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:36 p.m. the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) for the facility's failure to provide routine and emergency medications to its residents, and the facility's failure to acquire medications to meet the needs of the residents. The Administrator (ADMIN) and the Director of Nursing (DON) were notified of the IJ from the failure to ensure Residents 5 and 31 had medication available for administration at the scheduled times per physician orders. On [DATE] at 3:47 p.m., the IJ was removed in the presence of the ADMIN and the DON while onsite, after verifying through observation, interview, and record review the implementation of the facility's submitted and accepted IJ Removal Plan which included the following summarized actions: 1. Under the direction and leadership of the DON, all necessary medications for Residents 5 and 31 were reordered on [DATE]. 2. Licensed Vocational Nurse 1 (LVN 1) completed Situation, Background, Assessment, Recommendation (SBAR - a communication framework used to share information about a resident that needs attention tool) for Resident 5 for the potential change of condition related to the unavailability of medications and notified Physician 1 (P 1). 3. LVN 1 completed SBAR tool for Resident 31 for the potential change of condition related to the unavailability of medications and notified Medical Director 1 (MD 1). 4. P 1 ordered laboratory (lab) tests for Resident 5 and MD 1 ordered stat (emergent) lab tests for Resident 31. 5. Resident 5 and Family Representative 1 (FR 1) were made aware by The Interdisciplinary Team (IDT - a team of health care professionals from different disciplines who work together to provide personalized care for residents) and MD 1 of the medication omissions (not giving/skipping), lab tests ordered by P 1, and updated plan of care related to the medication omissions. Resident 31 was made aware by the IDT and MD 1 of the medication omissions, lab tests ordered by MD 1, and updated plan of care related to the medication omissions. 6. The IDT conducted a meeting to review SBAR tool for the potential change of condition related to the unavailability of medications, ordered lab tests, and updated plan of care related to the medication omissions for Resident 5. The IDT conducted meeting to review SBAR tool for the potential change of condition related to the unavailability of medications, ordered stat lab tests, and updated plan of care related to the medication omissions for Resident 31. 7. The Consulting Pharmacist (CP) and Consulting Pharmacy Registered Nurse 1 (CPRN 1) conducted an audit of Medication Cart 1 on [DATE] to reconcile (the process of identifying the most accurate list of all medications that the resident is taking) medications on hand against the physician orders for Residents 5 and 31, and all medications were on hand. 8. MD 1 conducted physical assessments and provided progress notes for Residents 5 and 31 on [DATE]. As of [DATE], no untoward (unexpected) findings or side effects related to medication omission have been noted for either Resident 5 or 31. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. The DON, the Director of Staff Development (DSD), and LVN 2 conducted an audit of Medication Carts 1 and 2 on [DATE] to reconcile medications on hand and medication administration record against the physician orders and identified 12 residents with total of 17 medications with less than 5 days' supply on hand and re-ordered the medications. 10. The CP and CPRN 1 conducted audits of Medication Carts 1 and 2 on [DATE] to reconcile medications on hand against the physician orders for all residents and identified nine remaining residents each with one medication with less than five-day supply on hand that was already re-ordered. 11. A Root Cause Analysis (RCA - a structured process for identifying the underlying cause of a problem and developing solutions to prevent it from happening again) was initiated on [DATE] by the ADMIN and the DON to determine causative factors for the systemic breakdown. 12. The DON conducted in-service (a type of training that takes place while an employee is on the job, and is designed to improve their skills and knowledge to enhance their performance) for the licensed nursing staff on [DATE] regarding the following: - Daily review of resident medication supply for availability, - Ensuring residents receive mediations as prescribed by the physician and administered at the scheduled times, - Ensuring all licensed nurses are following facility policy and procedures (P&P) on Ordering and Receiving medications from the Dispensing Pharmacy, indicating that medications are re-ordered five days in advance, - Following through daily with the dispensing pharmacy for timely delivery of all ordered medications, - How to utilize the Medication Refill Audit Tool. 13. The DON or designee will track the following during the Daily Nursing Huddles (short, regular meeting where a healthcare team discusses resident safety and care, and plans for the day ahead) Monday through Sunday: - Timely (5 days) Ordering of Medications - Timely Delivery of Medication - Timely Administration of Medication 14. The DON or designee will present findings at the Daily Stand-Up Meeting (short, daily meeting where healthcare team members share updates on their work and discuss progress) Monday through Friday for immediate intervention as warranted by the ADMIN and/or IDT. Trends will be discussed with MD 1, the IDT, and any relevant parties such as vendor pharmacy to support process improvement until 100% compliance is achieved. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	15. The CP and CPRN 1 will conduct critical medication pass audits with randomly selected licensed nurse monthly. The DON or designee will conduct medication pass audits with selected licensed nurse weekly. Trends will be discussed with MD 1, the IDT, and/or any relevant parties such as vendor pharmacy weekly or as often as necessary to support process improvement until 100% compliance is achieved. 16. The ADMIN will monitor the outcomes of the systemic change. Any trends noted shall be discussed at monthly Quality Assurance Performance Improvement (QAPI - a systematic, comprehensive, and data-driven approach conducted by the facility to improve the quality of care and services provided to the residents) meetings for three months with modifications to the process as warranted. Cross references: F759 and F760 Findings: a. During a review of Resident 5's Admission Record (a document containing demographic and diagnostic information), the Admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including cerebral infarction (a serious condition that occurs when blood flow to the brain is blocked, causing brain tissue to die,) atrial fibrillation (irregular heartbeat,) essential hypertension (high blood pressure that develops over time), and heart disease (a general term for conditions that affect the heart or blood vessels, and how they function which can lead to edema.) During a review of Resident 5's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated [DATE], the MDS indicated Resident 5 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 5 needed partial/moderate assistance (helper does less than half the effort; helper lifts, holds, or supports the trunk or limbs, but provides less than half the effort) with rolling from left and right, sitting to lying, and lying to sitting on side of bed. The MDS also indicated Resident 5 needed substantial/maximal assistance (helper does more than half the effort; helper lifts or holds the trunk or limbs and provides more than half the effort) with chair/bed-to-chair transfers. During a review of Resident 5's IDT Care Plan Conference Summary dated [DATE], the IDT Care Plan Conference Summary indicated Resident 5 is forgetful, able to express (make self understood), and able to understand others. During a review of Resident 5's Physician Orders (a report listing the physician order for the resident) from [DATE] to [DATE], the Physician Orders indicated Resident 5 was prescribed the following: 1. bumetanide 0.5 milligrams (mg - a measure of unit of mass) tablet by mouth once a day at 8 a.m. for fluid retention, starting [DATE], 2. metoprolol 25 mg tablet by mouth twice a day at 9 a.m. and 5 p.m. for hypertension, starting [DATE]. During a review of Resident 5's Medication Administration Record ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record], for [DATE], the MAR indicated the following: (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. For [DATE], there was no documentation noted in the MAR that Resident 5 was administered bumetanide 0.5 mg at 8 a.m. 2. For [DATE], there was no documentation noted in the MAR that Resident 5 was administered metoprolol 25 mg at 9 a.m. and 5 p.m. During a medication administration observation on [DATE] at 9:18 a.m. by Medication Cart 1, LVN 1 was observed not administering the following medications to Resident 5: 1. metoprolol 25 mg 2. bumetanide 0.5 mg LVN 1 informed Resident 5 that the metoprolol and bumetanide were not available that morning (9:18 a.m.) and that Resident 5 would have to wait for the pharmacy to deliver the medication to administer later that day. During an interview on [DATE] at 9:20 a.m. with LVN 1, LVN 1 stated that he (LVN 1) did not administer metoprolol 25 mg on [DATE] at 9 a.m. and bumetanide 0.5 mg on [DATE] at 8 a.m. to Resident 5, since the medications were not available in the medication carts, in the facility or in the emergency kits ([eKIT] - a kit with limited supply of medications needed during emergent situations). LVN 1 stated that medications should be re-ordered from the pharmacy three (3) to five (5) days prior to the last available dose and followed up as needed, to ensure timely availability of medications to all residents. LVN 1 stated that by missing doses of those critical medications (such as metoprolol) it increased the risk that Residents 5 could experience high blood pressure and stroke possibly resulting in hospitalization and/or death. During an interview on [DATE] at 2:01 p.m. with the DON, the DON stated that Resident 5 was not administered metoprolol 25 mg on [DATE] at 9 a.m. and 5 p.m. and bumetanide 0.5 mg on [DATE] at 8 a.m. due to the medications not being available. The DON stated those (metoprolol and bumetanide) medications were not available in the medication carts and not available in the eKIT. The DON stated Resident 5 was prescribed metoprolol for high blood pressure and bumetanide for edema. The DON stated missing the administrations of those critical medications (such as metoprolol) can cause elevated blood pressure by not maintaining normal pressures leading to potential stroke resulting in hospitalization and/or death. The DON stated that several licensed nurses failed to reorder those medications within the three (3) to five (5) day timeframe and that the DON failed to follow-up on the status of the re-ordered medications from pharmacy to prevent the unavailability of medications and interruption of medication therapy and continuity of care for Residents 5. The DON stated there was no consistent system in place to ensure timely reordering and follow-up of medications. The DON stated there needed to be a more proactive approach and better communications put in place to prevent those system failures from affecting other residents in the future. The DON stated she (DON) sees the immediacy of those deficient practices and why the facility needed to have immediate actions taken to prevent further harm to its residents. During an interview on [DATE] at 3:19 p.m. with LVN 1, LVN 1 stated that he (LVN 1) was not able to administer the 5 p.m. dose of metoprolol 25 mg for Resident 5 on [DATE] since the medication was not available. (continued on next page)

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	055192	A. Building B. Wing	10/04/2024

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 8:44 a.m. with the CP, the CP stated that the physician should be informed when medications are skipped and not administered to a resident as alternate medications and assessments may need to be ordered to prevent resident harm. The CP stated not administering critical medications like metoprolol can potentially increase the risk of elevated heart rate and elevated blood pressure resulting in hospitalization . During a review of the facility's pharmacy delivery manifests (detailed statement or invoice for shipment of medications) faxed to the facility on [DATE], the pharmacy delivery manifest indicated the facility received a 30-day supply of Resident 5's bumetanide 0.5 mg tablets on [DATE] and did not receive an additional supply until [DATE]. During a review of the facility's pharmacy Consolidated Delivery Sheets (record that includes the medications delivered to the facility from the dispensing pharmacy) faxed to the facility on [DATE], the Consolidated Delivery Sheets indicated the facility received a 30-day supply of Resident 5's metoprolol 25 mg tablets on [DATE] and did not receive an additional supply until [DATE]. b. During a review of Resident 31's Admission Record, the Admission Record indicated Resident 31 was originally admitted to the facility on [DATE] with diagnoses including myocardial infarction (heart attack,) atrial fibrillation (irregular heartbeat,) BPH, hypertensive heart disease (heart disease caused by constant high blood pressure). During a review of Resident 31's MDS dated [DATE], the MDS indicated Resident 31 had intact cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 31 needed partial/moderate assistance (helper does less than half the effort; helper lifts, holds, or supports the trunk or limbs, but provides less than half the effort) with rolling from left and right, sitting to lying, lying to sitting on side of bed, sitting to standing, and chair/bed-to-chair transfers. During a review of Resident 31's Physician Orders, from [DATE] to [DATE], the Physician Orders indicated Resident 31 was prescribed the following: 1. Eliquis 2.5 mg tablet by mouth twice a day at 9 a.m. and 5 p.m. for CVA prophylaxis (the prevention of disease or the measures taken to maintain health), starting [DATE], 2. brimonidine 0.2% one (1) drop each eye twice a day at 9 a.m. and 5 p.m. for glaucoma, starting [DATE], 3. finasteride five (5) mg tablet by mouth once a day at 9 a.m. for BPH, starting [DATE], 4. folic acid one (1) mg tablet by mouth once a day at 9 a.m. for anemia, starting [DATE], 5. tamsulosin 0.4 mg capsule by mouth once a day at 9 a.m. for BPH, starting [DATE]. During a review of Resident 31's MAR for [DATE], the MAR indicated the following: 1. For [DATE], there was no documentation noted in the MAR that Resident 31 was administered Eliquis 2.5 mg at 9 a.m. and 5 p.m. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. For [DATE], there was no documentation noted in the MAR that Resident 31 was administered brimonidine 0.2% at 9 a.m. and 5 p.m. 3. For [DATE], there was no documentation noted in the MAR that Resident 31 was administered finasteride five (5) mg at 9 a.m. 4. For [DATE], there was no documentation noted in the MAR that Resident 31 was administered folic acid one (1) mg at 9 a.m. 5. For [DATE], there was no documentation noted in the MAR that Resident 31 was administered tamsulosin 0.4 mg at 9 a.m. During a medication administration observation on [DATE] at 8:49 a.m. with LVN 1 at Medication Cart 1, LVN 1 was observed not administering the following medications to Resident 31: 1. Eliquis 2.5 mg tablet 2. Brimonidine 0.2% eye drops 3. finasteride five (5) mg tablet 4. folic acid one (1) mg tablet 5. Tamsulosin 0.4 mg tablet LVN 1 informed Resident 31 that the Eliquis, Brimonidine, finasteride, folic acid, and Tamsulosin were not available and that Resident 31 would have to wait for pharmacy to deliver the medications to administer later that day. During an interview on [DATE] at 9:20 a.m. with LVN 1, LVN 1 stated that he (LVN 1) did not administer Eliquis 2.5 mg and brimonidine 0.2%, finasteride five (5 mg), folic acid one (1) mg, and tamsulosin 0.4 mg on [DATE] at 9 a.m. to Resident 31, since the medications were not available in the medication carts or in the facility. LVN 1 stated that those medications were not available in the eKIT either. LVN 1 stated that he (LVN 1) will follow-up with the pharmacy for the refill of those (Eliquis, brimonidine, finasteride, folic acid, tamsulosin) medications and inform the physicians that the morning doses on [DATE] were not administered to Resident 31. LVN 1 stated that medications should be re-ordered from the pharmacy three (3) to five (5) days prior to the last available dose and followed up as needed, to ensure timely availability of medications to all residents. LVN 1 stated missing doses of those critical medications (such as Eliquis, brimonidine,) can harm Resident 31 by causing increased eye pressures, another CVA, and stroke resulting in hospitalization and/or death. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent observation and interview on [DATE] at 1:35 p.m. by Medication Cart 1 with LVN 1 and the DON, LVN 1 stated that due to the unavailability of Eliquis 2.5 mg from [DATE] to [DATE], LVN 1 used Resident 18's supply of Eliquis 2.5 mg to ensure that Resident 31 did not miss any doses of the critical medication. LVN 1 stated that he (LVN 1) should not have used another resident's medication supply. LVN 1 stated that according to facility policy, discharged resident's medications should be destroyed. LVN 1 stated that he (LVN 1) did not administer Eliquis 2.5 mg and brimonidine 0.2%, finasteride five (5 mg), folic acid one (1) mg and tamsulosin 0.4 mg on [DATE] at 9 a.m. to Resident 31, since the medications were not available in the medication carts or in the facility. LVN 1 stated that those medications were not available in the eKIT either, and LVN 1 pulled out Resident 18's medication bubble pack (medication packaging system that contains individual doses of medication per bubble) from the bottom drawer of Medication Cart 1. The medication bubble pack indicated Resident 18 was prescribed Eliquis 2.5 mg tablet to be given by mouth twice a day. LVN 1 stated that he (LVN 1) will follow-up with the pharmacy for the refill of those (Eliquis, brimonidine, finasteride, folic acid, tamsulosin) medications and inform the physicians that the morning doses on [DATE] were not administered to Resident 31. LVN 1 stated that medications should be re-ordered from the pharmacy three (3) to five (5) days prior to the last available dose and followed up as needed, to ensure timely availability of medications to all residents. LVN 1 stated missing doses of those critical medications (such as Eliquis, brimonidine,) can harm Resident 31 by causing increased eye pressures, another CVA, and stroke resulting in hospitalization and/or death. The DON stated per facility policy, medication refills should be re-ordered from the pharmacy about three (3) to five (5) days before the last dose to prevent medications from not being available to the residents at their scheduled times. The DON stated licensed nurses were expected to re-order medications timely (5 days) and follow-up on the refills to ensure medications were available to residents. The DON also stated that licensed nurses should ensure physician orders are followed and medications are administered at the scheduled times. The DON stated per facility policy, medications supplied for one resident should not be used for another resident, and when a resident was discharged the medications should have been destroyed or returned to the resident. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:01 p.m. with the DON, the DON stated that Resident 31 was not administered Eliquis 2.5 mg, brimonidine 0.2% drops, finasteride five (5) mg, folic acid one (1) mg, and tamsulosin 0.4 mg for the 9 a.m. and 5 p.m. doses on [DATE] due to the medications not being available. The DON stated those medications (Eliquis, brimonidine, finasteride, folic acid, tamsulosin) were not available in the medication carts and not available in the eKITS. The DON stated Resident 31 was prescribed Eliquis for CVA prophylaxis, finasteride and Tamsulosin for BPH, Brimonidine for glaucoma, and folic acid for anemia management. The DON stated missing the administrations of those critical medications (Eliquis, brimonidine, finasteride, folic acid, tamsulosin) can cause clotting (sticky lump that forms when blood dries up or becomes thick) of blood due to the blood not being properly thinned, the clot traveling the heart and brain forming an embolism (obstruction caused by clots) potentially causing a heart attack and stroke, elevated eye pressure by not maintaining normal pressures leading to potential stroke and vision impairment such as blindness, all resulting in potential hospitalization and/or death. The DON stated that several licensed nurses failed to reorder those medications (Eliquis, brimonidine, finasteride, folic acid, tamsulosin) within the three (3) to five (5) day timeframe and that the DON failed to follow-up on the status of the re-ordered medications from pharmacy to prevent the unavailability of medications and interruption of medication therapy and continuity of care for Residents 31. The DON stated there was no consistent system in place to ensure timely reordering and follow-up of medications. The DON stated there needed to be a more proactive approach and better communications put in place to prevent those system failures from affecting other residents in the future. The DON stated she (DON) sees the immediacy of those deficient practices and why the facility needed to have immediate actions taken to prevent further harm to its residents. During an interview on [DATE] at 2:10 p.m. with LVN 3, LVN 3 stated that medications should be re-ordered from the pharmacy five (5) to six (6) days in advance of using the last available dose to ensure timely delivery by pharmacy. LVN 3 stated that she (LVN 3) informed the DON that the Eliquis 2.5 mg for Resident 31 was not available (unable to recall the date). LVN 3 stated it was important for Resident 31 to receive Eliquis to prevent blood clots, heart attack, stroke, hospitalization , and/or death. LVN 3 stated she (LVN 3) used Resident 18's supply of Eliquis 2.5 mg from [DATE] to [DATE] nsure that Resident 31 did not miss any doses. LVN 3 stated that she (LVN 3) knew not to use another resident's medication supply but used it in desperation, and that it was wrong to do so. LVN 3 stated that she (LVN 3) did not inform anyone that she (LVN 3) was using another resident's Eliquis supply, and that discharged resident's medications should be destroyed according to facility policy. During an interview on [DATE] at 2:25 p.m. with the DON, in the presence of LVN 3, the DON stated that on [DATE] was the first day the DON followed up with pharmacy regarding the refill and delivery of Eliquis 2.5 mg for Resident 31. The DON stated she (DON) had not called or communicated with pharmacy personnel prior to [DATE] and only faxed Eliquis refill requests to the pharmacy on [DATE] and [DATE] and assumed the medication was delivered. The DON stated she (DON) failed to follow-up with the requests and that going forward there needs to be a system put in place for following up on medication refills. During an interview on [DATE] at 3:19 p.m. with LVN 1, LVN 1 stated that he (LVN 1) was not able to administer the 5 p.m. doses of Eliquis 2.5 mg and brimonidine 0.2% for Resident 31 on [DATE] since the medications were not available. (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	10/04/2024

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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 8:44 a.m. with the CP, the CP stated that medications supplied for one resident should not be used for another resident. The CP stated that the physician should be informed when medications are skipped and not administered to a resident as alternate medications and assessments may need to be ordered to prevent resident harm. The CP stated not administering critical medications like Eliquis and brimonidine for Resident 31 can potentially increase the risk of blood clotting, CVA, and elevated internal pressure of the eye resulting in hospitalization and/or death. During a review of the facility's P&P, titled Medication Administration - General Guidelines, dated [DATE], the P&P indicated: B. Administration 2) Medications are administered in accordance with written orders of the attending physician. 10) Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after) . routine medications are administered according to the established medication administration schedule for the facility. 12) Medications supplied for one resident are never administered to another resident. During a review of the facility's P&P, titled Ordering and Receiving Medications from The Dispensing Pharmacy, dated [DATE], the P&P indicated that Medications and related products are received from the dispensing pharmacy on a timely basis. 2.a. Reorder medications five days in advance of need to assure adequate supply is on hand. c. The refill is called in, faxed, or otherwise transmitted to the pharmacy. 3.a. If needed before the next regular delivery, inform pharmacy of the need for prompt delivery. During a review of the facility's P&P, titled Emergency Pharmacy Service and Emergency Kits, dated [DATE], the P&P indicated: D. Medications are not borrowed from other residents. The ordered medication is obtained either from the emergency supply or from the provider pharmacy. During a review of the facility's P&P, titled Medication Error Reporting, dated ,d+[DATE], the P&P indicated: Medication errors will include but not be limited to: d. dose skipped t. wrong Resident's card used to give medication. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of facility's P&P titled, Discontinued Medications, dated [DATE], the P&P indicated that When medications are expired, discontinued by a prescriber, a resident is transferred or discharged and does not take medications with him/her, or in the event of a resident's death, the medications are marked as discontinued or stored in a separate location and later destroyed. A. If a medication expires, or a prescriber discontinues a medication, the discontinued drug container shall be marked or otherwise identified or shall be stored in a separate location designated solely for this purpose. The date the medication was discontinued shall be indicated on the medication container. B. Medications awaiting disposal or return are stored in a locked secure area designated for that purpose until destroyed. Medications are removed from the medication cart or storage area prior to expiration, and immediately upon receipt of an order to discontinue. During a review of facility's P&P titled, Medication Destruction, dated [DATE], the P&P indicated that Discontinued medications and medications left in the facility after a resident's discharge .are destroyed. A. All medications are placed in the proper waste container per facility policy.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 43418 Based on interview and record review, the facility failed to ensure a resident's drug regimen was free from unnecessary drugs for one of five sampled residents (Resident 3) investigated under the unnecessary medication care area when the facility failed to ensure Resident 3's order for Eliquis (also known as apixaban, an anticoagulant [blood thinner] medication used to prevent blood clots) did not specify an indication (valid reason) for use. This deficient practice had the potential for Resident 3 to experience errors in treatment. Findings: During a review of Resident 3's Record of Admission, the Record of Admission indicated the facility originally admitted Resident 3 on 3/11/2015 and readmitted the resident on 5/1/2024 with diagnoses including acute respiratory failure with hypoxia (a condition when the body does not have enough oxygen in the tissues in the body) and generalized muscle weakness. During a review of Resident 3's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/14/2024, the MDS indicated Resident 3 did not have the capacity to understand and make decisions, required maximal assistance to set-up assistance with activities of daily living such as eating, hygiene, showering/bathing herself, dressing, and surface-to-surface transfers, and is taking anticoagulant medication. During a review of Resident 3's History and Physical (H&P), dated 5/11/2024, the H&P indicated Resident 3 does not have the capacity to understand and make decisions. During a review of Resident 3's Physician Orders, dated 5/1/2024, the physician orders indicated Resident 3 was ordered Eliquis five milligrams (mg, a unit of measure for mass), one tablet by mouth twice a day for anticoagulant. During a concurrent interview and record review with the MDS Nurse (MDSN), on 10/4/2024 at 10:27 a.m., Resident 3's Physician Orders dated 5/1/2024, was reviewed and the MDSN confirmed Resident 3's order for Eliquis five mg, one tablet by mouth twice a day for anticoagulant did not indicate what the medication is being used for or for what diagnosis. The MDSN further stated if the indication for use is not included in the physician order, the facility staff would not know what the medication is being used for and cause a potential delay in care. During a review of the facility's policy and procedure (P&P) titled, Medication Orders, last approved 10/2024, the P&P indicated medication orders specify the diagnosis or indication for use.

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review, the facility failed to maintain a medication error rate below five (5) percent (% - unit of measure) by having seven (7) medication errors out of 26 medication administration opportunities contributing to an overall error rate of 26.92% affecting two (2) of four (4) sampled residents (Resident 5 and 31) observed during the Medication Administration facility task. The medication errors were as follows: 1. Resident 5 did not receive the following medications as ordered by Resident 5's physician: - two (2) doses on [DATE] at 9 a.m. and 5 p.m. of metoprolol (a medication used to for hypertension [a condition in which the blood vessels have persistently raised pressure]) - one (1) dose on [DATE] at 8 a.m. of bumetanide (a medication used for edema [swelling of feet, ankles, legs, and other parts of the body, such as the face, hands, and abdomen caused by fluid retention]) 2. Resident 31 did not receive the following medications, as ordered by Resident 31's physician: - two (2) doses on [DATE] at 9 a.m. and 5 p.m. of Eliquis (a medication used for cerebrovascular accidents [CVA, also known as stroke] - an interruption in the flow of blood to cells in the brain caused by blood clots and high blood pressure]), - two (2) doses on [DATE] at 9 a.m. and 5 p.m. of brimonidine (a medication used for glaucoma [a condition of increased pressure in the eyeball]), - one (1) dose on [DATE] at 9 a.m. of finasteride (a medication used for benign prostatic hyperplasia ([BPH] - a condition in men where the prostate gland - a small gland located inside the groin - is enlarged), - one (1) dose on [DATE] at 9 a.m. of folic acid (a medication used for anemia [a condition with lower-than-normal number of red blood cells]), - one (1) dose on [DATE] at 9 a.m. of tamsulosin (a medication used for BPH) On [DATE] at 3:36 p.m. the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) in the presence of the Administrator (ADMIN) and the Director of Nursing (DON) under 42 Code of Federal Regulations (CFR) S483.45(f)(1) Medication error rates are not 5 percent or greater. The facility had seven (7) medication errors out of 26 medication administration opportunities contributing to an overall error rate of 26.92 %. (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	These deficient practices had the potential to cause Resident 5 serious harm, serious impairment, and serious complications, potentially resulting in elevated blood pressure, hospitalization , and/or death; and had the potential to cause Resident 31 serious harm, serious impairment, and serious complications, potentially resulting in blood clots, blindness, stroke, hospitalization , and/or death. On [DATE] at 3:47 p.m., the IJ was removed in the presence of the ADMIN and the DON while onsite, after verifying through observation, interview, and record review the implementation of the facility's submitted and accepted IJ Removal Plan which included the following summarized actions: 1. Under the direction and leadership of the DON, all necessary medications for Residents 5 and 31 were reordered on [DATE]. 2. Licensed Vocational Nurse 1 (LVN 1) completed Situation, Background, Assessment, Recommendation (SBAR - a communication framework used to share information about a resident that needs attention tool) for Resident 5 for the potential change of condition related to the unavailability of medications and notified Physician 1 (P 1). 3. LVN 1 completed SBAR tool for Resident 31 for the potential change of condition related to the unavailability of medications and notified Medical Director 1 (MD 1). 4. P 1 ordered laboratory (lab) tests for Resident 5 and MD 1 ordered stat (emergent) lab tests for Resident 31. 5. Resident 5 and Family Representative 1 (FR 1) were made aware by The Interdisciplinary Team (IDT - a team of health care professionals from different disciplines who work together to provide personalized care for residents) and MD 1 of the medication omissions, lab tests ordered by P 1, and updated plan of care related to the medication omissions. Resident 31 was made aware by the IDT and MD 1 of the medication omissions, lab tests ordered by MD 1, and updated plan of care related to the medication omissions. 6. The IDT conducted a meeting to review SBAR tool for the potential change of condition related to the unavailability of medications, ordered lab tests, and updated plan of care related to the medication omissions for Resident 5. The IDT conducted meeting to review SBAR tool for the potential change of condition related to the unavailability of medications, ordered stat lab tests, and updated plan of care related to the medication omissions for Resident 31. 7. The Consulting Pharmacist (CP) and Consulting Pharmacy Registered Nurse 1 (CPRN 1) conducted an audit of Medication Cart 1 on [DATE] to reconcile (the process of identifying the most accurate list of all medications that the resident is taking) medications on hand against the physician orders for Residents 5 and 31, and all medications were on hand. 8. MD 1 conducted physical assessments and provided progress notes for Residents 5 and 31 on [DATE]. As of [DATE], no untoward (unexpected) findings or side effects related to medication omission have been noted for either Resident 5 or 31. (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. The DON, the Director of Staff Development (DSD), and LVN 2 conducted an audit of Medication Carts 1 and 2 on [DATE] to reconcile medications on hand and medication administration record against the physician orders and identified 12 residents with total of 17 medications with less than 5 days' supply on hand and re-ordered the medications. 10. The CP and CPRN 1 conducted audits of Medication Carts 1 and 2 on [DATE] to reconcile medications on hand against the physician orders for all residents and identified nine remaining residents each with one medication with less than five-day supply on hand that was already re-ordered. 11. A Root Cause Analysis (RCA - a structured process for identifying the underlying cause of a problem and developing solutions to prevent it from happening again) was initiated on [DATE] by the ADMIN and the DON to determine causative factors for the systemic breakdown. 12. The DON conducted in-service (a type of training that takes place while an employee is on the job, and is designed to improve their skills and knowledge to enhance their performance) for the licensed nursing staff on [DATE] regarding the following: - Daily review of resident medication supply for availability, - Ensuring residents receive mediations as prescribed by the physician and administered at the scheduled times, Ensuring all licensed nurses are following facility policy and procedures (P&P) on Ordering and Receiving medications from the Dispensing Pharmacy, indicating that medications are re-ordered five days in advance, - Following through daily with the dispensing pharmacy for timely delivery of all ordered medications, - How to utilize the Medication Refill Audit Tool. 13. The DON or designee will track the following during the Daily Nursing Huddles (short, regular meeting where a healthcare team discusses resident safety and care, and plans for the day ahead) Monday through Sunday: - Timely (5 days) Ordering of Medications - Timely Delivery of Medication - Timely Administration of Medication 14. The DON or designee will present findings at the Daily Stand-Up Meeting (short, daily meeting where healthcare team members share updates on their work and discuss progress) Monday through Friday for immediate intervention as warranted by the ADMIN and/or IDT. Trends will be discussed with MD 1, the IDT, and any relevant parties such as vendor pharmacy to support process improvement until 100% compliance is achieved. (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	15. The CP and CPRN 1 will conduct critical medication pass audits with randomly selected licensed nurse monthly. The DON or designee will conduct medication pass audits with selected licensed nurse weekly. Trends will be discussed with MD 1, the IDT, and/or any relevant parties such as vendor pharmacy weekly or as often as necessary to support process improvement until 100% compliance is achieved. 16. The ADMIN will monitor the outcomes of the systemic change. Any trends noted shall be discussed at monthly Quality Assurance Performance Improvement (QAPI - a systematic, comprehensive, and data-driven approach conducted by the facility to improve the quality of care and services provided to the residents) meetings for three months with modifications to the process as warranted. Cross references: F755 and F760 Findings: a. During a review of Resident 5's Admission Record (a document containing demographic and diagnostic information), the Admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including cerebral infarction (a serious condition that occurs when blood flow to the brain is blocked, causing brain tissue to die,) atrial fibrillation (irregular heartbeat,) essential hypertension (high blood pressure that develops over time), and heart disease (a general term for conditions that affect the heart or blood vessels, and how they function which can lead to edema.) During a review of Resident 5's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated [DATE], the MDS indicated Resident 5 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 5 needed partial/moderate assistance (helper does less than half the effort; helper lifts, holds, or supports the trunk or limbs, but provides less than half the effort) with rolling from left and right, sitting to lying, and lying to sitting on side of bed. The MDS also indicated Resident 5 needed substantial/maximal assistance (helper does more than half the effort; helper lifts or holds the trunk or limbs and provides more than half the effort) with chair/bed-to-chair transfers. During a review of Resident 5's IDT Care Plan Conference Summary dated [DATE], the IDT Care Plan Conference Summary indicated Resident 5 is forgetful, able to express (make self understood), and able to understand others. During a review of Resident 5's Physician Orders (a report listing the physician order for the resident) from [DATE] to [DATE], the Physician Orders indicated Resident 5 was prescribed the following: 1. bumetanide 0.5 milligrams (mg - a measure of unit of mass) tablet by mouth once a day at 8 a.m. for fluid retention, starting [DATE], 2. metoprolol 25 mg tablet by mouth twice a day at 9 a.m. and 5 p.m. for hypertension, starting [DATE]. During a review of Resident 5's Medication Administration Record ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record], for [DATE], the MAR indicated the following: (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. For [DATE], there was no documentation noted in the MAR that Resident 5 was administered bumetanide 0.5 mg at 8 a.m. 2. For [DATE], there was no documentation noted in the MAR that Resident 5 was administered metoprolol 25 mg at 9 a.m. and 5 p.m. During a medication administration observation on [DATE] at 9:18 a.m. by Medication Cart 1, LVN 1 was observed not administering the following medications to Resident 5: 1. metoprolol 25 mg 2. bumetanide 0.5 mg LVN 1 informed Resident 5 that the metoprolol and bumetanide were not available that morning (9:18 a.m.) and that Resident 5 would have to wait for the pharmacy to deliver the medication to administer later that day. During an interview on [DATE] at 9:20 a.m. with LVN 1, LVN 1 stated that he (LVN 1) did not administer metoprolol 25 mg on [DATE] at 9 a.m. and bumetanide 0.5 mg on [DATE] at 8 a.m. to Resident 5, since the medications were not available in the medication carts or in the facility. LVN 1 stated that medications should be re-ordered from the pharmacy three (3) to five (5) days prior to the last available dose and followed up as needed, to ensure timely availability of medications to all residents. LVN 1 stated that by missing doses of those critical medications (such as metoprolol) it increased the risk that Residents 5 could experience high blood pressure and stroke possibly resulting in hospitalization and/or death. During an interview on [DATE] at 1:35 p.m. with the DON, the DON stated that licensed nurses should ensure physician orders are followed and medications are administered at the scheduled times by following the five (5) rights of medication administration, which includes: right patient, right drug, right dose, right time, right route. During an interview on [DATE] at 2:01 p.m. with the DON, the DON stated that Resident 5 was not administered metoprolol 25 mg on [DATE] at 9 a.m. and 5 p.m. and bumetanide 0.5 mg on [DATE] at 8 a.m. due to the medications not being available. The DON stated those (metoprolol and bumetanide) medications were not available in the medication carts and not available in the emergency kits ([eKIT] - a kit with limited supply of medications needed during emergent situations). The DON stated Resident 5 was prescribed metoprolol for high blood pressure and bumetanide for edema. The DON stated missing the administrations of those critical medications (such as metoprolol) can cause elevated blood pressure by not maintaining normal pressures leading to potential stroke resulting in hospitalization and/or death. The DON stated that several licensed nurses failed to reorder those medications within the three (3) to five (5) day timeframe and that the DON failed to follow-up on the status of the re-ordered medications from pharmacy to prevent the unavailability of medications and interruption of medication therapy and continuity of care for Residents 5. The DON stated there was no consistent system in place to ensure timely reordering and follow-up of medications. The DON stated there needed to be a more proactive approach and better communications put in place to prevent those system failures from affecting other residents in the future. The DON stated she (DON) sees the immediacy of those deficient practices and why the facility needed to have immediate actions taken to prevent further harm to its residents. (continued on next page)

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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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:19 p.m. with LVN 1, LVN 1 stated that he (LVN 1) was not able to administer the 5 p.m. dose of metoprolol 25 mg for Resident 5 on [DATE] since the medication was not available. During an interview on [DATE] at 8:44 a.m. with the CP, the CP stated that the physician should be informed when medications are skipped and not administered to a resident as alternate medications and assessments may need to be ordered to prevent resident harm. The CP stated not administering critical medications like metoprolol can potentially increase the risk of elevated heart rate and elevated blood pressure resulting in hospitalization . During a review of the facility's pharmacy delivery manifests (detailed statement or invoice for shipment of medications) faxed to the facility on [DATE], the pharmacy delivery manifest indicated the facility received a 30-day supply of Resident 5's bumetanide 0.5 mg tablets on [DATE] and did not receive an additional supply until [DATE]. During a review of the facility's pharmacy Consolidated Delivery Sheets (record that includes the medications delivered to the facility from the dispensing pharmacy) faxed to the facility on [DATE], the Consolidated Delivery Sheets indicated the facility received a 30-day supply of Resident 5's metoprolol 25 mg tablets on [DATE] and did not receive an additional supply until [DATE]. b. During a review of Resident 31's Admission Record, the Admission Record indicated Resident 31 was originally admitted to the facility on [DATE] with diagnoses including myocardial infarction (heart attack,) atrial fibrillation (irregular heartbeat,) BPH, hypertensive heart disease (heart disease caused by constant high blood pressure). During a review of Resident 31's MDS dated [DATE], the MDS indicated Resident 31 had intact cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 31 needed partial/moderate assistance (helper does less than half the effort; helper lifts, holds, or supports the trunk or limbs, but provides less than half the effort) with rolling from left and right, sitting to lying, lying to sitting on side of bed, sitting to standing, and chair/bed-to-chair transfers. During a review of Resident 31's Physician Orders, from [DATE] to [DATE], the Physician Orders indicated Resident 31 was prescribed the following: 1. Eliquis 2.5 mg tablet by mouth twice a day at 9 a.m. and 5 p.m. for CVA prophylaxis (the prevention of disease or the measures taken to maintain health), starting [DATE], 2. brimonidine 0.2% one (1) drop each eye twice a day at 9 a.m. and 5 p.m. for glaucoma, starting [DATE], 3. finasteride five (5) mg tablet by mouth once a day at 9 a.m. for BPH, starting [DATE], 4. folic acid one (1) mg tablet by mouth once a day at 9 a.m. for anemia, starting [DATE], 5. tamsulosin 0.4 mg capsule by mouth once a day at 9 a.m. for BPH, starting [DATE]. During a review of Resident 31's MAR for [DATE], the MAR indicated the following: (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	10/04/2024

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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. For [DATE], there was no documentation noted in the MAR that Resident 31 was administered Eliquis 2.5 mg at 9 a.m. and 5 p.m. 2. For [DATE], there was no documentation noted in the MAR that Resident 31 was administered brimonidine 0.2% at 9 a.m. and 5 p.m. 3. For [DATE], there was no documentation noted in the MAR that Resident 31 was administered finasteride five (5) mg at 9 a.m. 4. For [DATE], there was no documentation noted in the MAR that Resident 31 was administered folic acid one (1) mg at 9 a.m. 5. For [DATE], there was no documentation noted in the MAR that Resident 31 was administered tamsulosin 0.4 mg at 9 a.m. During a medication administration observation on [DATE] at 8:49 a.m., with LVN 1 by Medication Cart 1, LVN 1 was observed not administering the following medications to Resident 31: 1. Eliquis 2.5 mg tablet 2. brimonidine 0.2% eye drops 3. finasteride five (5) mg tablet 4. folic acid one (1) mg tablet 5. tamsulosin 0.4 mg tablet LVN 1 informed Resident 31 that the Eliquis, brimonidine, finasteride, folic acid and tamsulosin were not available and that Resident 31 would have to wait for pharmacy to deliver the medications to administer later that day. During an interview on [DATE] at 9:20 a.m. with LVN 1, LVN 1 stated that he (LVN 1) did not administer Eliquis 2.5 mg and brimonidine 0.2%, finasteride five (5 mg), folic acid one (1) mg and tamsulosin 0.4 mg on [DATE] at 9 a.m. to Resident 31, since the medications were not available in the medication carts or in the facility. LVN 1 stated that those medications were not available in the eKIT either. LVN 1 stated that he (LVN 1) will follow-up with the pharmacy for the refill of those (Eliquis, brimonidine, finasteride, folic acid, tamsulosin) medications and inform the physicians that the morning doses on [DATE] were not administered to Resident 31. LVN 1 stated that medications should be re-ordered from the pharmacy three (3) to five (5) days prior to the last available dose and followed up as needed, to ensure timely availability of medications to all residents. LVN 1 stated missing doses of those critical medications (such as Eliquis, brimonidine,) can harm Resident 31 by causing increased eye pressures, another CVA, and stroke resulting in hospitalization and/or death. (continued on next page)

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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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview, on [DATE] at 1:35 p.m. with the DON, the DON stated per facility policy, medication refills should be re-ordered from the pharmacy three (3) to five (5) days before the last dose to prevent medications from not being available to the residents at their scheduled times. The DON stated licensed nurses are expected to re-order residents' medications timely (5 days) and follow-up on the refills to ensure medications are available to residents. The DON also stated that licensed nurses should ensure physician orders are followed and medications are administered at the scheduled times. During an interview on [DATE] at 2:01 p.m. with the DON, the DON stated Eliquis, brimonidine, finasteride, folic acid, and tamsulosin were not available in the medication carts and not available in the eKITS. The DON stated Resident 31 was prescribed Eliquis for CVA prophylaxis, finasteride and Tamsulosin for BPH, Brimonidine for glaucoma, and folic acid for anemia management. The DON stated missing the administrations of those critical medications (Eliquis, brimonidine, finasteride, folic acid, tamsulosin) can cause clotting (sticky lump that forms when blood dries up or becomes thick) of blood due to the blood not being properly thinned, the clot traveling the heart and brain forming an embolism (obstruction caused by clots) potentially causing a heart attack and stroke, elevated eye pressure by not maintaining normal pressures leading to potential stroke and vision impairment such as blindness, all resulting in potential hospitalization and/or death. The DON stated that several licensed nurses failed to reorder those medications (Eliquis, brimonidine, finasteride, folic acid, tamsulosin) within the three (3) to five (5) day timeframe and that the DON failed to follow-up on the status of the re-ordered medications from pharmacy to prevent the unavailability of medications and interruption of medication therapy and continuity of care for Residents 31. The DON stated there was no consistent system in place to ensure timely reordering and follow-up of medications. The DON stated there needed to be a more proactive approach and better communications put in place to prevent those system failures from affecting other residents in the future. The DON stated she (DON) sees the immediacy of those deficient practices and why the facility needed to have immediate actions taken to prevent further harm to its residents. During an interview on [DATE] at 2:10 p.m. with LVN 3, LVN 3 stated that medications should be re-ordered from the pharmacy five (5) to six (6) days in advance of using the last available dose to ensure timely delivery by pharmacy. LVN 3 stated that she (LVN 3) informed the DON that the Eliquis 2.5 mg for Resident 31 was not available (unable to recall the date). LVN 3 stated it was important for Resident 31 to receive Eliquis to prevent blood clots, heart attack, stroke, hospitalization , and/or death. During an interview on [DATE] at 2:25 p.m. with the DON, in the presence of LVN 3, the DON stated that on [DATE] was the first day the DON followed up with pharmacy regarding the refill and delivery of Eliquis 2.5 mg for Resident 31. The DON stated she (DON) had not called or communicated with pharmacy personnel prior to [DATE] and only faxed Eliquis refill requests to the pharmacy on [DATE] and [DATE] and assumed the medication was delivered. The DON stated she (DON) failed to follow-up with the requests and that going forward there needs to be a system put in place for following up on medication refills. (continued on next page)

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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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 8:44 a.m. with the CP, the CP stated that the physician should be informed when medications are skipped and not administered to a resident as alternate medications and assessments may need to be ordered to prevent resident harm. The CP stated not administering critical medications like Eliquis and brimonidine for Resident 31 can potentially increase the risk of blood clotting, CVA, and elevated internal pressure of the eye resulting in hospitalization and/or death. During a review of the facility's pharmacy delivery manifests to the facility on [DATE], the pharmacy delivery manifests indicated the facility received a 30-day supply of Resident 31's brimonidine 0.2% drops on [DATE] and did not receive an additional supply until [DATE]. During a review of the facility's pharmacy delivery manifests faxed to the facility on [DATE], indicated the facility received 14-day supply (28 tablets) of Resident 31's Eliquis 2.5 mg tablets on [DATE] and did not receive an additional supply until [DATE]. During a review of the facility's pharmacy Consolidated Delivery Sheets faxed to the facility on [DATE], the Consolidated Delivery Sheets indicated the facility received a 30-day supply of Resident 31's finasteride five (5) mg tablets, folic acid one (1) mg tablets, and tamsulosin 0.4 mg tablets on [DATE] and did not receive an additional supply until [DATE]. During a review of the facility's P&P, titled Medication Administration - General Guidelines, dated [DATE], the P&P indicated: B. Administration 2) Medications are administered in accordance with written orders of the attending physician. 10) Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after) . routine medications are administered according to the established medication administration schedule for the facility. During a review of the facility's P&P, titled Ordering and Receiving Medications from The Dispensing Pharmacy, dated [DATE], the P&P indicated that Medications and related products are received from the dispensing pharmacy on a timely basis. 2.a. Reorder medications five days in advance of need to assure adequate supply is on hand. c. The refill is called in, faxed, or otherwise transmitted to the pharmacy. 3.a. If needed before the next regular delivery, inform pharmacy of the need for prompt delivery. During a review of the facility's P&P, titled Emergency Pharmacy Service and Emergency Kits, dated [DATE], the P&P indicated: D. The ordered medication is obtained either from the emergency supply or from the provider pharmacy. (continued on next page)

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the facility's P&P, titled Medication Error Reporting, dated ,d+[DATE], the P&P indicated: Medication errors will include but not be limited to: d. dose skipped.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) by not: 1. administering two (2) doses on [DATE] at 9 a.m. and 5 p.m. of metoprolol (a medication used to for hypertension [a condition in which the blood vessels have persistently raised pressure]) to one of four residents (Resident 5) observed during the Medication Administration facility task. 2. administering 24 doses of expired insulin (a medication used to regular blood sugar levels) from [DATE] to [DATE] by six different licensed nursing staff (Licensed Vocational Nurse [LVN]- 2, 3, 4, 5, 6, and Director of Nursing [DON]) to Resident 19 in one of two observed medications carts (Medication Cart 2). 3. administering two (2) doses on [DATE] at 9 a.m. and 5 p.m. of Eliquis (a medication used for cerebrovascular accidents [CVA, also known as stroke - an interruption in the flow of blood to cells in the brain caused by blood clots and high blood pressure,]) and two (2) doses on [DATE] at 9 a.m. and 5 p.m. of brimonidine (a medication used for glaucoma [a condition of increased pressure in the eyeball,]) to one of four residents (Residents 31) observed during the Medication Administration facility task. As a result, Resident 19 received a total of 24 doses of expired insulin from [DATE] to [DATE], Resident 5 did not receive metoprolol, and Resident 31 did not receive Eliquis and brimonidine on [DATE] in accordance with the physician's orders and standards of practice. These deficient practices had the potential to cause Resident 5 complications like elevated blood pressures; to cause Resident 31 complications like blood clots, blindness, and stroke; and to cause Resident 19 complications like diabetic ketoacidosis [a condition that develops when the body doesn't have enough insulin resulting in the buildup of acid in the blood to levels that can be life threatening] which may result in hospitalization and/or death. Cross Reference F759, F761 Findings: a. During a review of Resident 5's Admission Record (a document containing demographic and diagnostic information), the Admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including cerebral infarction (a serious condition that occurs when blood flow to the brain is blocked, causing brain tissue to die,) atrial fibrillation (irregular heartbeat,) essential hypertension (high blood pressure that develops over time), and heart disease (a general term for conditions that affect the heart or blood vessels, and how they function which can lead to edema.) (continued on next page)

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	055192	A. Building B. Wing	10/04/2024

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated [DATE], the MDS indicated Resident 5 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 5 needed partial/moderate assistance (helper does less than half the effort; helper lifts, holds, or supports the trunk or limbs, but provides less than half the effort) with rolling from left and right, sitting to lying, and lying to sitting on side of bed. The MDS also indicated Resident 5 needed substantial/maximal assistance (helper does more than half the effort; helper lifts or holds the trunk or limbs and provides more than half the effort) with chair/bed-to-chair transfers. During a review of Resident 5's Physician Orders (a report listing the physician order for the resident) from [DATE] to [DATE], the Physician Orders indicated Resident 5 was prescribed metoprolol 25 miligram ([mg]-a measure of unit of mass) tablet by mouth twice a day at 9 a.m. and 5 p.m. for hypertension, starting [DATE]. During a review of Resident 5's Medication Administration Record ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record], for [DATE], the MAR indicated for [DATE], there was no documentation noted in the MAR that Resident 5 was administered metoprolol 25 mg at 9 a.m. and 5 p.m. There was also no documentation that the metoprolol was held (not administered) due to the medication not being available. During a medication administration observation on [DATE] at 9:18 a.m. in Medication Cart 1, LVN 1 was observed not administering metoprolol 25 mg to Resident 5. LVN 1 informed Resident 5 that the metoprolol was not available that morning (9:18 a.m.) and that Resident 5 would have to wait for the pharmacy to deliver the medication to administer later that day. During an interview on [DATE] at 9:20 a.m. with LVN 1, LVN 1 stated that he (LVN 1) did not administer metoprolol 25 mg on [DATE] at 9 a.m. to Resident 5 since the medication was not available in the medication carts or in the facility. LVN 1 stated that medications should be re-ordered from the pharmacy three (3) to five (5) days prior to the last available dose and followed up as needed, to ensure timely availability of medications to all residents. LVN 1 stated that by missing doses of those critical medications (such as metoprolol) it increased the risk that Residents 5 could experience high blood pressure and stroke possibly resulting in hospitalization and/or death. During an interview on [DATE] at 1:35 p.m. with the DON, the DON stated per facility policy, medication refills should be re-ordered from the pharmacy three (3) to five (5) days before the last dose to prevent medications from not being available to the residents at their scheduled times. The DON stated licensed nurses are expected to re-order residents' medications timely (5 days) and follow-up on the refills to ensure medications are available to residents. The DON also stated that licensed nurses should ensure physician orders are followed and medications are administered at the scheduled times. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:01 p.m. with the DON, the DON stated that Resident 5 was not administered metoprolol 25 mg on [DATE] at 9 a.m. and 5 p.m. and bumetanide 0.5 mg on [DATE] at 8 a.m. due to the medications not being available. The DON stated those (metoprolol and bumetanide) medications were not available in the medication carts and not available in the emergency kits ([eKIT] - a kit with limited supply of medications needed during emergent situations). The DON stated Resident 5 was prescribed metoprolol for high blood pressure. The DON stated missing the administrations of those critical medications (such as metoprolol) can cause elevated blood pressure by not maintaining normal pressures leading to potential stroke resulting in hospitalization and/or death. The DON stated that several licensed nurses failed to reorder those medications within the three (3) to five (5) day timeframe and that the DON failed to follow-up on the status of the re-ordered medications from pharmacy to prevent the unavailability of medications and interruption of medication therapy and continuity of care for Residents 5. The DON stated there was no consistent system in place to ensure timely reordering and follow-up of medications. The DON stated there needed to be a more proactive approach and better communications put in place to prevent those system failures from affecting other residents in the future. The DON stated she (DON) sees the immediacy of those deficient practices and why the facility needed to have immediate actions taken to prevent further harm to its residents. During an interview on [DATE] at 8:44 a.m. with the CP, the CP stated that the physician should be informed when medications are skipped and not administered to a resident as alternate medications and assessments may need to be ordered to prevent resident harm. The CP stated not administering critical medications like metoprolol can potentially increase the risk of elevated heart rate and elevated blood pressure resulting in hospitalization . b. During a review of Resident 19's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on [DATE] with diagnosis including type 2 diabetes mellitus 2 (DM2 - a condition that affects how the body processes blood sugar.) During a review of Resident 19's Physician's Orders from [DATE] to [DATE], the Physician's Orders indicated Resident 19 was prescribed Lispro (short-acting insulin) to inject 6 units ([un] - a measure of dosage for insulin) subcutaneous ([SQ] - under the skin) before each meal for DM, and hold (do not administer) for blood glucose less than 130, starting [DATE]. During a review of Resident 19's MAR for September and [DATE], the MARs indicated Resident 19 was prescribed insulin Lispro to give 6 un SQ before each meal for DM, at 6:30 a.m., 11:30 a.m., and 4:30 p.m., and that Resident 19 received 24 doses of expired insulin Lispro from the following nurses on the following dates and times: - LVN 2 - 9 doses at 6:30 a.m. (on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]) - LVN 3 - 1 dose at 6:30 a.m. (on [DATE]), 3 doses on 11:30 AM (on [DATE], [DATE], [DATE]), and 3 doses on 4:30 PM (on [DATE], [DATE], [DATE]) - LVN 4 - 3 doses at 6:30 a.m. (on [DATE], [DATE], [DATE]) - LVN 5 - 1 dose at 11:30 a.m. (on [DATE]), 1 dose at 4:30 PM (on [DATE]) and 1 dose at 6:30 AM (on [DATE]) (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	10/04/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- LVN 6 - 1 dose at 6:30 a.m. (on [DATE]) - DON - 1 dose at 6:30 a.m. (on [DATE]) During an observation and concurrent interview on [DATE] at 3 p.m., in Medication Cart 2, with the Director of Staff Development (DSD), one open insulin Lispro Kwikpen (an injection device containing Lispro) for Resident 19 was found stored at room temperature with a label indicating that storage at room temperature began on [DATE], and to discard unused portion after 28 days. According to the manufacturer's product labeling, opened Lispro Kwikpen should be stored at room temperature below 86 degrees Fahrenheit (F - scale for measuring temperature) and used or discarded within 28 days of opening or once storage at room temperature began. The DSD stated that the insulin Lispro Kwikpen for Resident 19 was opened on [DATE] and expired on [DATE] and needed to be removed from the medication cart 28 days after opening and replaced with a new pen from pharmacy immediately. The DSD stated there was no new Lispro pen in the facility for Resident 19, and that several licensed nurses administered several doses of expired Lispro from [DATE] to [DATE] to Resident 19. The DSD stated that administering expired insulin will not be effective in keeping the blood sugar levels stable and can harm Resident 19 by causing high blood sugar levels leading to diabetic ketoacidosis, hospitalization , and death. During an interview on [DATE] at 3:43 p.m., with the DON and in the presence of the Administrator, the DON stated that the insulin Lispro Kwikpen for Resident 19 was expired and should have been removed from the medication cart and replaced with a new pen from pharmacy. The DON acknowledged that several LVNs failed to remove the expired insulin Lispro Kwikpen from the medication cart, which lead to the administration of expired insulin from [DATE] to [DATE] to Resident 19 resulting in significant medication error. The DON stated administering expired insulin to Resident 19 will not be effective in controlling the blood sugar levels and can harm the resident by causing high blood sugar levels, leading to coma, hospitalization and death. c. During a review of Resident 31's Admission Record, the Admission Record indicated Resident 31 was originally admitted to the facility on [DATE] with diagnoses including myocardial infarction (heart attack,) atrial fibrillation (irregular heartbeat,) benign prostatic hyperplasia [BPH] - a condition in men where the prostate gland - a small gland located inside the groin - is enlarged]), hypertensive heart disease (heart disease caused by constant high blood pressure.) During a review of Resident 31's Physician Orders, from [DATE] to [DATE], the Physician Orders indicated Resident 31 was prescribed the following: 1. Eliquis 2.5 mg tablet by mouth twice a day at 9 a.m. and 5 p.m. for CVA prophylaxis (the prevention of disease or the measures taken to maintain health), starting [DATE] and 2. brimonidine 0.2% one (1) drop each eye twice a day at 9 a.m. and 5 p.m. for glaucoma, starting [DATE]. During a review of Resident 31's MAR for [DATE], the MAR indicated the following: 1. For [DATE], there was no documentation noted in the MAR that Resident 31 was administered Eliquis 2.5 mg at 9 a.m. and 5 p.m. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. For [DATE], there was no documentation noted in the MAR that Resident 31 was administered brimonidine 0.2% at 9 a.m. and 5 p.m. During a medication administration observation on [DATE] at 8:49 a.m., in Medication Cart 1, Licensed Vocational Nurse (LVN) 1 was observed not administering Eliquis 2.5 mg tablet and brimonidine eye drops to Resident 31. LVN 1 informed Resident 31 that the Eliquis and brimonidine were not available that morning and will have to wait for pharmacy to deliver the medications to administer later that day. During an interview on [DATE] at 9:20 a.m., with LVN 1, LVN 1 stated that he (LVN 1) did not administer Eliquis 5mg and brimonidine 0.2% drops to Resident 31 at the scheduled times on [DATE] since the medications were not available in the medication cart or in the facility. LVN 1 stated that these (metoprolol and brimonidine) medications were not available in eKITs. LVN 1 stated he (LVN 1) will follow-up with the pharmacy for the refill of these medications and inform the physicians that the morning doses on [DATE] were not administered to Resident 31. LVN 1 stated that medications should be re-ordered from the pharmacy three (3) to five (5) days prior to the last available dose and followed up as needed, to ensure timely availability of medications to all residents. LVN 1 stated it was important to receive these (metoprolol and brimonidine) medications as ordered by the physicians for preventing CVA, high blood pressure and worsening glaucoma. During an interview on [DATE] at 2:01 p.m. with the DON, the DON stated that Resident 31 was not administered Eliquis 2.5 mg and brimonidine 0.2% drops for the 9 a.m. and 5 p.m. doses on [DATE] due to the medications not being available. The DON stated those medications (Eliquis, brimonidine) were not available in the medication carts and not available in the eKITS. The DON stated Resident 31 was prescribed Eliquis for CVA prophylaxis and brimonidine for glaucoma. The DON stated missing the administrations of those critical medications (Eliquis, brimonidine) can cause clotting (sticky lump that forms when blood dries up or becomes thick) of blood due to the blood not being properly thinned, the clot traveling the heart and brain forming an embolism (obstruction caused by clots) potentially causing a heart attack and stroke, elevated eye pressure by not maintaining normal pressures leading to potential stroke and vision impairment such as blindness, all resulting in potential hospitalization and/or death. The DON stated that several licensed nurses failed to reorder those medications (Eliquis, brimonidine) within the three (3) to five (5) day timeframe and that the DON failed to follow-up on the status of the re-ordered medications from pharmacy to prevent the unavailability of medications and interruption of medication therapy and continuity of care for Residents 31. The DON stated there was no consistent system in place to ensure timely reordering and follow-up of medications. The DON stated there needed to be a more proactive approach and better communications put in place to prevent those system failures from affecting other residents in the future. The DON stated she (DON) sees the immediacy of those deficient practices and why the facility needed to have immediate actions taken to prevent further harm to its residents. During an interview on [DATE] at 2:10 p.m., with LVN 3, LVN 3 stated it was important for Resident 31 to receive Eliquis to prevent blood clots, heart attack, stroke, hospitalization and/or death. During an interview on [DATE] at 2:25 p.m., with the DON, in the presence of LVN 3, the DON stated that on [DATE] was the first day the DON followed up with pharmacy regarding the refill and delivery of Eliquis 2.5 mg for Resident 31. The DON stated the she (DON) failed to follow-up with the requests and that going forward there needs to be a system put in place for following up on medication refills. (continued on next page)

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	055192	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3:19 p.m., with LVN 1, LVN 1 stated that he (LVN 1) was not able to administer the 5 PM doses of metoprolol 25 mg for Resident 5, and Eliquis 2.5 mg and Brimonidine 0.2% for Resident 31 on [DATE] since the medications were not available. During an interview on [DATE] at 8:44 a.m., with the Consultant Pharmacist (CP,) the CP stated that the physician should be informed when medications are skipped and not administered as alternate medications and assessments may need to be ordered to prevent resident harm. The CP stated not administering critical medications like Eliquis and brimonidine can potentially increase the risk of blood clotting, CVA, and elevated internal pressure of the eye resulting in hospitalization and/or death. During a review of the facility's policy and procedures (P&P), titled Medication Administration - General Guidelines, dated [DATE], the P&P indicated: B. Administration 2) Medications are administered in accordance with written orders of the attending physician. 10) Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after), . routine medications are administered according to the established medication administration schedule for the facility. During a review of the facility's P&P, titled Ordering and Receiving Medications from The Dispensing Pharmacy, dated [DATE], the P&P indicated that Medications and related products are received from the dispensing pharmacy on a timely basis. 2.a. Reorder medications five days in advance of need to assure adequate supply is on hand. c. The refill is called in, faxed, or otherwise transmitted to the pharmacy. 3.a. If needed before the next regular delivery, inform pharmacy of the need for prompt delivery. During a review of the facility's P&P, titled Medication Error Reporting, dated ,d+[DATE], the P&P indicated: Medication errors will include but not be limited to: d. dose skipped. During a review of the facility's P&P, titled Storage of Medications, dated [DATE], the P&P indicated that Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. M. Outdated, contaminated, or deteriorated medications and those in containers that are are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's P&P, titled Vials and Ampules of Injectable Medications, dated [DATE], the P&P indicated that Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal. F. Medication in multi-dose vials may be used until the manufacturer's expiration date or 6 months after opening unless otherwise specified. During a review of the facility's P&P, titled Procedures for All Medications, dated [DATE], the P&P indicated To administer medications in a safe and effective manner. E. Check expiration date on package/container. During a review of facility's P&P titled, Discontinued Medications, dated [DATE], the P&P indicated that When medications are expired, discontinued by a prescriber, a resident is transferred or discharged and does not take medications with him/her, or in the event of a resident's death, the medications are marked as discontinued or stored in a separate location and later destroyed. A. If a medication expires, or a prescriber discontinues a medication, the discontinued drug container shall be marked or otherwise identified or shall be stored in a separate location designated solely for this purpose. The date the medication was discontinued shall be indicated on the medication container. B. Medications awaiting disposal or return are stored in a locked secure area designated for that purpose until destroyed. Medications are removed from the medication cart or storage area prior to expiration, and immediately upon receipt of an order to discontinue.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review the facility failed to: 1. Remove and discard from use one expired insulin (medication used to regulate blood sugar levels) Lispro (fast-acting insulin) Kwikpen (type of injection device) for Resident 19, in accordance with manufacturer's requirements in one of two inspected medication carts (Medication Cart 2). 2. Remove and discard from use one open Aplisol (medication used to diagnose tuberculosis [a contagious infection in the lungs that is usually spread through the air]) vial for facility stock, in accordance with manufacturer's requirements and facility policy and procedures in one of one inspected medication rooms (Medication room [ROOM NUMBER]). These deficient practices increased the risk that Resident 19 and other residents in the facility could receive medication that had become ineffective or toxic due to improper storage or labeling, possibly leading to health complications (like diabetic ketoacidosis [a condition that develops when the body doesn't have enough insulin resulting in the buildup of acid in the blood to levels that can be life threatening] and inaccurate treatment of tuberculosis which may result in hospitalization or death. Findings: a. During a review of Resident 19's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on [DATE] with diagnosis including type 2 diabetes mellitus 2 (DM2 - a condition that affects how the body processes blood sugars). During a review of Resident 19's Physician's Orders from [DATE] to [DATE], the Physician's Orders indicated Resident 19 was prescribed Lispro to inject 6 units ([un] - a measure of dosage for insulin) subcutaneous ([SQ] - under the skin) before each meal for DM, and hold (do not administer) for blood glucose less than 130, starting [DATE]. During a review of Resident 19's Medication Administration Records ([MARs] - a document of the medications administered to a resident that is part of the resident's permanent medical record] for September and [DATE], the MARs indicated Resident 19 was prescribed insulin Lispro to give 6 un SQ before each meal for DM at 6:30 a.m, 11:30 a.m, and 4:30 p.m. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and concurrent interview on [DATE] at 3 p.m., in Medication Cart 2, with the Director of Staff Development (DSD), one open insulin Lispro Kwikpen for Resident 19 was found stored at room temperature with a label indicating that storage at room temperature began on [DATE] and to discard unused portion after 28 days. According to the manufacturer's product labeling, opened Lispro Kwikpen should be stored at room temperature below 86 degrees Fahrenheit (F - scale for measuring temperature) and used or discarded within 28 days of opening or once storage at room temperature began. The DSD stated that the insulin Lispro Kwikpen for Resident 19 was opened on [DATE] and expired on [DATE] and needed to be removed from the medication cart 28 days after opening and replaced with a new pen from pharmacy immediately. The DSD stated there was no new Lispro pen in the facility for Resident 19, and that several licensed nurses administered several doses of expired Lispro from [DATE] to [DATE] to Resident 19. The DSD stated that administering expired insulin will not be effective in keeping the blood sugar levels stable and can harm Resident 19 by causing high blood sugar levels leading to diabetic ketoacidosis, hospitalization , and death. During an observation and concurrent interview, on [DATE] at 3:15 p.m., with the DSD, in Medication room [ROOM NUMBER], one opened Aplisol multi-dose vial for facility stock was found stored in the refrigerator without a label indicating when storage or use began. According to the manufacturer's product storage and labeling, Aplisol vials should be stored in the refrigerator between 36 and 46 degrees Fahrenheit and used or discarded from use within 30 days of opening the vial. The DSD stated that the Aplisol vial in the refrigerator in Medication room [ROOM NUMBER] was open and did not have a label indicating when the vial was opened. The DSD stated without a label indicating when the vial was opened it would be unknown when the Aplisol would expire. The DSD stated the vial was considered expired and should be removed from the refrigerator and placed in the expired medication bin to be disposed of and not accidentally used for residents. The DSD stated administering expired Aplisol to residents may result in inaccurate results (either false negative or false positive) and therefore lead to providing the incorrect treatment to the residents. During an interview on [DATE] at 3:43 p.m., with the Director of Nursing (DON) and in the presence of the Administrator, the DON stated that the insulin Lispro Kwikpen for Resident 19 was expired and should have been removed from the medication cart and replaced with a new pen from pharmacy. The DON stated several LVNs failed to remove the expired insulin Lispro Kwikpen from the medication cart, which lead to the administration of expired insulin from [DATE] to [DATE] to Resident 19 resulting in significant medication error. The DON stated administering expired insulin to Resident 19 will not be effective in controlling the blood sugar levels and can harm the resident by causing high blood sugar levels, leading to coma, hospitalization , and death. During the same interview, the DON stated that the Aplisol vial for facility stock was not labeled with a date indicating when use began. The DON stated multi-dose products should be labeled with a date opened to know when they expire and not to be used beyond that date as the sterility and potency (amount of drug needed to produce a certain response) of the medication will be affected. The DON stated using Aplisol vials beyond the expiration date in error may potentially provide inaccurate results for tuberculosis leading to inaccurate treatment for residents. The DON stated the Aplisol vial was considered expired and needed to be removed from the medication room and be discarded to prevent accidental use. During a review of the facility's policy and procedures (P&P), titled Storage of Medications, dated [DATE], the P&P indicated that Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	M. Outdated, contaminated, or deteriorated medications and those in containers that are are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. During a review of facility's P&P, titled Vials and Ampules of Injectable Medications, dated [DATE], the P&P indicated that Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal. B. The date opened and the initials of the first person to use the vial are recorded on multi-dose vials. F. Medication in multi-dose vials may be used until the manufacturer's expiration date or six (6) months after opening unless otherwise specified. During a review of the facility's P&P, titled Procedures for All Medications, dated [DATE], the P&P indicated To administer medications in a safe and effective manner. E. Check expiration date on package/container. When opening a multi-dose container, place the date on the container. During a review of facility's P&P titled, Discontinued Medications, dated [DATE], the P&P indicated that When medications are expired, discontinued by a prescriber, a resident is transferred or discharged and does not take medications with him/her, or in the event of a resident's death, the medications are marked as discontinued or stored in a separate location and later destroyed. A. If a medication expires, or a prescriber discontinues a medication, the discontinued drug container shall be marked or otherwise identified or shall be stored in a separate location designated solely for this purpose. The date the medication was discontinued shall be indicated on the medication container. B. Medications awaiting disposal or return are stored in a locked secure area designated for that purpose until destroyed. Medications are removed from the medication cart or storage area prior to expiration, and immediately upon receipt of an order to discontinue.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 44244 Based on observation, interview, and record review, the facility failed to follow the established menu to meet nutritional needs by failing to follow the 10/1/2024 lunch menu when corn bread was omitted, and green beans were substituted for seasoned peas for 42 of 45 facility residents including one of one sampled residents (Resident 10) reviewed under the Food care area. This deficient practice had the potential to result in unwanted resident weight loss. Findings: During a review of Resident 10's Record of Admission, the Record of Admission indicated the facility admitted the resident on 5/24/2022 and most recently readmitted the resident on 6/16/2022. During a review of Resident 10's Client Diagnosis Report, undated, the Client Diagnosis Report indicated diagnoses that included sepsis (a life-threatening blood infection), metabolic encephalopathy (a general term that describes brain disease, damage, or malfunction usually related to inflammation within the body), dysphagia (difficulty swallowing), anxiety disorder (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear), and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 10's History and Physical, dated 3/1/2024, the History and Physical indicated the resident had the capacity to understand and make decisions. During a review of Resident 10's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/23/2023, indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident required partial / moderate staff assistance with bathing, dressing, and mobility; and required substantial staff assistance for toileting and putting on / taking off footwear. During a review of Resident 10's Nutrition Screen, dated 8/20/2024, the Nutrition Screen indicated during the last three months the resident had a weight loss greater than 6.6 pounds (lbs - a unit of measurement) and the resident was at risk for malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets). During an observation of the kitchen tray line preparation on 10/1/2024 at 11:40 a.m., observed green beans were prepared for all diet type trays and there was no corn bread prepared or served. During a concurrent observation, interview, and record review on 10/1/2024 at 12:45 p.m., the Dietary Supervisor (DS) reviewed the facility Good for Your Health Menu, dated 9/30/2024 to 10/6/2024. The DS stated the menu indicated that lunch on 10/1/2024 included seasoned peas and cornbread. The DS stated the facility kitchen substituted the seasoned peas with green beans for all resident diets and did not serve cornbread. The DS stated the cornbread was omitted for all resident diets and was not substituted. The DS stated the kitchen should follow the facility menu to meet the nutritional needs of the residents and for resident expectations. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/1/2024 at 12:55 p.m., Resident 10 sat in bed while eating lunch. Resident 10 stated he was not served peas or cornbread. Resident 10 stated he didn't have a menu for the day, but it didn't matter because the facility kitchen never followed the menu. Resident 10 stated it would be nice to be provided a menu that was followed. During a follow-up interview on 10/2/2024 at 10:59 a.m., the DS stated the facility residents were not notified on 10/1/2024 that the seasoned peas would be substituted with green beans. The DS stated there was cornbread mix in the kitchen, but the cook forgot to make it. During an interview on 10/4/2024 at 9:53 a.m., the Registered Dietician (RD) stated the menus are planned to meet the recommended daily nutritional allowances for residents. The RD stated the menus are suggested by the menu company and there are planned alternatives offered. The RD stated cornbread is a grain and is included on the fall menu that provides residents with starch and additional calories. The RD stated when the cornbread was left off the menu, there should have been a substitute food provided. The RD stated it was appropriate to substitute peas with green beans. The RD stated it would have been nice to notify the residents of the change, but she wasn't sure who would have the time to go around and tell the residents and they might not even notice. The RD stated when the menu is not followed there is a potential that there may be resident satisfaction issues that may result in residents complaining. The RD stated when residents are not satisfied, they may eat less, and it could eventually result in weight loss. During an interview on 10/3/2024 at 7:32 a.m., the Director of Nursing (DON) stated the facility menu should be followed because residents are given a menu and have expectations for their nutrition. During a review of the facility policy and procedures (P&P) titled, Menu Planning, last reviewed on 6/6/2024, the (P&P) indicated menus with corresponding recipes will be provided to the facility at least two weeks in advance. All daily menu changes, with the reason for the change, are to be noted and only the RD or cook can make these changes. Menu changes should also be noted on menus on the consumers' board and any other menus which may be posted. The menus are planned to meet nutritional needs of residents in accordance with established national guidelines. Physician's orders and, to the extent medically possible, in accordance with the most recent recommended dietary allowances of the Food and Nutrition Board of the National Research Council National Academy of Sciences. During a review of the facility (P&P) titled, Menu Planning to Meet Recommended Daily Dietary Allowances, last reviewed on 6/6/2024, the (P&P) indicated a variety of food selection is the key to good nutrition. Include foods from each of the food groups each day. Serve four or more servings daily of the grain group. If all foods are served in recommended amounts and a extra servings of these foods plus other foods round out the menu, and enough food is provided to satisfy calorie needs, then the menu will meet the recommended daily dietary allowances.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen for 42 of 45 facility residents by failing to ensure: 1. Food items in the kitchen refrigerator, in the dry storage area, and in the resident refrigerator were labeled according to facility policy. 2. Ensure two large, plastic food storage bin lids were secured in the dry storage area. 3. Ensure an open carton of almond milk, in the kitchen refrigerator, had a cap closure and was not left open. 4. Ensure a staff member's personal cup was not located in the kitchen prep area. 5. Ensure a zucchini with a mold-appearing substance was not readily available to be served in the outside Fridge #3. These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (transfer of bacteria from one object to another) in 42 of 45 medically-compromised residents who received food from the kitchen. Findings: 1.During a kitchen observation tour and concurrent interview on [DATE] at 7:50 a.m. with the Dietary Supervisor (DS), the DS stated the kitchen staff labels opened and prepared food items with the opened or prepared date, the contents, and the expiration date. The DS stated food items are labeled to ensure staff know what they are serving and to ensure old or expired food items are not served to residents because it may make them sick. The DS noted the following in the facility kitchen and food storage areas: -In the kitchen fridge, there was an unlabeled metal bowl containing a prepared whipped cream-like food item. - In the kitchen fridge, there was bowl containing prepared chocolate pudding with no prepared date. - In the kitchen fridge, there was an unlabeled plastic bin containing an apple sauce-like food item. - In the kitchen fridge, there was an unlabeled large bowl and one small bowl containing prepared salad-like food items. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- In the kitchen fridge, there was an unlabeled small bowl containing a watermelon-like food item. - In the kitchen fridge, there was an unlabeled container of a yellow food item. The DS stated the item was egg salad or prepared garlic butter. - In the kitchen fridge, there were six unlabeled cups containing cut fruit-like food items. - In the kitchen fridge, there was an unlabeled bag containing a white opened bin of a tofu-like food item. - In the kitchen fridge, there were 26 margarine cubes removed from the original box with no open date. - In the kitchen fridge, there was an opened jar of strawberry jam with no open date. - In the kitchen fridge, there was one opened container of beef base with no open date. - In the kitchen fridge, there was one opened container of vegetable base with no open date. - In the kitchen fridge, there was one opened container of whipped cream cheese with no open date. - In the kitchen fridge, there was one opened container of cottage cheese with no open date. - In the kitchen fridge, there was one opened container of sour cream with no open date. - In the kitchen fridge, there was one opened carton of almond milk missing a cap and left open with no open date. The DS stated the milk should always have a cap to ensure nothing gets into the carton. - In the kitchen fridge, there was one bowl labeled chocolate pudding and dated [DATE] and no labeled expiration date. The DS stated he thinks the pudding is good for two weeks, but he would have to check. - In the outside Fridge #3, there was one zucchini with a white mold-like substance. The DS stated the zucchini should have been discarded to ensure that it was not served because there was a potential it could cause illness in residents. - In the dry storage area, there were two opened boxes of biscuit mix with no open date. - In the dry storage area, there was one large opened box of chocolate cake mix with no open date. -In the dry storage area, there was one opened bag of muffin mix with no open date. -In the dry storage area, there was one food storage bin containing dry macaroni with the lid pushed to the side and the contents open to the room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In the dry storage area, there was one food storage bin containing dry pinto beans with no lid and the contents open to the room. The DS stated staff should ensure all food storage bin lids are secured to ensure no dirt, debris, or pests have access to the food and to prevent cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). -In the kitchen preparation area there was one staff member's pink cup. The DS stated staff personal items should not be in the kitchen preparation area to prevent cross contamination. The DS further stated all improperly labeled and stored food items would need to be thrown out to prevent potential illness in residents. During a follow-up interview and record review on [DATE] at 10:59 p.m. with the DS, the DS reviewed the facility policy for food storage. The DS stated the facility policies were not followed when the food items were not labeled and stored per facility policy. During an interview on [DATE] at 7:32 a.m. with the Director of Nursing (DON), the DON stated food should be labeled and stored properly because food is consumed by residents and it should be clean, well cooked, and not expired. The DON stated when contaminated food is served to residents it can potentially result in a change of condition like gastrointestinal upset. During an interview on [DATE] at 9:53 a.m., the Registered Dietician (RD) stated the RD oversees the kitchen and provides monthly audits and in-services for kitchen staff. The RD stated it was important to label opened and prepared food with the contents, so it is clear what it is, ensure residents with allergies are served the correct food, and to ensure the correct shelf life of the food is determined. The RD stated once any food item is removed from its original container it must be labeled with a date. The RD stated the food in the kitchen is labeled for safety and should not be served after the expiration date because there was a potential for food born illnesses in residents. The RD stated when residents' get a foodborne illness they generally do not feel well and it may result in nausea, diarrhea, and may affect their ability to eat adequately. During a review of the facility policy and procedures (P&P) titled, Labeling and Dating of Foods, last reviewed on [DATE], the (P&P) indicated all food items in the storeroom, refrigerator, and freezer will be labeled and dated. Newly opened food items will need to be closed and labeled with an open date and used by date that follows the various storage guidelines. All prepared foods need to be covered, labeled, and dated. Leftovers will be covered, labeled, and dated. During a review of the facility (P&P) titled, Leftovers, last reviewed on [DATE], indicated leftover foods will be stored and served in a safe manner. Leftover foods are those that have been prepared for a meal and not served. Leftovers will be stored with the label and date. Use refrigerator leftovers within 72 hours. (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	10/04/2024

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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility (P&P) titled, Storage of Food and Supplies, last reviewed on [DATE], the (P&P) indicated food and supplies will be stored properly and in a safe manner. All food containers are to be stored in a manner that protects it from contamination. Dry bulk foods (dry beans, etc) should be stored in metal or plastic containers with tight covers. Food stores should be arranged in food groups. Labels should be visible, and the arrangement should permit rotation of supplies so that the oldest items will be used first. Dry food items that have been opened will be tightly closed and labeled and dated. These items are to be used per times specified in the Dry Storage Guidelines. 2.During a follow-up kitchen observation tour on [DATE] at 10:59 p.m. with the DS, the DS stated the facility has a small fridge located in the employee lounge for the storage of resident food items. The DS stated resident food items should be labeled with the resident name and the date the food was placed in the refrigerator. The DS noted the following food items not labeled per facility policy in the resident refrigerator: - Two water bottles labeled with a room number only. - One bottle of cultured low-fat milk with no resident identifier label or date. - One bottle of organic carrot juice with no resident identifier label or date. - One carton of yogurt with no resident identifier label or date. - Two soda bottles with no resident identifier label or date. - Two take out meals labeled with room numbers only. - One container of gumbo (stew) labeled with resident name only and no date. - One container of lobster bisque (soup) labeled with resident name only and no date. - One container of cooked rice labeled with a room number only. - One can of pears labeled with a room number only. - One container of fruit mix labeled with resident name only and no open date. - One package of rice pudding, labeled with a room number only. The DS further stated none of the food items in the resident refrigerator were properly labeled and all food items would need to be thrown out to prevent resident illness because there was no way to know how long they were stored in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:47 a.m., with the facility Infection Preventionist (IP), the IP stated the resident refrigerator was the responsibility of the nursing staff to monitor daily because the nursing staff places the items in the refrigerator. The IP stated food brought by residents was to be labeled with the resident name, room number, and the date placed in the fridge. The IP stated food brought by residents was thrown out after three days. The IP stated when resident food items are not properly labeled, expired food may be served causing food poisoning in residents. During an interview on [DATE] at 7:32 a.m. with the DON, the DON stated food should be labeled and stored properly because food is consumed by residents and it should be clean, well cooked, and not expired. The DON stated the nursing staff is responsible for ensuring food brought by residents is properly labeled and not served past the expiration of three days. The DON stated when contaminated food is served to residents it can potentially result in a change of condition like gastrointestinal upset. During an interview on [DATE] at 9:53 a.m., the RD stated nursing staff should oversee the resident refrigerator and ensure food is labeled with the date and the resident name. The RD stated it was important to label the resident's name and not just the room number because residents can move rooms. The RD stated the food in the kitchen and resident refrigerator is labeled for safety and should not be served after the expiration date because there was a potential for food born illnesses in residents. The RD stated when residents' get a food born illness they generally do not feel well and it may result in nausea, diarrhea, and may affect their ability to adequately eat. During a review of the facility (P&P) titled, Food for Residents from Outside Sources, last reviewed on [DATE], the (P&P) indicated food brought in from outside the facility kitchen for residents consumption will be monitored. Prepared foods, beverages, or perishable food that requires refrigeration, can be stored for the resident in the kitchen facility, the refrigerator within the nurses' station, or in the resident's personal refrigerator. In the Food and Nutrition Services Department, the policy of food storage will apply. Otherwise, if unopened, refrigerated or frozen items will be disposed of by the expiration date on the container. If opened, the food must be sealed, dated to date opened and disposed of in two days after opening.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to: 1.Implement Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, microorganisms, mainly bacteria, that are resistant to one or more classes of antibiotics] that uses targeted gown and glove use during high contact resident care activities) when Licensed Vocational Nurse 7 (LVN 7) did not don (put on) a gown while providing gastrostomy (GT, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach, common for people with swallowing problems) care for one of one sampled residents (Resident 1) reviewed under the Tube Feeding care area. 2.Ensure the facility EBP policy and procedure was reviewed annually and updated to reflect current standards of practice. 3.Ensure the nasal cannula (NC - tubing connected to a device that gives additional oxygen [O2] through the nose) and humidification bottled (water is combined with the normal flow of O2, reducing sensations of dryness in the upper airways) were changed weekly and labeled with the date last changed for one of one sampled residents (Resident 26) reviewed under the Respiratory care area. 4 Ensure the urinary catheter bag was not touching the floor for one of one sampled residents (Resident 148) investigated under the urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) or Urinary Tract Infection (UTI, an infection in the bladder/urinary tract) care area. These deficient practices had the potential to spread infections and illnesses among residents and staff. Findings: 1.During a review of Resident 1's Record of Admission, the Record of Admission indicated the facility admitted the resident on 5/22/2014 and most recently readmitted the resident on 10/19/2023. During a review of Resident 1's Client Diagnosis Report, undated, the Client Diagnosis Report indicated diagnoses that included unspecified dementia (a progressive state of decline in mental abilities), spinal stenosis (a narrowing of the spinal canal in the lower back that may cause pain or numbness in the legs) cervical region (the neck), encounter for GT, and acquired absence of unspecified parts of the digestive tract. During a review of Resident 1's History and Physical, dated 11/8/2023, the History and Physical indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 5/3/2024, the MDS indicated the resident was usually able to understand others and sometimes was able to make herself understood. The MDS further indicated the resident was dependent on staff for oral hygiene, toileting, dressing, and mobility. During a review of Resident 1's Physician's Orders, the Physician's Orders indicated a treatment order for the GT site during the day shift, to cleanse the GT site with normal saline, pat dry, apply a dry dressing every day, and may do as needed treatment if GT dressing is soiled/dislodged, dated 12/16/2024. During a review of Resident 1's Care Plan (CP) titled, (Resident 1) requires tube feeding, GT related dysphagia (difficulty swallowing), .potential for, . tube site infection initiated 5/5/2023, indicated a goal that the resident would have no GT site infections. During a concurrent observation and interview on 10/2/2024 at 8 a.m., observed Licensed Vocational Nurse 7 (LVN 7) provide GT care for Resident 1. Observed no EBP indication signs posted outside or inside the room. Observed LVN 7 enter the resident's room wearing a surgical mask, perform hand hygiene, and then placed gloves on her hands. LVN 7 accessed Resident 1's GT, removed the dressing, cleansed the skin surrounding the entrance site of the GT, then placed a new dressing. LVN 7 then exited the resident's room and stated she wore gloves and a mask to provide GT care to the resident and no other PPE is needed to provide GT care to residents. During an interview on 10/2/2024 at 11:32 a.m., with the Infection Preventionist (IP), the IP stated EBP are precautions taken for resident with Multidrug-Resistant Organisms (MDROs, bacteria that have become resistant to certain antibiotics). The IP stated when a resident has an MDRO, then they are placed on EBP and staff must wear a gown and gloves while providing direct care to the resident. The IP stated there were currently no residents in the facility that required EBP. The IP stated the facility has an EBP policy. During a follow up concurrent interview and record review on 10/2/2024 at 11:47 a.m., the IP reviewed the facility policy and procedure regarding EBP and the Centers for Disease Control and Prevention (CDC, a federal government agency charged with the investigation and control of contagious disease in the nation) website regarding EBP. The IP stated the facility policy was provided by the company that owns the facility and indicates to use targeted gown and gloves during high contact resident care activities for residents with MDRO infections or MDRO colonization. The IP stated based on the policy a resident with a GT would not need EBP if they did not have an MDRO infection or colonization. The IP stated the CDC provides guidance for EBP. The IP referred to the CDC website and noted the following: - EBP are an infection control intervention for residents known to be infected, or those that are at increased risk of infection from an MDRO. - Residents with increased risk of infection from MDROs include residents with wounds and indwelling devices. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The IP further stated the facility policy was not correct because residents with wounds or indwelling devices need to be placed on EBP because they are at increased risk of infections. The IP stated Resident 1 has a GT, and a GT is an indwelling device. The IP stated the LVN should have donned a gown for EBP while providing GT care to Resident 1, but she did not. The IP stated she wasn't aware of the CDC guidance, but she is responsible for implementing EBP in the facility and she is involved with ensuring that the facility policy reflects current guidance. The IP stated when the facility policy was not correct and EBP were not implemented for Resident 1, there was an increased risk for infection with the potential of resulting in the death of the resident. During a concurrent interview and record review on 10/4/2024 at 9 a.m., the Administrator (ADM) reviewed the facility policy and procedure titled, SNF Enhanced Barrier Precautions. The ADM stated policies and procedures are reviewed and/or revised annually. The ADM stated policy review is an administrative duty and it was the ADM responsibility to ensure the facility policy and procedures were reviewed annually. The ADM stated he had been the facility ADM for three months and the EBP policy was last revised 4/2023 and was not reviewed and updated to reflect current practice annually, but it should have been. During a review of the facility policy and procedure titled, SNF Enhanced Barrier Precautions, last revised and approved 4/2023, indicated EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are designed to reduce the transmission of Multidrug-Resistant Organisms (MDROs, bacteria that have become resistant to certain antibiotics). EBP are indicated for residents and patients with MDRO infections and/or colonization. The policy indicates it follows the Centers for Disease Control (CDC)'s recommendations described on Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug resistant Organisms (MDROs) webpage. During a review of the CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug resistant Organisms (MDROs) pdf, dated 7/12/2022, the CDC indicates MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP may be indicated for residents with any of the following: o Wounds or indwelling medical devices, regardless of MDRO colonization status o Infection or colonization with an MDRO. EBP expands the use of PPE and refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for EBP include device care or use of feeding tubes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility policy and procedure titled, Infection Prevention and Control Program, last approved 11/2023, the policy indicated the facility maintains an infection prevention and control program to prevent the development and transmission of infectious disease. Infection control policy and practices are guided by recommendations of national, state, and local public health authorities, applied in or adapted for the long-term care setting. Every employee is accountable for knowing and implementing parts of the infection prevention program applicable to their job. During a review of the Administrator Job Description, dated 9/7/2011, the Job Description indicated the ADM assures adherence to all policies, procedures and regulatory requirements with regard to infection control and ensures effective direction of all nursing services and appropriate training and development of clinical staff. The ADM implements standards of service for care and ensures regulatory guidelines are met. During a review of the facility policy titled, Policy Management, last approved 5/2024, the policy indicated the purpose of the policy was to establish a framework and best standard of practice for the creation, structure, and organization of facility policies. Existing policies will be revised when there are changes in procedures, regulatory standards, or evidence-based standards. All documents must be reviewed as defined by service specific regulatory requirements. 2. During a review of Resident 26's Record of Admission, the Record of Admission indicated the facility admitted the resident on 8/13/2024. During a review of Resident 26's Client Diagnosis Report, undated, the Client Diagnosis Report indicated diagnoses that included heart failure (HF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), emphysema (also called chronic obstructive pulmonary disease, COPD - a chronic lung disease that damages the air sacs in the lungs, making it difficult to breathe), and anxiety disorder (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear. During a review of Resident 26's History and Physical, dated 8/16/2024, the History and Physical indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 26's MDS dated [DATE], indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated the resident required partial / moderate staff assistance with toileting, bathing, dressing, and mobility. During a review of Resident 26's Physician's Orders for October, the Physician's Orders indicated an order for as needed (PRN) O2, monitor SpO2 (oxygen saturation level, O2 sat - a measurement of how much oxygen the blood is carrying as a percentage) and administer oxygen at 2 to 4 liters per minute (a unit of measurement) via NC during each shift as needed for O2 Sat less than 92 %, dated 8/13/2024. During an observation on 10/1/2024 at 10:35 a.m., observe Resident 26 sitting up in bed while administered O2 Via NC at 3 LPM. The resident stated she uses the oxygen on and off. Observe the NC and humidifier bottle was not labeled. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/1/2024 at 10:40 a.m., Certified Nursing Assistant 3 (CNA 3) entered Resident 26's room and stated the resident was administered O2 via NC. CNA 3 state the NC and humidifier bottle were not labeled with the date. CNA 3 stated the resident was provided the NC and humidifier bottles by the hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) and the hospice staff are supposed to label them, but they didn't. During an interview on 10/02/2024 at 11:47 a.m., with the IP, the IP stated oxygen tubing and humidifier bottles are changed weekly and as needed. The IP stated there are stickers that are placed on the NC and bottle that indicate the date they were changed. The IP stated the hospice nurses change the tubing and bottles when they are at the facility and the facility nurses make rounds to check the NC and humidifier bottles. The IP stated facility nurses ensure that the NC and humidifier bottles are labeled. The IP stated the importance of changing the NC and humidifier bottles weekly is to prevent the growth of bacteria that could potentially lead to a respiratory infection in the resident. During an interview on 10/3/2024 at 7:32 a.m. with the Director of Nursing (DON), the DON stated facility nurses are responsible for ensuring the NC and humidifier bottles are labeled. The DON stated the label indicates when the tubing was last changed. The DON stated oxygen tubing and humidifier bottles should be labeled because if they are used for longer than a week it could potentially cause an infection in the resident. During a review of the facility policy and procedure titled, Oxygen Equipment Cleaning, last reviewed 10/2024, the policy indicated to use disposable pre-filled humidifiers, tubing, masks, and cannulas for residents who need oxygen therapy. This equipment is discarded after use and per policy. It is the responsibility of the night shift licensed nurse to ensure the following infection control and maintenance measures occur weekly: pre-filled humidifiers and cannulas are to be dated and replaced every seven days. During a review of the facility policy and procedure titled, Oxygen Therapy, last approved 9/2024, the policy indicated the objective of the policy was to administer oxygen in conditions in which insufficient oxygen is carried by the blood to the tissues. Discard disposable cannulas and humidifier bottles every seven days. During a review of the facility policy and procedure titled, Infection Prevention and Control Program, last approved 11/2023, the policy indicated the facility maintains an infection prevention and control program to prevent the development and transmission of infectious disease. 43418 3. During a review of Resident 148's Record of Admission, the Record of Admission indicated the facility admitted Resident 148 on 9/20/2024 with diagnoses including, but not limited to, fusion of spine (surgery to connect two or more bones in any part of the spine), cervical region, generalized muscle weakness, and history of falling. During a review of Resident 148's Internal Medicine Initial Evaluation, dated 9/23/2024, the Internal Medicine Initial Evaluation indicated Resident 148 has the capacity to understand and make decisions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 148's Physician Order, dated 9/27/2024, the Physician Order indicated an order for bladder scan (a noninvasive procedure that uses ultrasound to measure the volume of urine in the bladder) every six hours and if urinary retention (a condition that makes it difficult to empty the bladder, either partially or completely) is more than 350 milliliters (ml, a unit of measure for volume) for two consecutive six hours (two shifts), reinsert urinary catheter 16 French (Fr, a unit of measure for the diameter of a catheter tube) with 10 ml and contact the physician for further orders. During a review of Resident 148's Care Plan, dated 9/20/2024, the care plan indicated Resident 148 had a urinary catheter related to urinary retention with a goal for the resident to not develop infection or injury related to catheter use. The care plan further indicated interventions included following the standard of care and/or policy for catheter care and documentation. During a concurrent observation and interview with Resident 148, on 10/1/2024, at 8:57 a.m., inside Resident 148's room, Resident 148 was lying down in bed with a urinary catheter bag hanging at the side of the foot of the bed. Resident 148's urinary catheter bag was touching the floor. Resident 148 confirmed his urinary catheter bag was touching the floor and stated he has a urinary catheter due to having urinary retention. During a concurrent observation and interview with the Director of Staff Development (DSD), on 10/1/2024, at 9:13 a.m., inside Resident 148's room, the DSD confirmed Resident 148's urinary catheter bag was hanging at the side of the foot of the bed and was touching the floor. The DSD stated Resident 148's urinary catheter bag should not be touching the floor due to infection control. During an interview with the Administrator, on 10/4/2024, at 3:47 p.m., the Administrator stated urinary catheters should not be touching the floor because of the transmission process of germs and can potentially cause an infection in residents. During a review of the facility's policy and procedure (P&P) titled, Indwelling Urinary Catheter (Foley) Care and Management, last revised 12/10/2023, the P&P indicated to not place the drainage bag on the floor to reduce the risk of contamination and subsequent catheter associated urinary tract infection (CAUTI).

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 43418 Based on observation, interview, and record review, the facility failed to ensure that 16 of 25 resident rooms (Rooms 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 22, 23, and 28) met the square footage requirement of 80 square feet (sq. ft.) per resident in multiple resident rooms. The room sizes for these rooms had the potential to have inadequate space for resident care and mobility. Findings: During the Resident Council Meeting, on 10/1/2024, at 2:32 p.m., the residents did not bring up concerns or issues regarding the space in their rooms. During an observation from 10/1/2024 to 10/4/2024, residents residing in rooms with an application for variance had enough space for residents to move freely inside the rooms. There was adequate room for the operation and use of wheelchairs, walkers, or canes. The room variance did not affect the care and services provided by nursing staff for the residents. During a review of the letter titled, Re: Room Size Variance Waiver, dated 10/1/2024, the letter indicated the Administrator submitted the application for the Room Variance Waiver for 16 resident rooms. The room variance letter indicated the following rooms did not meet the 80 square feet per resident requirement per federal regulation: Room Beds #Square Footage Number of Beds 1 154 2 2 154 2 3 154 2 4 154 2 5 22.63 3 12 154 2 13 154 2 14 154 2 15 154 2 (continued on next page)

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	16 154 2 17 154 2 18 154 2 19 154 2 22 151.9 2 23 296.3 4 26 286.2 4 The minimum requirement for a 2 bedroom should be at least 180 sq. ft. The minimum requirement for a 3 bedroom should be at least 240 sq. ft. The minimum requirement for a 4 bedroom should be at least 320 sq. ft. The letter further indicated There is enough space to provide for each resident`s care dignity, and privacy. The rooms are in accordance with the special needs of the resident and would not have an adverse effect on the residents' health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being. During a review of the facility's policy and procedure (P&P) titled, Accommodations Assessment, effective as of 4/2024, the P&P indicated a distance of at least three feet between all beds must be maintained to provide adequate space for residents to get in and out of bed or into wheelchairs or to ambulate/negotiate the area between the bed and bathroom and to provide adequate space for nursing care.