STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055710	A. Building B. Wing	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Hollywood Healthcare & Wellness Centre, LP	855 North Fairfax Avenue Los Angeles, CA 90046

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure resident's right to be informed were honored and implemented accordingly to her decision on health care treatment for one of five sampled residents (Resident 43). This deficient practice violated resident's right to make an informed decision and resulted to failure in the delivery of necessary care and services. Findings: A review of Resident 43's Admission Record indicated Resident 43 was admitted to the facility on [DATE] with diagnosis including urinary tract infection (UTI- an infection in any part of the urinary system, including the kidney, bladder or urethra), sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), and paroxysmal atrial fibrillation (afib- a sudden irregular and very rapid heart rhythm that and can lead to blood clots in the heart). A review of Resident 43's Minimum Data Set (MDS - a comprehensive assessment and care screening tool), dated 5/6/2024, indicated Resident 43's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making were mildly impaired and required moderate to maximal assistance from staff for activities of daily livings (ADLs- toileting hygiene, shower/bathing self, upper and lower body dressing, repositioning from sit to lying and sit to stand). A review of Resident 43's Care Plan (CP) for at risk for Multidrug-resistant organisms (MDROs - are microorganisms, mainly bacteria, that are resistant to one or more classes of antimicrobial agents), and other transmissible infectious pathogens due to presence of indwelling foley catheter (a device that drains urine [pee] from urinary bladder into a collection bag outside of the body when a person can't pee on their own or for various medical reasons), initiated on 5/25/2024, the CP indicated an intervention to educate resident (Resident 43), and resident family/representatives regarding the use and purpose of enhanced standard precaution (ESP - involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices), , educate staff regarding the use and purpose of ESP and initiate ESP. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055710	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024
NAME OF PROVIDER OR SUPPLIER West Hollywood Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 855 North Fairfax Avenue Los Angeles, CA 90046	

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with Resident 43 on 5/25/2024 at 6:47 p.m., Resident 43 was observed with an ESP signage posted outside the door. Resident 43 asked the surveyor why staff wear gowns while changing diapers and doing care for her. Resident 43 stated, what is going on? Am I sick? I know nurses wear gowns when a patient is sick. Resident 43 further stated, no one explained it to her, they just come in her room with gowns and did not explain when she asked the nurses. During a concurrent observation with Licensed Vocational Nurse 2 (LVN2), on 5/25/2024 at 6:50 p.m., LVN 2 went inside Resident 43's room and Resident 43 asked LVN2 why staff wears gown and gloves when they come in her room, with Resident 43 stating, am I sick?. LVN2 answered Resident 43 and stated, we do not need to wear gowns, don't worry. During an interview with LVN 2 on 5/25/2024 at 6:52 p.m., LVN 2 stated, Resident 43 is not on any ESP, LVN 2 further stated, she told Resident 43 that they don't need to wear any gowns and gloves when doing care for her (Resident 43). During an interview with Infection Preventionist Nurse 1 (IPN1), on 5/27/2024 at 5:34 p.m., IPN1 stated, staff should be educating residents regarding any transmission-based precautions. IPN1 stated, they are still learning about ESP and in process of finalizing their protocols on ESP. A review of the facility's policy and procedures (P&P) titled, Resident Rights, reviewed on 1/29/2024, the P&P indicated that State and Federal laws guarantee certain basic rights to all residents of the facility. These rights include, but not limited to, a resident's right to: be informed about what rights and responsibilities he or she has. In order to facilitate resident choices, facility staff will inform (and regularly remind) the resident and family members of the resident's right to self-determination and participation.

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F 0557

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43454

Based on observation, interview and record review, the facility failed to enhance a resident's dignity and respect by failing to provide personal hygiene and assistance to one of five sampled residents (Resident 1).

This deficient practice had the potential to negatively affect the residents' psychosocial well-being.

Findings:

A review of Resident 1's Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including unspecified dementia (loss of cognitive functioning-thinking, remembering, and reasoning), moderate protein-calorie malnutrition (lack of sufficient nutrients in the body), and heart failure (a condition in which the heart does not pump blood as well as it should).

A review of Resident 1's Minimum Data Set (MDS - a comprehensive assessment and care screening tool), dated 5/2/2024, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making were severely impaired and required moderate assistance to clean-up assistance from staff for activities of daily livings (ADLs- eating, toileting hygiene, repositioning from sit to stand, bed to chair transfer).

A review of Resident 1's Care Plan (CP) for ADL self-care performance deficit, initiated on 2/20/2024, the CP indicated an intervention that Resident 1 requires set up assistance by one staff to each and Resident 1 required extensive assistance by staff with personal hygiene and oral care.

A review of Resident 1's ADL log, dated 5/25/2024, the ADL log did not indicate any record that ADL care and assistance was provided to Resident 1 during dinner.

During an observation of Resident 1 on 5/25/2024 at 6:44 p.m., Resident 1 was observed laying on the bed, eyes closed with pieces of food all over his clothes and all his bed.

During an interview and a concurrent observation with Certified Nursing Assistant 8 (CNA 8), on 5/25/2024 at 6:46 p.m., CNA 8 observed Resident 1 was observed with having food all over his clothes and on his bed. CNA 8 stated, Resident 1 eats on his own. When asked if Resident 1 was assisted after eating and when food tray was removed, CNA 8 stated, no. CNA 8 was then observed removing pieces of food from Resident 1's clothes and bed. CNA 8 further stated, she does not think Resident 1 was comfortable sleeping with food all over his clothes and bed.

A review of the facility's policy and procedures (P&P) titled, Resident Rights - Quality of Life, reviewed on 1/29/2024, the P&P indicated that each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in a attaining or maintaining his/her highest practicable well-being.

(continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled, Resident Rooms and Environment, reviewed on 1/29/2024, the P&P indicated that facility provides residents with a safe, clean, comfortable, and homelike environment. Facility Staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. Facility staff aim to create a personalized, homelike atmosphere, paying close attention to the following: . cleanliness and order.

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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** 43454 Based on interview and record review, the facility failed to ensure residents were informed, offered or followed up regarding Advance Directive (ACHD - written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) in a timely manner for four of 18 sampled residents (Residents 48, 43, 3, and 58). This deficient practice had the potential to cause conflict with resident's wishes regarding health care. Findings: 1. A review of Resident 43's Admission Record indicated Resident 43 was admitted to the facility on [DATE] with diagnosis including urinary tract infection (UTI- an infection in any part of the urinary system, including the kidney, bladder or urethra), sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), and paroxysmal atrial fibrillation (afib- a sudden irregular and very rapid heart rhythm that and can lead to blood clots in the heart). A review of Resident 43's Minimum Data Set (MDS - a comprehensive assessment and care screening tool), dated 5/6/2024, indicated Resident 43's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making were mildly impaired and required moderate to maximal assistance from staff for activities of daily livings (ADLs- toileting hygiene, shower/bathing self, upper and lower body dressing, repositioning from sit to lying and sit to stand). The same MDS indicated, Resident 43 Advance Directive was not completed. A review of Resident 43's Advance Directive form assessment during admission, dated 5/2/2024, indicated that Resident 43 chose the option that she (Resident 43) has executed an ACHD. A review of Resident 43's Baseline Care Plan, dated 5/1/2024 indicated, Social Services documentation with what was provided to Resident 43 was blank. A review of Resident 43's Progress Notes as of 5/26/2024, there were no notes by the Social Services Department regarding obtaining a copy of Resident 43's Advance Directive. During a concurrent interview and record review with Social Services Director (SSD) on 5/26/2024 at 5:23 p.m., SSD stated, residents were inquired if they have an ACHD and/or if they would like to execute an ACHD upon admission by the Admission Coordinator (AC). SSD reviewed Resident 43's electronic record with surveyor and stated, according to ACHD assessment form upon admission indicated Resident 43 have an ACHD but there was no copy of Resident 43's ACHD. SSD stated, if a resident has executed an ACHD, SSD is to follow-up with a copy, and it should be filed. SSD stated, she did not follow-up with Resident 43's regarding her actual ACHD. SSD further stated, she did not document that she followed-up with Resident 43's actual ACHD. SSD stated, ACHD is important so that they know what resident's wishes are when they are no longer able to make decision. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 3's Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including hemiplegia and hemiparesis (loss of the ability to move in one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting right dominant side, Parkinson's disease (a disorder in the brain that affects movement, often including tremors), dysphagia (difficulty swallowing food or liquid), and Alzheimer's disease (a progressing brain disorder that destroys memory and other important mental function). A review of Resident 3's MDS dated [DATE], indicated Resident 3's cognitive skills for daily decision-making were moderately impaired and required total dependence from staff for ADLs-eating, toileting hygiene, shower/bathing self, upper and lower body dressing, repositioning from sit to lying and sit to lying. The same MDS also indicated, Resident 3's Advance Directive was not completed. A review of Resident 3's Advance Directive form assessment during admission, dated 5/26/2023, indicated that Resident 3/family representative chose the option that she (Resident 3) has executed an ACHD. A review of Resident 3's Baseline Care Plan, dated 5/17/2023 indicated, SSD documented that, ancillaries offered and provided as needed. A review of Resident 3's Progress Notes as of 5/26/2024, there was no notes by the Social Services Department regarding obtaining a copy of Resident 3's Advance Directive and what are the ancillaries that SSD offered and provided. During a concurrent interview and record review with SSD on 5/26/2024 at 5:25 p.m., SSD stated, residents were inquired if they have an ACHD and/or if they would like to execute an ACHD upon admission by the AC. SSD reviewed Resident 3's electronic record with surveyor and stated, according to ACHD assessment form upon admission indicated Resident 3 have an ACHD but there was no copy of Resident 43's ACHD. SSD stated, if a resident has executed an ACHD, SSD is to follow-up with a copy, and it should be filed. SSD stated, she did not follow-up with Resident 43's regarding her actual ACHD. SSD further stated, she did not document that she followed-up with Resident 43's actual ACHD. SSD stated, ACHD is important so that they know what resident's wishes are when they are no longer able to make decision. 3. A review of Resident 48's Admission Record indicated resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain), acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood) and pneumonia (lung infection that inflames air sacs with fluid or pus). A review of Resident 48's MDS dated [DATE], indicated Resident 48's cognitive skills for daily decision-making were moderately impaired and required maximal to total dependence ADLs-eating, toileting hygiene, shower/bathing self, upper and lower body dressing, repositioning from sit to lying and rolling left to right. The same MDS also indicated, Resident 48 does not have Advance Directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 48's Advance Directive form assessment during admission, dated 4/9/2024, indicated that Resident 48 chose the option that she (Resident 48) will bring in a copy of the Advance Directive for the medical record. A review of Resident 48's Baseline Care Plan, dated 4/29/2024 indicated, SSD documented that, discharge planning was discussed, home health services and psychosocial wellbeing and support. There were no notes indicating about AHCD. A review of Resident 48's Progress Notes as of 5/26/2024, there was no notes by the Social Services Department regarding obtaining a copy of Resident 3's Advance Directive. During a concurrent interview and record review with SSD on 5/26/2024 at 5:28 p.m., SSD stated, residents were inquired if they have an ACHD and/or if they would like to execute an ACHD upon admission by the AC. SSD reviewed Resident 48's electronic record with surveyor and stated, according to ACHD assessment form upon admission indicated Resident 48 have an ACHD and resident's representative will bring a copy for their record but there was no copy of Resident 48's ACHD. SSD stated, if a resident has executed an ACHD, SSD is to follow-up with a copy, and it should be filed. SSD stated, she did not follow-up with Resident 43's regarding her actual ACHD. SSD further stated, she did not document that she followed-up with Resident 43's actual ACHD. SSD stated, ACHD is important so that they know what resident's wishes are when they are no longer able to make decision. 4. A review of Resident 58's Admission Record indicated resident was admitted to the facility on [DATE] with diagnosis including metabolic encephalopathy, hypertension (HTN - elevated blood pressure), history of falling and muscle weakness. A review of Resident 58's MDS dated [DATE], indicated Resident 58's cognitive skills for daily decision-making were moderately impaired and required moderate to maximal assistance from staff for ADLs- toileting hygiene, shower/bathing self, upper and lower body dressing, repositioning from sit to lying and sit to stand). The same MDS also indicated, Resident 48's Advance Directive was not completed. A review of Resident 58's Advance Directive form assessment during admission, dated 4/17/2024, indicated that Resident 58 chose the option that she (Resident 48) was interested in executing an Advance Directive (refer to Social Services). A review of Resident 58's Baseline Care Plan, dated 4/29/2024 indicated, SSD documented that, discharge planning was discussed, home health services, ancillaries offered and psychosocial wellbeing support. There were no notes indicating about a referral for AHCD. A review of Resident 58's Progress Notes as of 5/26/2024, there was no notes by the Social Services Department regarding following up with Resident 58's request to execute an Advance Directive and what are the ancillaries that were offered. (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 concurrent interview and record review with SSD on 5/26/2024 at 5:31 p.m., SSD stated, residents were inquired if they have an ACHD and/or if they would like to execute an ACHD upon admission by the AC. SSD reviewed Resident 58's electronic record with surveyor and stated, according to ACHD assessment form upon admission, it indicated Resident 58 was interested in executing an ACHD. Resident 58's had a power of attorney (POA) financial on file, dated 4/26/2024 which indicated, that this form is not valid for healthcare decisions. SSD stated, if a resident requested to execute an ACHD, SSD is to follow-up with a referral. SSD further stated, she did not document that she followed-up with Resident 58's request. SSD stated, ACHD is important so that they know what resident's wishes are when they are no longer able to make decision. During an interview with Director of Nursing (DON) on 5/27/2024 at 2:58 p.m., DON stated, the POA for on file for Resident 58 was for financial decisions and it was not valid for health care decisions. During a follow-up interview with SSD and AC on 5/26/2024 at 8:07 p.m., AC stated, residents are inquired about ACHD upon admission, and they document it, but surveyor does not have access to their documentation in the electronic charting. AC stated, if resident would like to execute an ACHD and/or they have executed an ACHD, they must follow-up with residents. AC stated, they don't document for any follow-up and/or education that was provided with residents. SSD stated and agreed with stating, they don't need to document any follow-up and education that was provided to residents. SSD stated, all they need to do is document it during admission process. A review of the facility's policy and procedures (P&P) titled, Advance Directive, reviewed on 1/29/2024, the P&P indicated, the facility will respect a resident's advance directive and will comply with the resident's wishes expressed in an advance directive. Upon admission, the Admission Staff or designee will obtain a copy of a resident's advance directive. A copy of the resident's advance directive will be included in the resident's medical record. If a resident does not have an Advance Directive, the facility will provide the resident and/or resident's next of kin with information about advance directives upon request . During the Social Services Assessment process, the Director of Social Services or designee will also ask the resident whether he or she has a written advance directive.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on interview and record review, the facility failed to notify the physician when the resident continued to refuse to take her medications for one of two sampled residents (Resident 58). This deficient practice had the potential to result in delayed provision of necessary care, treatment and services. Cross Reference F656 Findings: A review of Resident 58's Admission Record indicated resident was admitted to the facility on [DATE] with diagnosis including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain), hypertension (HTN - elevated blood pressure), history of falling and muscle weakness. A review of Resident 58's Minimum Data Set (MDS - a comprehensive assessment and care screening tool), dated 4/21/2024, indicated Resident 58's cognitive skills for daily decision-making were moderately impaired and required moderate to maximal assistance from staff for activities of daily livings (ADLs- toileting hygiene, shower/bathing self, upper and lower body dressing, repositioning from sit to lying and sit to stand). During an interview with Resident 58 on 5/25/2024 at 11:28 a.m., Resident 58 stated, she has multiple of vitamins and medications that nurses bring in every morning, but she does not like taking them. Resident 58 stated, she likes to take the medications with food or after eating so she would ask the nurses to put it on an empty bottle of medication. Resident 58 stated, nurses does not inform her of what the risks of not taking the medications. During a review of Resident 58's Medication Administration Record (MAR) for the month of May 2024, the MAR indicated the following: i. amlodipine (can treat high blood pressure and chest pain) oral tablet 5 milligram (mg - unit of measurement) - give 1 tablet by mouth one time a day for HTN. ii. arginaid oral packet (nutritional supplements) - give 1 packet by mouth one time a day for wound healing. iii. atorvastatin calcium (medication use to lower cholesterol and triglycerides [fats] levels) oral tablet 20 mg - give 1 tablet by mouth in the evening. iv. docusate sodium (prevents and treats occasional constipation) oral tablet 100 mg - give 1 tablet by mouth one time a day for bowel management. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	v. Enoxaparin sodium (used to prevent deep venous thrombosis, [a condition in which harmful blood clots] form in the blood vessels of the legs) injection prefilled syringe 40mg/0.4 millimeter (ml) - inject 40 mg subcutaneously (SQ - the injection is given in the fatty tissue, just under the skin) one time a day for blood clots. vi. Multivitamins-minerals oral tablet - give 1 tablet by mouth one time a day. vii. Zinc sulfate (supplemental for growth and for the development and health of body tissues) capsule 200 mg - give 1 capsule by mouth one time a day. viii. Pro-stat (indicated for increased protein needs) oral liquid - give 30 ml by mouth two times a day. ix. Vitamin C (used for growth and repair of tissues in parts of body) oral tablet 500 mg - give 1 tablet by mouth two times a day. Resident 58's MAR indicated, there were multiple consecutive days of refusals documented for the medications listed above. A review of Resident 58's Progress Notes as of 5/27/2024, indicated, there was no documentation that physician was notified, and if any education was provided to Resident 58 upon refusals of medications. During an interview with Director of Nursing (DON) on 5/27/2024 at 11:34 a.m., DON stated, physician should be notified for refusals of medications, it should be documented the reason of refusals and if any educations was provided to residents. A review of the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, reviewed on 1/29/2024, the P&P indicated, that medication refusal must be reported to the prescriber after (XX) number of doses are refused and there must be a documentation of prescriber notification of such. A review of the facility's P&P titled, Refusal of Treatment, reviewed on 1/29/2024, the P&P indicated that the Attending Physician will be notified of refusal of treatment in a time frame determined by the resident's condition and potential serious consequences of the refusal.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on interview and record review, the facility failed to provide a safe, comfortable, and homelike environment by failing to ensure residents' rooms were kept with comfortable sound levels maintained for two of five sampled residents (Residents 18 and 53). This deficient practice had the potential to negatively impact the resident's quality of life and placing Residents 18 and 53 an increased level of discomfort and inability to sleep during the night. Findings: 1. A review of Resident 18's Admission Record indicated that Resident 18 was admitted to the facility on [DATE] with diagnosis including monoplegia (paralysis limited to a single limb [arm/leg]) of lower leg, spinal stenosis (narrowing of the spaces within the spine, which can put pressure on the nerves that travel through the spine) and generalized muscle weakness. A review of Resident 18's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool) dated 3/27/2024, MDS indicated Resident 18 has a moderately intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and requiring moderate assistance from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). 2. A review of Resident 53's Admission Record indicated Resident 53 was admitted to the facility on [DATE] with diagnosis including diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and generalized muscle weakness. A review of Resident 53's MDS dated [DATE], indicated Resident 53 had a moderately intact cognition for daily decision-making and requiring minimal assistance from staff for ADLs. During the resident council meeting on 5/26/2024 at 12:14 p.m., both Residents 18 and 53 stated that staff were heard shouting and yelling across the hallway during the night. Both residents stated that they are unable to sleep during the night. A review of resident council minutes dated 4/4/2024, resident council minutes indicated that residents complained of needing to promote quiet time during the night to enhance quality of sleep and facilitate resident's recovery process. A review of resident council department response form dated, 4/9/2024, form indicated that nursing was made aware of the noise issues. Form also indicated no other information that issue was addressed. During an interview with the Activity Director (AD), on 5/27/2024 at 12:02 p.m., AD stated that the noise issue was addressed to the nursing department and in-service was supposed to be completed. (continued on next page)

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	055710	A. Building B. Wing	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Hollywood Healthcare & Wellness Centre, LP	855 North Fairfax Avenue Los Angeles, CA 90046

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Staff and Development (DSD), on 5/27/2024 at 4:35 p.m., DSD stated he (DSD) was made aware about the noise issue and added that he (DSD) has not done any in-services to the staff regarding the issues. DSD also stated that staff should be courteous and tone their voices down. A review of the facility's policy and procedures (P&P), titled, Resident Rooms and Environment, reviewed on 1/29/2024, P&P indicated that facility provides residents with a safe, clean, comfortable and homelike environment and facility staff will provide residents with a pleasant environment and person-centered care plan that emphasizes the resident's comfort, independence and personal needs and preferences; paying close attention to the comfortable noise levels.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055710	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024
NAME OF PROVIDER OR SUPPLIER West Hollywood Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 855 North Fairfax Avenue Los Angeles, CA 90046	

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure nine out of nine sampled residents (Residents 48, 43, 50, 178, 44, 40, 36, 277, 278 and 227) were free from physical restraint by failing to: 1. Obtain a physician's order and informed consent from residents/responsible party for the use of bilateral bed side rails according to facility's policy and procedures (P & P) titled, Bed Rails, for Residents 50, 178, 44, 40, 36, 277, and 278 2. Obtain a physician's order for the use of bilateral bed siderails for Resident 48. 3. Obtain a physician's order and informed consent from residents/responsible party for the use of the bilateral bed side rails and bed side rails assessment were accurate for Resident 43. These deficient practices had the potential to result in entrapment, injury, and residents not being treated with respect and dignity with the use of restraints. Cross Reference F656 Findings: 1a. A review of Resident 43's Admission Record indicated Resident 43 was admitted to the facility on [DATE] with diagnosis including urinary tract infection (UTI- an infection in any part of the urinary system, including the kidney, bladder or urethra), sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), and paroxysmal atrial fibrillation (afib- a sudden irregular and very rapid heart rhythm that and can lead to blood clots in the heart). A review of Resident 43's Minimum Data Set (MDS - a comprehensive assessment and care screening tool), dated 5/6/2024, indicated Resident 43's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making were mildly impaired and required moderate to maximal assistance from staff for activities of daily livings (ADLs- toileting hygiene, shower/bathing self, upper and lower body dressing, repositioning from sit to lying and sit to stand). A review of Resident 43's physician order summary report (POSR), as of 5/27/2024, POSR indicated no orders for side rails. A review of Resident 43's informed consent as of 5/27/2024 indicated, there was no informed consent signed from resident/responsible party for the use of bilateral bed siderails. A review of Resident 43's Bed Rail Assessment, dated 4/29/2024 indicated, side rails/assist bar are not indicated at this time. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 43's Care Plan (CP) as of 5/27/2024 indicated, there was no CP developed for the use of bilateral bed siderails. During a concurrent observation and interview with Resident 43 on 5/25/2024 at 12:00 p.m., Resident 43 was observed with a bilateral upper bed siderails up. Resident 43 stated, she is unable to get up on her own and needs assistance with getting out of bed and walking. Resident 43 was observed unable to move the bilateral bed siderails down on her own. During a concurrent observation of Resident 43 and interview with Director of Nursing (DON), on 5/26/2024 at 7:25 p.m., DON stated and confirmed, Resident 43 is on bilateral bed side rails. During a follow-up interview with DON, on 5/26/2024 at 11:50 a.m., DON stated, the use of bilateral bed siderails does not need a physician's order and no informed consent needed as they were not utilizing it for restraints. When asked regarding Resident 43's bed rails assessment which indicated, side rails/assist bar are not indicated at this time, DON was unable to answer. When asked if Resident 43 is able to move the siderails on her own, DON stated, no. 1b. A review of Resident 48's Admission Record indicated Resident 48 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain), acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood) and pneumonia (lung infection that inflames air sacs with fluid or pus). A review of Resident 48's MDS dated [DATE], indicated Resident 48's cognitive skills for daily decision-making were moderately impaired and required maximal to total dependence from staff for activities of daily livings (ADLs-eating, toileting hygiene, shower/bathing self, upper and lower body dressing, repositioning from sit to lying and rolling left to right). A review of Resident 48's POSR, as of 5/27/2024, POSR indicated no orders for side rails. A review of Resident 48's care plan (CP), indicated Resident 48 was at risk for fall related to gait/balance problems initiated on 4/29/2024. The CP indicated an intervention that facility will provide siderails for turning and repositioning. During a concurrent observation and interview with Resident 48 on 5/26/2024 at 11:16 a.m., Resident 48 was observed with a bilateral bed siderail up. Resident 48 stated, she is unable to get up on her own and unable to move herself up from bed to sitting position. Resident 48 was observed unable to move the bilateral bed side rails down on her own. During a concurrent observation of Resident 48 and interview with DON, on 5/26/2024 at 7:27 p.m., DON stated and confirmed, Resident 48 is on bilateral bed side rails and bed siderails does not need a physician's order because it is a nursing scope of practice. During a follow-up interview with DON on 5/27/2024 at 11:53 a.m., DON stated, the use of bilateral bed siderails does not need a physician's order and no informed consent needed as they were not utilizing it for restraints. When asked if Resident 48 is able to move the bed siderails on her own, DON stated, no. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1c. A review of Resident 50's Admission Record indicated resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including surgical aftercare following surgery on the skin, congestive heart failure (CHF- a progressive condition that affects the pumping power of the heart muscle) and paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease) A review of Resident 50's MDS dated [DATE], indicated Resident 50's cognitive skills for daily decision-making were mildly impaired and required total dependence from staff for ADLs- toileting hygiene, shower/bathing self, lower body dressing, repositioning from sit to lying and lying to sitting on side of bed. A review of Resident 50's POSR, as of 5/27/2024, POSR indicated no orders for side rails. A review of Resident 50's informed consent as of 5/27/2024 indicated, there was no informed consent signed from resident/responsible party for the use of bilateral bed siderails. A review of Resident 50's CP, indicated Resident 50 was at risk for fall related to gait/balance problems initiated on 4/26/2024. The CP indicated an intervention that facility will provide siderails for turning and repositioning. During a concurrent observation and interview with Resident 50 on 5/26/2024 at 9:25 a.m., Resident 50 stated, he is unable to get up on his own and needs assistance to get up from bed to wheelchair. Resident 50 was asked if he's able to put his bed siderails down on his own and Resident 50 stated, he cannot. During a concurrent observation of Resident 50 and interview with DON on 5/26/2024 at 7:30 p.m., DON stated and confirmed, Resident 50 is on bilateral bed side rails for mobility and bed siderails does not need a physician's order because it is a nursing scope of practice. During a follow-up interview with DON on 5/27/2024 at 11:53 a.m., DON stated, the use of bilateral bed siderails does not need a physician's order and no informed consent needed as they were not utilizing it for restraints. When asked if Resident 50 is able to move the bed siderails on her own, DON stated, no. A review of the facility's P&P titled, Bed Rails, reviewed on 1/29/2024, the P&P indicated that facility will attempt alternatives prior to the installation of bed rails, prior to installation, assess the resident's risk of entrapment with bed rails. Review the risks and benefits of bed rails with the resident or resident's representative and obtain informed consent prior to installation. The same P&P also indicated that, a bed rails is an assistive device and must be used in accordance with the following regulations: a. Only permissible if they are used to treat a Resident's medical symptoms b. Are classified as a physical restraint when bed rails are used to limit a Resident's freedom of movement (i.e., prevent the Resident from leaving the bed) c. The length of the bed rail (quarter, half, full, etc.) does not determine if the bed rail is a (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	restraint or an enabler d. Bed rails cannot be used for staff convenience or as discipline, such as prevention of falls when less restrictive methods have not been attempted or ruled out e. A detailed order by a healthcare provider (e.g., a physician, nurse practitioner) is required before any restraints can be utilized. A review of the facility's P&P titled, Informed Consent, reviewed on 1/29/2024, the P&P indicated that Informed consent is required for any medical intervention that is not emergency care or routine nursing care; When informed consent is required, the physician who orders or performs the intervention is required to obtain informed consent. 43261 1d. A review of Resident 44's Admission Record indicated Resident 44 was originally admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses including injury of head, dementia (loss of cognitive functioning-thinking, remembering, and reasoning), generalized weakness, history of falling and epilepsy (a disorder in which a nerve cell activity in the brain is disturbed causing seizure [a sudden, uncontrolled electrical disturbance in the brain]). A review of Resident 44's MDS dated [DATE], indicated Resident 44's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making was moderately impaired and requiring maximal assistance from staff for activities of daily living (ADLs- bed mobility, transfer, dressing, and toilet use). A review of Resident 44's physician order summary report (POSR), as of 5/27/2024, POSR indicated no orders for side rails. A review of Resident 44's care plan, indicated Resident 44 was at risk for fall related to gait/balance and history of falls, reviewed on 3/15/2024. Care plan also indicated interventions that facility will provide siderails for turning and repositioning. During an observation on 5/26/2024 at 10:02 a.m., Resident 44 was observed in bed with padded bilateral upper side rails up. During an interview with the LVN 3 on 5/27/2024 at 11:50 a.m., LVN 3 stated that Resident 44 needed to have padded bilateral upper side rails up when in bed for safety. LVN 3 stated that since according to the care plan that bilateral upper side rails up are supposed to be for turning and repositioning, side rails should only be used when Resident 44 was being turned and repositioned. LVN 3 also stated that she was unsure if side rails as enabler needs to have a physician order. During an interview with the DON, on 5/27/2024 at 5:23 p.m., DON stated not needing a physician order for having bilateral upper side rails up for turning and repositioning. DON also stated that as long as there was a care plan in the intervention indicating that a resident needs a side rail for turning and repositioning, resident should be okay to have the side rails up at all times when in bed. (continued on next page)

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F 0604

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

1e. A review of Resident 178's Admission Record indicated Resident 178 was originally admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses including diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), end stage renal failure (ESRD-a medical condition in which a person's kidney [organ in the body that lifters waste and excess fluid from the blood] function stop functioning on a permanent basis), hemodialysis (HD-filtering the blood of a person whose kidneys are not working normally) dependence and generalized muscle weakness.

A review of Resident 178's MDS, dated [DATE], indicated Resident 178's cognitive skills for daily decision-making was moderately impaired and requiring maximal assistance from staff for ADLs. MDS also indicated Resident 178 was on hemodialysis since admission.

A review of Resident 178's POSR, as of 5/27/2024, POSR indicated no orders for side rails.

A review of Resident 178's care plan, indicated Resident 178 has an ADL self-care performance deficit, reviewed on 5/6/2024. Care plan also indicated interventions that facility will provide siderails for repositioning.

During an observation on 5/25/2024 at 11:23 a.m., Resident 178 was observed in bed with bilateral upper side rails up.

During an observation on 5/26/2024 at 10:02 a.m., Resident 178 was observed in bed with bilateral upper side rails up.

During an observation on 5/26/2024 at 4:20 p.m., Resident 178 was observed in bed with bilateral upper side rails up.

During an interview with the LVN 3 on 5/27/2024 at 11:41 a.m., LVN 3 stated being unsure if Resident 178 needed to have bilateral upper side rails up when in bed. LVN 3 stated that since according to the care plan that bilateral upper side rails up are supposed to be used for turning and repositioning, side rails should only be used when Resident 178 was being turned and repositioned. LVN 3 also stated that she was unsure if side rails as enabler needs to have a physician order.

During an interview with the DON, on 5/27/2024 at 5:23 p.m., DON stated not needing a physician order for having bilateral upper side rails up for turning and repositioning. DON also stated that as long as there was a care plan in the intervention indicating that a resident needs a side rail for turning and repositioning, resident should be okay to have the side rails up at all times when in bed.

A review of facility's P&P, titled, Restraints, reviewed on 1/29/2024, P&P indicated that facility will honor resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. P&P also indicated that restraints require a physician orders.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1g. A review of Resident 36's Admission Record, dated 5/28/2024, indicated Resident 36 was originally admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses including DM, major depressive disorder (depressed mood or loss of interest in activities, causing significant impairment in daily life), abnormal posture, and generalize muscle weakness. A review of Resident 36's MDS, dated [DATE], indicated Resident 36's had moderate cognitive impairment, and required substantial/maximal assistance from staff for toileting, bathing, dressing, personal hygiene and bed mobility. A review of Resident 36's POSR, as of 5/28/2024, POSR indicated no orders or consent for side rails. During an observation on 5/25/2024 at 12:48 p.m., Resident 36 was observed in bed with bilateral upper side rails up. During an observation on 5/26/2024 at 9:48 a.m., Resident 36 was observed in bed with bilateral upper side rails up. During an observation on 5/27/2024 at 11:01 a.m., Resident 36 was observed in bed with bilateral upper side rails up. 1h. A review of Resident 40's Admission Record, dated 5/28/2024, indicated Resident 40 was originally admitted to the facility on [DATE], with diagnoses including, depressive disorder (depressed mood or loss of interest in activities, causing significant impairment in daily life), heart failure (a medical condition where the heart muscle doesn't pump blood as well as it should), hypertension (high blood pressure) and chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breath). A review of Resident 40's MDS, dated [DATE], indicated Resident 40's had mild cognitive impairment, and required moderate to maximal assistance from staff for toileting, bathing, dressing, personal hygiene, and bed mobility. A review of Resident 40's POSR, as of 5/28/2024, POSR indicated no orders or consent for side rails. During an observation on 5/25/2024 at 12:56 p.m., Resident 40 was observed in bed with bilateral upper side rails up. During an observation on 5/26/2024 at 9:49 a.m., Resident 40 was observed in bed with bilateral upper side rails up. During an observation on 5/27/2024 at 3:00 p.m., Resident 40 was observed in bed with bilateral upper side rails up. 1i. A review of Resident 277's Admission Record indicated Resident 277 was originally admitted to the facility on [DATE], with diagnoses including hypertensive (high blood pressure) heart disease with heart failure (disease when heart doesn't pump enough blood for your body's needs), muscle weakness, difficulty walking and anemia (not enough oxygen carrying red blood cells in the blood). (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 277's MDS, dated [DATE], indicated Resident 277 had mild cognitive impairment and required supervision or touching assistance from staff for eating, oral hygiene, and upper body dressing, and moderate and maximum assistance from staff for toileting, bathing, lower body dressing and personal hygiene. A review of Resident 277's POSR, as of 5/28/2024, POSR indicated no orders or consent for side rails. During an observation on 5/25/2024 at 11:06 a.m., Resident 277 was observed in bed with bilateral upper side rails up. During an observation on 5/26/2024 at 10:00 a.m., Resident 277 was observed in bed with bilateral upper side rails up. During an observation on 5/27/2024 at 11:05 a.m., Resident 277 was observed in bed with bilateral upper side rails up. 1j. A review of Resident 278's Admission Record indicated Resident 278 was originally admitted to the facility on [DATE], with diagnoses including diabetes mellitus, muscle weakness, discitis (inflammation of the intervertebral [area between bones of the spine] disc space) lumbar (lower back) region, and malignant neoplasm (cancerous tumor) of the breast. A review of Resident 278's MDS, dated [DATE], indicated Resident 278 had moderate cognitive impairment and required supervision or touching assistance from staff for toileting, bathing, dressing and personal hygiene. A review of Resident 278's POSR, as of 5/28/2024, POSR indicated no orders or consent for side rails. During an observation on 5/25/2024 at 5:28 p.m., Resident 278 was observed in bed with bilateral upper side rails up. During an observation on 5/26/2024 at 9:42 a.m., Resident 278 was observed in bed with bilateral upper side rails up. During an observation on 5/27/2024 at 11:05 a.m., Resident 278 was observed in bed with bilateral upper side rails up.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on observations, interview, and record review the facility failed to identify and notify the Medical Director (MD) about a change in condition for Resident 62's noncompliance of not using a humidifier (are devices that add moisture to the air to prevent dryness that can cause irritation in many parts of the body) for his oxygen. This deficient practice had the potential to place Resident 62 at a risk of having dry mucus membranes mucus membranes which could lead to break in skin resulting in bacteria entering through the broken skin. Findings: A review of Resident 62 admission record indicated the resident was initially admitted to the facility on [DATE] with diagnoses that included hemiplegia (loss of strength in the arm, leg, and sometimes the face on one side of the body) and hemiparesis (loss of use in the arm, leg, and sometimes the face on one side of the body) following cerebral infarction (stroke), diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), and dependence on renal dialysis (a treatment for people whose kidneys are failing. When you have kidney failure, your kidneys don't filter blood the way they should. As a result, wastes and toxins build up in your bloodstream. Dialysis does the work of your kidneys, removing waste products and excess fluid from the blood). A review of Resident 62's Minimum Data Set (MDS- standardized data collection tool used to assess cognitive and functional status, and care needs) dated 4/5/24, indicated the Resident 62 was moderately impaired (a slight decline in cognitive function, such as memory, language, and thinking) and required between supervision or touching assistance to setup or clean-up assistance for Activities of Daily Living (ADL- Eating, oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing). During a concurrent observation and interview with Resident 62 on 5/25/2024 at 11: 30 am., Resident 62 was observed lying down on his bed with the oxygen concentrator (a medical device that separates nitrogen from the air around you so you can breathe up to 95% pure oxygen) completely turned off and the humidifier. Resident 62 stated that he had turned off the oxygen because it was causing his nose to feel dry and that the nursing staff were all aware. Resident 62 stated that he especially did not like the white container with water. Resident 62 admitted that he did not know much about it because he was not offered any education on the importance of keeping the humidifier on. During an interview with the Infection Preventionist Nurse 2 (IPN 2), on 5/26/24 10 am, IPN 2 stated that she had noted that Resident 62 was not using the humidifier this morning and a Change of Condition (COC) was completed. IPN 2 admitted that the other nursing staff working directly with Resident 62 should have reported the change sooner for timely treatment. IPN 2 stated that the oxygen Resident 62 could be drying to the mucous membranes to his nose which may cause cracking of the skin. The cracked skin may serve as a portal for infection. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Policy and Procedure titled Change of Condition Notification, revised 1/29/2024 indicated, To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. The same P&P indicated the following: I. The Facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident's legal representative or an interested family member, if known, when the resident endures a significant change in their condition caused by, but not limited to: A. An accident; B. A significant change in the resident's physical, mental or psychosocial status; and/or C. A significant change in treatment. II. Change of Condition related to Attending Physician notification is defined as when the Attending Physician must be notified when any sudden and marked adverse change in the resident's condition which is manifested by signs and symptoms different than usual denote a new problem, complication or permanent change in status and require a medical assessment, coordination and consultation with the Attending Physician and a change in the treatment plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055710	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024
NAME OF PROVIDER OR SUPPLIER West Hollywood Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 855 North Fairfax Avenue Los Angeles, CA 90046	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on observation, interview and record review, the facility failed to develop and implement individualized (resident-specific) comprehensive care plans (plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) for 12 out of 12 sampled residents (Residents 36, 40, 227, 277, 278, 48, 43, 50, 3, 178, 330 and 44) by: 1. Failing to develop and implement care plans for bilateral upper bed side rails as mobility enabler (assist in turning and transferring in and out of bed) for residents 36, 40, 277, and 278. 2. Failing to develop and implement a care plan for Resident 277's Venofer (iron sucrose - an IV iron medication) intravenous (IV, medical technique that administers fluids, medications, and nutrients directly into a person's vein) solution 100 milligrams (mg) intravenously in the evening for iron deficiency. 3. Failing to implement a care plan for transmission-based precautions (a set of infection control measures used in addition to standard precautions for patients who may be infected with pathogens that can transmit disease) for Resident 178. 4. Failing to implement care plans for side rails for turning and repositioning for Residents 48, 50, 44 and 178. Residents 48, 50, 44 and 178 required the bilateral (both sides) upper bed side rails to be in the up position when in bed. 5. Failing to develop and implement a comprehensive care plan for the Resident 48's Desitin cream (used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations [such as diaper rash, skin burns from radiation therapy]) inside the resident's bedside drawer and [NAME] tears eyedrops (used to help relieve dryness of the eyes) left on top of the bedside table by facility staff. 6. Failing to develop and implement a comprehensive care plan for the use of oxygen supplement therapy for Resident 3 and Resident 10. 7. Failing to develop and implement a care plan for the use of bilateral bed side rails for Resident 43. 8. Failing to develop and implement a care plan for Contact Precautions (intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment) for Resident 330. The deficient practices placed Residents 36, 40, 277, 278, 43, 48, 50, 3, 178, 330, and 44 at risk for missed care and treatment, worsening of current medical conditions, infections, organ failure, and death. Findings: (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

1. A review of Resident 36's Admission Record, dated 5/28/2024, indicated Resident 36 was originally admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses including diabetes (a disease in which your body does not produce enough insulin needed to control sugar levels in the blood), major depressive disorder (depressed mood or loss of interest in activities, causing significant impairment in daily life), abnormal posture, and generalize muscle weakness.

A review of Resident 36's Minimum Data Set (MDS- standardized data collection tool used to assess cognitive brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions] and functional status, and care needs) dated 3/25/2024, indicated Resident 36's had moderate cognitive (ability to think, read, learn, remember, reason, express thoughts, and make decisions) impairment, and required substantial/maximal assistance from staff for toileting, bathing, dressing, personal hygiene and bed mobility.

A review of Resident 36's physician order summary report (POSR) as of 5/28/2024, indicated there were no orders for side rails.

A review of Resident 36's care plans indicated Resident 36 had no care plan for side rails to be utilized as enablers for mobility.

During an observation on 5/25/2024 at 12:48 p.m., Resident 36 was observed in bed with bilateral upper side rails up.

During an observation on 5/26/2024 at 9:48 a.m., Resident 36 was observed in bed with bilateral upper side rails up.

During an observation on 5/27/2024 at 11:01 a.m., Resident 36 was observed in bed with bilateral upper side rails up.

A review of Resident 40's Admission Record, dated 5/28/2024, indicated Resident 40 was originally admitted to the facility on [DATE], with diagnoses including, depressive disorder, heart failure (a medical condition where the heart muscle doesn't pump blood as well as it should), hypertension (high blood pressure) and chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breath).

A review of Resident 40's MDS, dated [DATE], indicated Resident 40's had mild cognitive impairment, and required moderate to maximal assistance from staff for toileting, bathing, dressing, personal hygiene, and bed mobility.

A review of Resident 40's POSR as of 5/28/2024, indicated there were no orders for side rails.

A review of Resident 40's care plans indicated Resident 40 had no care plan for side rails to be utilized as enablers for mobility.

During an observation on 5/25/2024 at 12:56 p.m., Resident 40 was observed in bed with bilateral upper side rails up.

During an observation on 5/26/2024 at 9:49 a.m., Resident 40 was observed in bed with bilateral upper side rails up.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/27/2024 at 3:00 p.m., Resident 40 was observed in bed with bilateral upper side rails up. A review of Resident 277's Admission Record indicated Resident 277 was originally admitted to the facility on [DATE], with diagnoses including hypertensive (high blood pressure) heart disease with heart failure (disease when heart doesn't pump enough blood for your body's needs), muscle weakness, difficulty walking and anemia (not enough oxygen carrying red blood cells in the blood). A review of Resident 277's MDS, dated [DATE], indicated Resident 277 had mild cognitive impairment and required supervision or touching assistance from staff for eating, oral hygiene, and upper body dressing, and moderate and maximum assistance from staff for toileting, bathing, lower body dressing and personal hygiene. A review of Resident 277's POSR as of 5/28/2024, indicated there were no orders for side rails. A review of Resident 277's care plans, indicated Resident 277 had no care plan for side rails to be utilized as enablers for mobility. During an observation on 5/25/2024 at 11:06 a.m., Resident 277 was observed in bed with bilateral upper side rails up. During an observation on 5/26/2024 at 10:00 a.m., Resident 277 was observed in bed with bilateral upper side rails up. During an observation on 5/27/2024 at 11:05 a.m., Resident 277 was observed in bed with bilateral upper side rails up. A review of Resident 278's Admission Record indicated Resident 278 was originally admitted to the facility on [DATE], with diagnoses including diabetes mellitus, muscle weakness, discitis (inflammation of the intervertebral [area between bones of the spine] disc space) lumbar (lower back) region, and malignant neoplasm (cancerous tumor) of the breast. A review of Resident 278's MDS, dated [DATE], indicated Resident 278 had moderate cognitive impairment and required supervision or touching assistance from staff for toileting, bathing, dressing and personal hygiene. A review of Resident 278's POSR as of 5/28/2024, indicated there were no orders for side rails. A review of Resident 278's care plans, indicated Resident 278 had no care plan for side rails to be utilized as enablers for mobility. During an observation on 5/25/2024 at 5:28 p.m., Resident 278 was observed in bed with bilateral upper side rails up. During an observation on 5/26/2024 at 9:42 a.m., Resident 278 was observed in bed with bilateral upper side rails up. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/27/2024 at 11:05 a.m., Resident 278 was observed in bed with bilateral upper side rails up. 2. A review of Resident 277's Admission Record indicated Resident 277 was originally admitted to the facility on [DATE], with diagnoses including hypertensive, heart disease with heart failure muscle weakness, difficulty walking and anemia. A review of Resident 277's MDS, dated [DATE], indicated Resident 277 had mild cognitive impairment and required supervision or touching assistance from staff for eating, oral hygiene, and upper body dressing, and moderate and maximum assistance from staff for toileting, bathing, lower body dressing and personal hygiene. A review of Resident 277's prescription order sheet dated 5/21/2024, indicated an order for Venofer intravenous solution (iron sucrose - an IV iron medication) 100 milligrams (mg) intravenously in the evening for iron deficiency. A record review of Resident 277's care plans, indicated no care plan created for the resident's Venofer IV therapy. During an observation on 5/26/24 at 10:00 a.m., Registered Nurse 1 (RN 1) was observed caring or Resident 277's IV access. During an interview on 5/28/2024 at 2:11 p.m., with the Infection Prevention Nurse 1 (IPN 1), IPN 1 confirmed by stating Resident 277 did not have a care plan for IV therapy and stated there should have been a care plan for a resident on IV therapy. 43261 3. A review of Resident 178's Admission Record indicated Resident 178 was originally admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses including diabetes mellitus, end stage renal failure (ESRD-a medical condition in which a person's kidney [organ in the body that lifters waste and excess fluid from the blood] function stop functioning on a permanent basis), hemodialysis (HD-filtering the blood of a person whose kidneys are not working normally) dependence and generalized muscle weakness. A review of Resident 178's MDS dated [DATE], indicated Resident 178's cognitive skills for daily decision-making was moderately impaired and the resident required maximal assistance from staff for activities of daily living (ADLs- bed mobility, transfer, dressing, and toilet use). The MDS also indicated Resident 178 was on hemodialysis since admission. A review of Resident 178's POSR as of 5/28/2024, indicated there were no orders for enhanced standard precaution. A review of Resident 178's care plan created on 5/25/2024, indicted Resident 178 was at risk for MDRO (multi drug resistant organism-bacteria that have become resistant to certain antibiotic medications). The care plan indicated interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) included to initiate enhance standard precautions and educate staff regarding the use and purpose of the precaution. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of Resident 178's room on 5/25/2024 at 12:49 p.m., Resident 178's signage was observed indicating Resident 178 did not need to be on transmission-based precautions. During an observation on 5/26/2024 at 10:04 a.m., Certified Nursing Assistant 4 (CNA 4) was observed not wearing any personal protective equipment (PPE) while providing Resident 178's care. CNA 4 stated Resident 178 was not on transmission-based precautions; therefore CNA 4 did not need any PPE. During an observation of Resident 178's room door and interview on 5/27/2024 at 11:41 a.m., Licensed Vocational Nurse 3 (LVN3) observed the signage on the front door of Resident 178's room indicating the resident did not need to be on enhanced standard precaution. LVN 3 stated and verified that Resident 178 was supposed to be in enhanced standard precaution since re-admission (5/21/2024). During an interview on 5/27/2024 at 4:56 p.m., IPN 1 confirmed by stating Resident 178 was supposed to be on enhanced standard precautions since re-admission (5/21/2024). IPN 1 stated the signage was not updated and that Resident 178 was at risk for infection if staff was not wearing proper PPE when caring for the resident. 4. A review of Resident 44's Admission Record indicated Resident 44 was originally admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses including injury of head, dementia (loss of cognitive functioning-thinking, remembering, and reasoning), generalized weakness, history of falling and epilepsy (a disorder in which a nerve cell activity in the brain is disturbed causing seizure [a sudden, uncontrolled electrical disturbance in the brain]). A review of Resident 44's MDS dated [DATE], indicated Resident 44's cognitive skills for daily decision-making were moderately impaired, requiring maximal assistance from staff for activities of daily living (ADLs- bed mobility, transfer, dressing, and toilet use). A review of Resident 44's POSR as of 5/27/2024, indicated there were no orders for side rails. A review of Resident 44's care plan reviewed on 3/15/2024, indicated Resident 44 was at risk for falls related to gait/balance and history of falls. The care plan indicated interventions included the facility was to provide siderails for turning and repositioning. During an observation in Resident 44's room on 5/26/2024 at 10:02 a.m., Resident 44 was observed in bed with padded bilateral upper side rails in the up position. During an interview on 5/27/2024 at 11:50 a.m., LVN 3 stated Resident 44 needed to have padded bilateral upper side rails in the up position when in bed for safety. LVN 3 stated according to the care plan bilateral upper side rails were supposed to be in the up position for turning and repositioning. LVN 3 stated the side rails were to only be used when Resident 44 was being turned and repositioned. LVN 3 stated she was unsure if using side rails as enabler required a physician order. A review of Resident 178's Admission Record indicated Resident 178 was originally admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses including DM, ESRD, HD dependence and generalized muscle weakness. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 178's MDS dated [DATE], indicated Resident 178's cognitive skills for daily decision-making were moderately impaired and the resident required maximal assistance from staff for ADLs. The MDS also indicated Resident 178 was on hemodialysis since admission. A review of Resident 178's POSR, as of 5/27/2024, indicated there were no orders for side rails. A review of Resident 178's care plan reviewed on 5/6/2024, indicated Resident 178 had an ADL self-care performance deficit. The care plan indicated interventions included the facility was to provide siderails for turning and repositioning. During an observation of Resident 178's room on 5/25/2024 at 11:23 a.m., Resident 178 was observed in bed with bilateral upper side rails in the up position. During an observation of Resident 178's room on 5/26/2024 at 10:02 a.m., Resident 178 was observed in bed with bilateral upper side rails in the up position. During an observation Resident 178's room on 5/26/2024 at 4:20 p.m., Resident 178 was observed in bed with bilateral upper side rails in the up position. During an interview on 5/27/2024 at 11:41 a.m., LVN 3 stated she was unsure if Resident 178 needed to have bilateral upper side rails in the up position when in bed. LVN 3 stated according to the resident's care plan the bilateral upper side rails were supposed to be used for turning and repositioning. LVN 3 stated side rails were to be used only when Resident 178 was being turned and repositioned. LVN 3 stated she was unsure if using side rails as enabler required a physician order. During an interview on 5/27/2024 at 5:23 p.m., the Director of Nursing (DON) stated a physician order was not needed for bilateral upper side rails for turning and repositioning. The DON stated if there was an intervention in the care plan indicating a resident needed a side rail for turning and repositioning it was okay to always have the side rails up when in bed. A review of facility's policy and procedure (P&P), titled, Comprehensive Person-Centered Care Planning reviewed on 1/29/2024, indicated all care plans will be developed and implemented, using the necessary combination of problem specific care plans since resident's admission to properly care for the resident. 43454 4. A review of Resident 48's Admission Record indicated resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain), acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood) and pneumonia (lung infection that inflames air sacs with fluid or pus). A review of Resident 48's MDS dated [DATE], indicated the resident's cognitive skills for daily decision-making were moderately impaired and the resident required maximal to total assistance from staff for eating, toileting hygiene, shower/bathing self, upper and lower body dressing, repositioning from sit to lying and rolling left to right. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 48's POSR as of 5/27/2024, indicated there were no orders for side rails. A review of Resident 48's care plan initiated on 4/29/2024, indicated the resident was at risk for falls related to gait/balance problems. The care plan indicated interventions included the facility was to provide siderails for turning and repositioning. During a concurrent observation in Resident 48's room and interview on 5/26/2024 at 11:16 a.m., Resident 48 was observed with a bilateral bed siderail in the up position. Resident 48 stated she was unable to get up independently and unable to move independently from bed to a sitting position. Resident 48 was observed unable to move the bilateral bed side rails from the up to down position. During a concurrent observation of Resident 48 and interview on 5/26/2024 at 7:27 p.m., the DON stated and confirmed Resident 48 had bilateral bed side rails in the up position and the bed siderails did not need a physician's order because the side rails were in the nursing scope of practice. During a follow-up interview on 5/27/2024 at 11:53 a.m., the DON stated the use of bilateral bed siderails did not need a physician's order or informed consent (the process of providing people with information so they can make their own decisions about accepting or refusing treatment or services) since the facility was not utilizing the bed rails as restraints (devices used to limit or obstruct independent movement in and out of bed). When asked if Resident 48 was able to move the bed siderails on independently the DON stated, no. The DON stated that if there was a care plan with an intervention indicating a resident needed side rails for turning and repositioning it was okay to always have the side rails in the up position when in bed. A review of Resident 50's Admission Record indicated resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including surgical aftercare following surgery on the skin, congestive heart failure (CHF- a progressive condition that affects the pumping power of the heart muscle) and paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease). A review of Resident 50's MDS dated [DATE], indicated the resident's cognitive skills for daily decision-making were mildly impaired and the was resident was totally dependent on staff for toileting hygiene, shower/bathing self, lower body dressing, repositioning from sit to lying, and lying to sitting on side of bed. A review of Resident 50's POSR, as of 5/27/2024, indicated there were no orders for side rails. A review of Resident 50's informed consents as of 5/27/2024 indicated, there was no informed consent signed by the resident or the resident's responsible party for the use of bilateral bed siderails. A review of Resident 50's care plan initiated on 4/26/2024, indicated Resident 50 was at risk for falls related to gait/balance problems. The care plan indicated interventions included the facility was to provide siderails for turning and repositioning. During a concurrent observation of Resident 50's room and interview on 5/26/2024 at 9:25 a.m., Resident 50 stated he was unable to get up independently and needed assistance to get up from bed to wheelchair. Resident 50 was asked if he was able to put the side rails in the down position independently and Resident 50 stated he could not. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation of Resident 50 on 5/26/2024 at 7:30 p.m., the DON stated and confirmed Resident 48 had bilateral bed side rails in the up position and the bed siderails did not need a physician's order because the side rails were in the nursing scope of practice. During a follow-up interview with DON on 5/27/2024 at 11:53 a.m., the DON stated the use of bilateral bed siderails did not need a physician's order or informed consent (the process of providing people with information so they can make their own decisions about accepting or refusing treatment or services) since the facility was not utilizing the bed rails as restraints (devices used to limit or obstruct independent movement in and out of bed). When asked if Resident 50 was able to move the bed siderails on independently the DON stated, no. The DON stated that if there was a care plan with an intervention indicating a resident needed side rails for turning and repositioning it was okay to always have the side rails in the up position when in bed. 5. A review of Resident 48's Admission Record indicated resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy, acute respiratory failure, acute kidney failure and pneumonia. A review of the MDS dated [DATE], indicated Resident 48's cognitive skills for daily decision-making were moderately impaired and the resident was totally dependent on staff for eating, toileting hygiene, shower/bathing self, upper and lower body dressing, and personal hygiene. A review of Resident 48's Self-Administration of Medication form dated 4/14/2024, indicated Resident 48 was not approved for self-administration of medications and the resident was not allowed to keep medications at bedside. A review of Resident 48's care plans as of 5/27/2024, indicated there was no care plan in place for medications to be left at bedside. During a concurrent observation of Resident 48's room and interview on 5/26/2024 at 11:16 a.m., Resident 48 was observed with an opened Desitin cream inside the resident's bedside drawer and [NAME] tears eyedrops on top of the bedside table. Resident 48 stated the Desitin cream was brought in from the hospital and the eyedrops was from the facility and facility staff left the eyedrops on the bedside. During a concurrent observation of Resident 48's room and interview on 5/26/2024 at 7:45 p.m., the DON observed Resident 48's Desitin cream and [NAME] tears eyedrops at bedside. The DON stated and confirmed that Resident 48 was not allowed to keep medications at bedside. The DON stated she (DON) would have to store the medications in the facility's locked cabinet. The DON stated the medications left at the bedside put Resident 48 at risk of accidents due to not being able to properly administer the medications and put other residents at risk of accidents by allowing other residents to access medications that were not prescribed for them. The DON stated and confirmed there was no care plan developed for Resident 48's medication to be left at the bedside. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. A review of Resident 3's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (loss of the ability to move in one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting right dominant side, Parkinson's disease (a disorder in the brain that affects movement, often including tremors), Alzheimer's disease (a progressing brain disorder that destroys memory and other important mental function), hypertension, and hyperlipidemia (abnormally high levels of fats in the blood) A review of the MDS dated [DATE], indicated Resident 3's cognitive skills for daily decision-making were moderately impaired and the resident was totally dependent on staff for eating, toileting hygiene, repositioning from sit to stand, bed to chair transfer. A review of Resident 3's Physician's History and Physical (H&P), dated 3/19/2024, indicated Resident 3 was unable to be fully assessed by the physician and did not follow commands. A review of Resident 3's POSR dated 1/17/2024, indicated a physician order was in place for oxygen at 2 liters per minute (l/min - unit of measurement) via nasal cannula (NC - a device used to deliver supplemental oxygen that should be placed directly on the resident's nostrils) to keep oxygen saturation (O2 sat) above 93 percent (% - unit of measurement) every shift for shortness of breath (SOB)/desaturation (the condition of a low blood oxygen concentration). A review of Resident 3's care plan for altered cardiovascular (pertaining to the heart and blood vessels that make up the circulatory system) status related to (r/t) HTN, hyperlipidemia, revised on 5/2/2024, indicated a goal for the resident to be free from complications of cardiac problems. The care plan indicated on 5/25/2024 and intervention to provide O2 via N/C per order was not added until 5/25/2024. A review of Resident 3's vital sign (VS - measurements of the body's most basic functions) dated 5/26/2024 at 8:16 a.m., indicated that Resident 3's O2 sat was 92%. During an observation of Resident 3 on 5/25/2024 at 11:03 a.m., Resident 3 was observed in bed, eyes closed, and no oxygen machine or NC were observed in the room. During a follow-up observation with Resident 3 on 5/26/2024 at 11:52 a.m., Resident 3 was observed in bed, and no oxygen machine or NC were observed in the room. During a concurrent interview and record review of Resident 3's Order Summary on 5/27/2024 at 12:23 p.m., the Minimum Data Set Nurse 1 (MDSN1) stated confirmed Resident 3 had a physician's order for O2 supplement and stated the physician's order had to be followed. During an interview on 5/27/2024 at 12:31 p.m., the DON confirmed by stating there was no oxygen machine set-up for Resident 3. The DON stated the facility was not implementing Resident 3's care plan regarding oxygen therapy. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER West Hollywood Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 855 North Fairfax Avenue Los Angeles, CA 90046	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 10's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute respiratory failure with hypoxia (low levels of oxygen in the body tissues), heart failure and toxic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood). A review of the MDS dated [DATE], indicated Resident 10's cognitive skills for daily decision-making were severely impaired and the resident was totally dependent on staff for oral hygiene, toileting hygiene, shower/bathing, upper and lower body dressing, and personal hygiene. A review of Resident 10's POSR dated 8/18/2023, indicated physician's order was in place for oxygen at 2l/min via NC to keep O2 sat above 93 percent every shift for SOB every shift. A review of Resident 10's CP for altered respiratory status/difficulty breathing r/t acute hypoxic respiratory failure revised on 5/8/2024, indicated a goal for the resident to be free from complications r/t SOB, with interventions including to provide oxygen as ordered. During an observation of Resident 10 on 5/25/2024 at 11:56 a.m., Resident 10 was observed on O2 supplement via NC. Resident 10's oxygen machine was observed at 1.5 l/min (not the ordered 2l/min). During an interview on 5/27/2024 at 12:35 p.m., the DON stated physician's orders for O2 supplement had to be followed. The DON stated she (DON) would check Resident 10's O2 supplement machine and would call physician to update the order. During a follow-up interview on 5/27/2024 at 5:51 p.m., the DON confirmed by stating Resident 10's O2 machine was less than 2 l/min which was not what was indicated on the physician's order or care plan. A review of the facility's policy and procedures (P&P) titled, Oxygen Therapy, reviewed on 1/29/2024, indicated to administer oxygen per physician's orders. 7. A review of Resident 43's Admission Record indicated resident was admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI- an infection in any part of the urinary system, including the kidney, bladder or urethra), sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), and paroxysmal atrial fibrillation (afib- a sudden irregular and very rapid heart rhythm that and can lead to blood clots in the heart). A review of Resident 43's MDS dated [DATE], indicated the resident's cognitive skills for daily decision-making were mildly impaired and the resident required moderate to maximal assistance from staff for toileting hygiene, shower/bathing self, upper and lower body dressing, repositioning from sit to lying, and sit to stand. A review of Resident 43's POSR as of 5/27/2024, indicated there were no orders for side rails. A review of Resident 43's informed consents as of 5/27/2024 indicated, there was no informed consent signed by the resident or the resident's responsible party for the use of bilateral bed siderails. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 43's Bed Rail assessment dated [DATE], indicated the use of side rails or assist bars were not indicated. A review of Resident 43's care plans as of 5/27/2024 indicated, there was no care plan developed or implemented for the use of bilateral bed siderails. During a concurrent observation of Resident 43 on 5/25/2024 at 12:00 p.m., Resident 43 was observed with bilateral upper bed siderails in the up position. Resident 43 stated she was unable to get up independently and needed assistance from staff to get out of bed and with walking. Resident 43 was observed unable to move the bilateral bed siderails down independently. During a concurrent observation of Resident 43 and interview on 5/26/2024 at 7:25 p.m., the DON confirmed by stating Resident 43 had bilateral side rails in the up position. During a follow-up interview on 5/26/2024 at 11:50 a.m., the DON stated the use of bilateral bed siderails did not need a physician's order and an informed consent was not needed as the side rails were not utilized as restraints. When asked regarding Resident 43's bed rails assessment which indicated side rails/assist bar are not indicated at this time, the DON was unable to answer. When asked if Resident 43 was able to move the siderails independently, the DON stated, no. The DON stated if there was a care plan with an intervention indicating that a resident needed a side rail for turning and repositioning, it was okay to always have the side rails up when the resident was in bed. 45524 8. A review of Resident 330's Admission Record indicated Resident 330 was originally admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses including toxic encephalopathy, anemia, and chronic kidney disease stage 3 (kidneys have mild to moderate damage, and they are less able to filter waste and fluid out of the blood). A review of Resident 330's MDS dated [DATE], indicated Resident 330's cognitive skills for daily decision-making were severely impaired and the resident required supervision or touching assistance to partial/moderate assistance for ADLs. During a co

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to provide an environment free from risks and hazards for one of six sampled residents, (Resident 48) by failing to ensure Resident 48's Desitin cream (used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations [such as diaper rash, skin burns from radiation therapy]) inside the resident's bedside drawer and [NAME] tears eyedrops (used to help relieve dryness of the eyes) were not left on top of the resident's bedside table by facility staff without a proper physician's order and per facility's policy and procedures (P&P) titled Self-Administration of Medications with a review date of 1/29/2024. This deficient practice increased the risk for accidents, under or overdosing, medication diversion (medication used for a purpose or on a person not prescribed for), and jeopardized residents' health and safety. Cross Reference F656 Findings: A review of Resident 48's Admission Record indicated resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain), acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood) and pneumonia (lung infection that inflames air sacs with fluid or pus). A review of the Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 4/10/2024, indicated Resident 48's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making were moderately impaired and the resident required maximal to total assistance from staff for eating, toileting hygiene, shower/bathing self, upper and lower body dressing, repositioning from sit to lying and rolling left to right. A review of Resident 48's Self-Administration of Medication form dated 4/14/2024, indicated Resident 48 was not approved for self-administration of medications and the resident was not allowed to keep medications at bedside. During a concurrent observation of Resident 48's room and interview on 5/26/2024 at 11:16 a.m., Resident 48 was observed with an opened Desitin cream inside the resident's bedside drawer and [NAME] tears eyedrops on top of the bedside table. Resident 48 stated the Desitin cream was brought in from the hospital and the eyedrops was from the facility and facility staff left the eyedrops on the bedside. (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 of Resident 48's room and interview on 5/26/2024 at 7:45 p.m., the DON observed Resident 48's Desitin cream and [NAME] tears eyedrops at bedside. The DON stated and confirmed that Resident 48 was not allowed to keep medications at bedside. The DON stated she (DON) would have to store the medications in the facility's locked cabinet. The DON stated the medications left at the bedside put Resident 48 at risk of accidents due to not being able to properly administer the medications and put other residents at risk of accidents by allowing other residents to access medications that were not prescribed for them. A review of the facility's P&P titled, Self-Administration of Medications, reviewed on 1/29/2024, indicated bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer. When the interdisciplinary team determines that bedside or in-room storage of medications would be a safety risk to other residents, the medications of residents permitted to self-administer are stored in the central medication cart or medication room. A review of the facility's P&P titled, Storage of Medications, reviewed on 1/29/2024, the P&P indicated, that medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on observation, interview and record review, the facility failed to provide intravenous (IV, insertion of a cannula or catheter into a vein to provide access to the bloodstream) access care consistent with professional standards of practice and as per facility policy and procedures (P&P) titled Central Venous Catheter Dressing Changes dated May 2022, for two of two sampled residents (Residents 277 and Resident 278). By failing to ensure: 1. A care plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) was developed and implemented for Resident 277's IV therapy. 2. Resident 278's peripherally inserted central catheter (PICC, a thin, soft tube inserted into a vein in the arm, leg, or neck for long-term intravenous antibiotics) was labeled with date and time the dressing was changed and the initials of the staff member changing the dressing. 3. Registered nurse 1 (RN 1) wore the required personal protective equipment (PPE, protective clothing for the eyes, head, ears, hands, respiratory system, body, and feet used to protect employee and resident against infectious materials) when providing the resident PICC line care. These failures had the potential to result improper treatment and care for Resident 277's IV therapy placed the resident at risk for sepsis (a life-threatening medical emergency that occurs when the body's immune system has an extreme response to an infection. Can also be called septicemia, which is the medical term for blood poisoning caused by bacteria, viruses, or fungi) which could result in organ failure and death. Cross reference F656 and F880. Findings: 1. A review of Resident 277's Admission Record indicated Resident 277 was originally admitted to the facility on [DATE], with diagnoses including hypertensive (high blood pressure) heart disease with heart failure (disease when heart doesn't pump enough blood for your body's needs), muscle weakness, difficulty walking and anemia (not enough oxygen carrying red blood cells in the blood). A review of Resident 277's Minimum Data Set (MDS- standardized data collection tool used to assess cognitive brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions] and functional status, and care needs), dated 5/9/2024, indicated Resident 277 had mild cognitive (ability to think, read, learn, remember, reason, express thoughts, and make decisions) impairment and required supervision or touching assistance from staff for eating, oral hygiene, and upper body dressing, and moderate and maximum assistance from staff for toileting, bathing, lower body dressing and personal hygiene. A review of Resident 277's prescription order sheet dated 5/21/2024, indicated the resident had an order for Venofer intravenous solution (iron sucrose - an IV iron medication) 100 milligrams (mg) intravenously in the evening for iron deficiency. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 277's care plans, indicated no care plan created for the resident's Venofer IV therapy. During an observation on 5/26/24 at 10:00 a.m., Registered Nurse 1 (RN 1) was observed caring or Resident 277's IV access. During an interview on 5/28/2024 at 2:11 p.m., with the Infection Prevention Nurse 1 (IPN 1), IPN 1 confirmed by stating Resident 277 did not have a care plan for IV therapy and stated there should have been a care plan for a resident on IV therapy. 2. A review of Resident 278's Admission Record indicated Resident 278 was originally admitted to the facility on [DATE], with diagnoses including diabetes mellitus (a disease in which your body does not produce enough insulin needed to control sugar levels in the blood), muscle weakness, discitis (inflammation of the intervertebral [area between bones of the spine] disc space) lumbar (lower back) region, and malignant neoplasm (cancerous tumor) of the breast. A review of Resident 278's MDS, dated [DATE], indicated Resident 278 had moderate cognitive impairment and required supervision or touching assistance from staff for toileting, bathing, dressing and personal hygiene. The MDS indicated Resident 278 was on IV antibiotic therapy and had a PICC line. A review of Resident 278's physician order summary report (POSR), dated 5/27/2024, indicated on 5/8/2024 the resident's physician orders the PICC line dressing and cap (disinfecting cap placed on ports of PICC line to help prevent the transmission of infections) be changed every day shift every seven days until 6/20/2024. During a concurrent observation in Resident 277's room and interview on 5/26/2024 at 9:48 a.m., RN 1 observed the resident's PICC line dressing with a date of 5/25/2024 and initials. RN 1 was observed providing PICC line care without donning (putting on) a gown as indicated on the Enhanced Standard Precautions (a resident-centered and activity-based approach of care for preventing multi drug resistant organisms [MDRO, germs that are not ablet be treated with most medications available] transmission in skilled nursing facilities) sign posted outside the resident's room door. RN 1 stated she was supposed to have donned a gown and along with her gloves while providing PICC care and stated the dressing should have been labeled with the time changed, not just the date and initials. During an interview and concurrent record review on 5/26/2024 at 10:05 a.m., RN 1 reviewed the Enhanced Standard Precautions signage on Resident 277's door dated September 2021. The sign indicated providers and staff were required to clean hands upon entering and exiting the resident's room. The sign indicated providers and staff were to wear gloves and a gown for high-contact resident care activities or when caring for devices and giving medical treatments. RN 1 stated she should have put on a gown when caring for the resident's PICC. A review of the facility's P&P titled Central Venous Catheter Dressing Changes dated May 2022, indicated To apply sterile dressing . 6. Apply sterile transparent dressing (no gauze) to area, making sure to center the dressing over the insertion site . Label with initials, date and time. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled, Resident Isolation - Categories of Transmission-Based Precautions, reviewed on 1/29/2024, the P&P indicated that transmission-based precautions are used accordingly when caring for residents who are documented or are suspected of having communicable diseases or infection that can be transmitted to others. A review of the facility's P&P titled, Compliance with Laws and Professionals Standards reviewed on 1/29/2024, indicated that facility policies and procedures were developed and maintained in accordance with local, state, and federal laws and with currently accepted professional standards and principles that apply to professionals providing services in a skilled nursing facility. A. Policies and procedures are reviewed at least annually and updated as necessary. B. Facility staff perform their duties in accordance with the policies and procedures adopted by the Facility.

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe and appropriate respiratory care for a resident when needed.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 43454

Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for two of two sampled residents (Resident 3 and Resident 10) by failing to ensure:

1. Resident 3 received oxygen at 2 liters per minute (l/min - unit of measurement) via nasal cannula (NC - a device used to deliver supplemental oxygen that should be placed directly on the resident's nostrils) to keep oxygen saturation (O2 sat) above 93 percent (% - unit of measurement) every shift for shortness of breath (SOB)/desaturation (the condition of a low blood oxygen concentration) as per physician's order dated 1/17/2024.

2. Resident 10 received oxygen at 2l/min via NC to keep O2 sat above 93 percent every shift for SOB every shift, as per physician's orders dated 8/18/2023.

This deficient practice had the potential to deny Resident 3 and Resident 10's the oxygen needed to ensure brain and organ health and function.

Cross Reference: F656

Findings:

1. A review of Resident 3's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (loss of the ability to move in one side of the body) following cerebral infarction (stroke: lack of blood flow resulting in severe damage to some of the brain tissue) affecting right dominant side, Parkinson's disease (a disorder in the brain that affects movement, often including tremors), Alzheimer's disease (a progressing brain disorder that destroys memory and other important mental function), hypertension (HTN - elevated blood pressure) and hyperlipidemia (abnormally high levels of fats in the blood)

A review of Resident 3's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 2/16/2024, indicated Resident 3's cognitive skills for daily decision-making were moderately impaired and the resident was totally dependent on staff for eating, toileting hygiene, repositioning from sit to stand, bed to chair transfer.

A review of Resident 3's Physician's History and Physical (H&P), dated 3/19/2024, indicated Resident 3 was unable to be fully assessed by the physician and did not follow commands.

A review of Resident 3's Order Summary Report dated 1/17/2024, indicated the resident had an order for oxygen at 2 liters per minute via NC to keep the resident's O2 sat above 93 % every SOB/desaturation.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 3's care plan for altered cardiovascular (pertaining to the heart and blood vessels that make up the circulatory system) status related to (r/t) HTN, hyperlipidemia, revised on 5/2/2024, indicated a goal for the resident to be free from complications of cardiac problems. The care plan indicated on 5/25/2024 and intervention to provide O2 via N/C per order was not added until 5/25/2024. A review of Resident 3's vital sign (VS - measurements of the body's most basic functions) dated 5/26/2024 at 8:16 a.m., indicated Resident 3's O2 sat was 92%. During an observation of Resident 3 on 5/25/2024 at 11:03 a.m., Resident 3 was observed in bed, eyes closed, and no oxygen machine or NC were observed in the room. During a follow-up observation with Resident 3 on 5/26/2024 at 11:52 a.m., Resident 3 was observed in bed, and no oxygen machine or NC were observed in the room. During a concurrent interview and record review of Resident 3's Order Summary on 5/27/2024 at 12:23 p.m., the Minimum Data Set Nurse 1 (MDSN1) stated confirmed Resident 3 had a physician's order for O2 supplement and stated the physician's order had to be followed. During an interview on 5/27/2024 at 12:31 p.m., the DON confirmed by stating there was no oxygen machine set-up for Resident 3. The DON stated the facility was not implementing Resident 3's care plan regarding oxygen therapy. 2. A review of Resident 10's Admission Record indicated resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) with hypoxia (low levels of oxygen in the body tissues), heart failure (a condition in which the heart does not pump blood as well as it should) and toxic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood). A review of Resident 10's MDS dated [DATE], indicated Resident 10's cognitive skills for daily decision-making were severely impaired and the resident was totally dependent on staff for oral hygiene, toileting hygiene, shower/bathing, upper and lower body dressing, and personal hygiene. A review of Resident 10's Order Summary Report dated 8/18/2023 indicated physician's order was in place for oxygen at 2l/min via NC to keep O2 sat above 93 percent every shift for SOB every shift. A review of Resident 10's CP for altered respiratory status/difficulty breathing r/t acute hypoxic respiratory failure revised on 5/8/2024, indicated a goal for the resident to be free from complications r/t SOB, with interventions including to provide oxygen as ordered. During an observation of Resident 10 on 5/25/2024 at 11:56 a.m., Resident 10 was observed on O2 supplement via NC. Resident 10's oxygen machine was observed at 1.5 l/min. During an interview on 5/27/2024 at 12:35 p.m., the DON stated physician's orders for O2 supplement had to be followed. The DON stated she (DON) would check Resident 10's O2 supplement machine and would call physician to update the order. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 5/27/2024 at 5:51 p.m., the DON confirmed by stating Resident 10's O2 machine was less than 2 l/min which was not what was indicated on the physician's order or care plan. A review of the facility's policy and procedure (P&P) titled, Oxygen Therapy, reviewed on 1/29/2024, the P&P indicated to administer oxygen per physician's orders.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review the facility failed to provide the necessary care and services to attain or maintain the highest practical emotional/physical well-being and pain management for two of two sampled residents (Resident 9 and Resident 58), by: 1. Failing to administer Resident 9's Lidocaine External Patch 5 percent (% - unit of measurement)- apply to affected area topically one time a day for pain management leave on for only 12 hours only within a 24-hour period at the scheduled time (9:00 a.m.). 2. Failing to remove Resident 9's lidocaine patch (a prescription-only topical local anesthetic) 12 hours after application as per physician's order and timely administered medications per physician's order. 3. Failing to ensure Resident 58's lidocaine patch was labeled according to facility's policy and procedure, titled Transdermal Drug Delivery System (Patch) Application reviewed on 1/29/2024. This deficient practice placed Resident 9 and Resident 58 at risk for experiencing untreated pain and discomfort, insomnia, impaired healing, and physical and emotional harm. Findings: 1. A review of Resident 9's Admission Record indicated resident was admitted to the facility on [DATE] with diagnoses including aftercare following joint replacement surgery (a procedure in which a surgeon removes a damaged joint and replaces it with a new, artificial part), polyneuropathy (a condition in which a person's peripheral nerves are damaged), and major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy). A review of the Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 4/28/2024, indicated Resident 9's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making were intact and the resident required moderate supervision from staff for activities of daily livings (ADLs-oral hygiene, toileting hygiene, shower/bathing self, upper and lower body dressing, repositioning from sit to lying and sit to lying). A review of Resident 9's Order Summary Report dated 4/21/2024, indicated the resident had an order for Lidocaine External Patch 5 %, apply to affected area topically one time a day for pain management leave on for only 12 hours only within a 24-hour period, scheduled at 9:00 a.m. A review of Resident 9's Care Plan for at risk for pain related to (r/t) recent hospitalization , recent surgery, disease process, initiated on 4/22/2024, indicated a goal of the resident not having discomfort related to side effects of analgesia (a class of drugs, designed to relieve pain). The care plan indicated interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) including to administer medication as ordered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation in Resident 9's room and interview on 5/24/2024 at 12:20 p.m., Resident 9 was observed with a patch on the left knee, there was no label with a date and time the patch was applied. Resident 9 stated it was a lidocaine patch the nurses applied once a day. Resident 9 stated the nursed kept the patch on the resident the whole day and applied a new patch in the morning. A review of Resident 9's Medication Administration Record (MAR) for the month of May 2024, indicated there was no documentation indicating the time the lidocaine patch was removed from 5/1/2024 - 5/28/2024. The MAR indicated on 5/24/2024, the lidocaine patch was applied at 3:45 p.m. not at the scheduled time of 9:00 a.m. 2. A review of Resident 58's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a chemical imbalance in the blood affecting the brain), hypertension (HTN - elevated blood pressure), a history of falling and muscle weakness. A review of Resident 58's MDS dated [DATE], indicated the resident's cognitive skills for daily decision-making were moderately impaired and the resident required moderate to maximal assistance from staff for toileting hygiene, shower/bathing self, upper and lower body dressing, repositioning from sit to lying and sit to stand. A review of Resident 58's Order Summary Report, dated 5/6/2024, indicated the resident had an order for Lidocaine External Patch 4% - apply to affected area topically one time a day for pain management on 12 hours, off 12 hours, scheduled at 9:00 a.m. A review of Resident 58's care plan for at risk for pain r/t recent hospitalization , disease process, physical limitation initiated on 4/17/2024, indicated a goal of the resident not having any discomfort related to side effects of analgesia with interventions including to administer medication as ordered. During a concurrent observation of Resident 58 and interview on 5/24/2024 at 11:28 a.m., Resident 58 was observed with patches on the left and right knee, no labels indicating the date and time the patches were applied were observed. Resident 58 stated she has also had a patch on her back. Resident 58 stated she didn't remember when the patches were applied or if the patches were to be removed at night. Resident 58 stated she believed the patch on her back was put on the day prior (5/23/2024). Resident 58 reported having a lot of pain on the right knee and right side of the body because of a fall sustained at home (the resident fell on the right side). A review of Resident 58's MAR for the month of May 2024, indicated that there was no documentation when the lidocaine patch was removed from 5/6/2024 - 5/25/2024. The MAR indicated the following: Lidocaine patch 4%, scheduled at 9:00 a.m.: On 5/13/2024, the lidocaine patch was applied at 12:26 p.m., on 5/19/2024, the lidocaine patch was applied at 1:56 p.m., and on 5/24/2024, the lidocaine patch was applied at 3:02 p.m. During a concurrent interview and record review of Resident 9 and Resident 58's order summary report and MAR, the Director of Nursing (DON) reviewed the resident's order summary reports and MARs and stated the medication order had to be specific on where to apply the patch and a time should have been documented when the patch was removed. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled, Pain Management reviewed on 1/29/2024, indicated that the licensed nurse would administer pain medication as ordered and document medication administered on the MAR. A review of the facility's P&P titled, Transdermal Drug Delivery System (Patch) Application reviewed on 1/29/2024, indicated the purpose of the Transdermal Drug Delivery System (Patch) Application was to administer medication through the skin through proper placement of the patch and care of the application site(s) . Write the date and nurse's initials on a sticker and place the sticker on the back of the patch before application.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 46) received the care and services consisted with professional standards of practice for hemodialysis (HD-filtering the blood of a person whose kidneys are not working normally) by failing to assess and documented resident 46's condition for complications after hemodialysis treatment. This deficient practice had the potential to allow for unidentified malfunctioning AV shunt, infections and bleeding from the AV shunt site which could all lead to serious harm and/or death. Findings: A review of Resident 46's Admission Record indicated Resident 46 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), end stage renal failure (ESRD-a medical condition in which a person's kidney [organ in the body that lifters waste and excess fluid from the blood] function stop functioning on a permanent basis), hemodialysis (HD-filtering the blood of a person whose kidneys are not working normally) dependence and generalized muscle weakness. A review of Resident 46's Minimum Data Set (MDS - a comprehensive assessment and care screening tool), dated 3/28/2024, indicated Resident 46's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making was moderately impaired and the resident required maximal assistance from staff for activities of daily living (ADLs- bed mobility, transfer, dressing, and toilet use). The MDS indicated Resident 46 was receiving hemodialysis treatment. A review of Resident 46's order summary report dated 1/12/2024, indicated the resident was to have hemodialysis every Monday, Wednesday, and Friday. A review of Resident 46's pre-dialysis evaluation form dated 5/24/2024, indicated an assessment was to be done before and during hemodialysis. A review of Resident 46's post dialysis evaluation form for5/24/2024, indicated the post dialysis evaluation form was missing. During an interview on 5/27/2024 at 12:05 p.m., Licensed Vocational Nurse 3 (LVN 3) stated residents who were scheduled for HD were required to have an assessment before leaving the facility, during the HD treatment which would be done by the HD staff, and when the resident returned to the facility. LVN 3 stated the nursing staff had to assess the resident and document the assessment to make sure the resident tolerated the HD with no complications. A review of facility policy and procedure (P&P) titled, Dialysis Care, reviewed on 1/29/2024, indicated that all documentation concerning dialysis services and care of the dialysis resident would be maintained in the resident's medical record.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on interview, and record review, the facility failed to provide sufficient staffing to accommodate resident needs by not answering call lights (device(s) with a button or touch pad a resident uses to set off an alarm that flashes/rings to alert the facility staff the resident needs assistance) in a timely manner for four of five sampled residents (Resident 8, 18, 50 and 53). This deficient practice resulted in Resident 8, 18, 50 and 53 not receiving needed services timely and efficiently and had the potential to affect the quality of life and treatment given to all 72 facility residents. Findings: A review of Resident 8's Admission Record indicated Resident 8 was originally admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses including obesity (a disorder involving excessive body fat that increases the risk of health problems), osteoarthritis (inflammation of the bone) and generalized muscle weakness. A review of Resident 8's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 3/11/2024, indicated Resident 8's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making was intact and the resident required moderate assistance from staff for activities of daily living (ADLs- bed mobility, transfer, dressing, and toilet use). A review of Resident 18's Admission Record indicated Resident 18 was admitted to the facility on [DATE] with diagnoses including monoplegia (paralysis limited to a single limb [arm/leg]) of lower leg, spinal stenosis (narrowing of the spaces within the spine, which can put pressure on the nerves that travel through the spine) and generalized muscle weakness. A review of Resident 18's MDS dated [DATE], indicated Resident 18 had moderately intact cognition for daily decision-making and required moderate assistance from staff for ADLs. A review of Resident 50's Admission Record indicated Resident 50 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including bronchitis (inflammation of the bronchi [airways in the lungs] of the lungs), obesity and congestive heart failure (CHF-a chronic condition in which the heart does not pump blood as well as it should). A review of Resident 50's MDS dated [DATE], indicated Resident 50 had moderately intact cognition for daily decision-making and required moderate assistance from staff for ADLs. A review of Resident 53's Admission Record indicated Resident 53 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and generalized muscle weakness. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 53's MDS dated [DATE], indicated Resident 53 had moderately intact cognition for daily decision-making and required minimal assistance from staff for ADLs. During the resident council (an organized group of residents who meet regularly to discuss and address concerns about their rights, quality of care, and quality of life) meeting on 5/26/2024 at 12:08 p.m., Resident 8, 18, 50 and 53 stated that they had to wait 30 minutes to an hour to get assistance when using the call light system. Resident 8, 18, 50 and 53 stated that they had to wait until their assigned certified nursing assistant (CNAs) were done with lunch breaks before getting any assistance since no other CNAs would assist them. Resident 8, 18, 50 and 53 stated they could hear the staff talking to one another outside their (Resident 8, 18, 50 and 53) rooms and would still not answer the call lights. During an interview on 5/27/2024 at 4:54 p.m., the Director of Staff and Development (DSD) stated any staff could answer the call lights and call lights had to be answered within two minutes. The DSD stated waiting for 30 minutes to an hour was unacceptable. A review of a facility's policy and procedures (P&P) titled Communication-Call System reviewed on 1/29/2024, indicated facility staff were to provide a mechanism for residents to promptly communicate with Nursing Staff. The P&P indicated nursing staff were to answer call bells promptly and in a courteous manner.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 43261 Based on observation, interview and record review, the facility failed to ensure facility staff possessed the appropriate competencies to provide nursing and related services to assure resident safety four of nine sampled nursing staff (Registered Nurse 1-RN 1, Infection Prevention Nurse 1-IPN 1, Certified Nursing Assistant 4-CNA 4 and Certified Nursing Assistant 7-CNA 7) had the specific competencies and skills sets necessary to care for the residents. This deficient practice had the potential to lead to inadequate care and a delay resident's care. Findings: During a concurrent interview and record review of employee files on 5/27/2024 at 4:35 p.m., the Director of Staff and Development (DSD) reviewed nine sampled nursing staff files and confirmed by stating there were missing skills competencies (verification of the ability to perform a task with the necessary knowledge, skills, and abilities to provide safe and effective care to residents) for RN 1, IPN 1, CNA 4 and CNA 7. The DSD stated nursing skills competencies were required to be verified upon hire, yearly, and as needed. A review of a facility's policy and procedures (P&P) titled Staff Competency Assessment reviewed on 1/29/2024, indicated competency assessments would be performed upon hire during the 90-day employment period, annually or anytime new equipment or a procedure was introduced and as needed. The P&P indicated the competency assessments would be kept in the employee file for current employees and for seven years from the last date of employment.

Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 43261 Based on observation, interview and record review, the facility failed to post the federally required daily actual hours worked by the facility staff in an area accessible to the public for one of four days (5/25/2024) for the month of May 2024. As a result, the actual hours worked by the staff was not readily accessible to residents, family, or visitors. And had the potential to cause inadequate staffing. Findings: During an observation of the nurse's station on 5/25/2024 at 9:55 a.m., nurse staffing hours information was observed posted with a date of 5/23/2024. During an interview with on 5/27/2024 at 4:35 p.m., the Director of Staff and Development (DSD) stated since he (DSD) had been in vacation, the facility was not able to update and post the nursing hours. The DSD stated nurse posting was to be done daily. A review of a facility's policy and procedures (P&P) titled Nursing Department-Staffing, Scheduling & Posting reviewed on 1/29/2024, indicated the facility will post the following information on a daily basis: i. Facility name ii. Current date iii. Total number and the actual hours worked of all the licensed and unlicensed nursing staff directly responsible for resident care per shift.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44252 Based on observation, interview, and record review, the facility failed to ensure pharmaceutical services included procedures to ensure the emergency kit (e-kit - secured container or secured electronic system containing drugs which are used for either immediate administration to residents or in an emergency or as a starter dose) was securely sealed and medciation used from the E-kit was reordered. By failing to: 1. Ensure the Intravenous (IV, insertion of a cannula or catheter into a vein to provide access to the bloodstream) E-kit located in one of one sampled medication storage closet (medication storage closet 1) was properly resealed, had an open date documented, and medication used was reordered. 2. Ensure the narcotic (any psychoactive compound with numbing or paralyzing properties) E-kit located in one of two sampled medication carts (medication cart 1B) was properly resealed and medication used was reordered. This deficient practice had the potential for harm to residents due to a lack of availability of medications leading to delays in the timely administration of medications in the event of an emergency. Findings: 1. During a concurrent observation and interview on 5/26/2024 9:48 a.m., with Director of Nursing (DON), one used IV E-kit was observed stored inside the medication storage closet 1, the E-kit was dated filled 4/17/2024. The E-kit had a red zip-tie (indicating the E-kit had been opened, unopened box would have green zip-tie) to reseal box, that was improperly applied because the box was opened by DON without cutting the zip-tie. The DON stated the E-kit was not properly secured and the E-kit should have been picked up by the pharmacy for replacement within 48 hours after opening. During a concurrent interview and record review on 5/26/2024 9:48 a.m., with Director of Nursing (DON), a yellow carbon copy of the Emergency Kit Pharmacy Log from inside the E-kit was reviewed. The log indicated NS (normal saline, mixture of salt and water, used to treat dehydration [insufficient water in the body]) 0.9%, 1 bag removed on 4/9/2024. The log had missing entries in columns for Pharmacist taking order and Serial #. The DON verified the missing entries on the log and stated al sections of the log should have been filled out by the nurse when removing the medication from the E-kit. A review of the facility Emergency Kit Pharmacy Log, dated 4/9/2024, indicated Instructions: 1. Submit orders to the pharmacy. 2. Contact pharmacy to obtain authorization from the pharmacist before removing item from the E-kit. 3. Enter information on E-kit log. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Place white copy in E-kit binder and return yellow copy with E-kit to the pharmacy. 5. Reseal E-kit. 43261 2. During a concurrent observation and interview on 5/26/2024 10:14 a.m., with Registered Nurse 2 (RN 2), observed a narcotic E-kit located inside the medication cart with a red zip tie. Upon opening the narcotic E-kit, an E-kit pharmacy log was inside the narcotic E-kit, indicated that on 5/15/2024, the E-kit was opened and a medication was removed. RN 2 stated that once they opened an E-kit, the licensed nurse was supposed to re-order a new E-kit as soon as possible via phone call and fax to the pharmacy, needing to have it refilled within 72 hours of opening. A review of the facility's policy and procedures titled Emergency Pharmacy Service and Emergency Kits, revised January 2018, indicated, G. When an emergency or stat order is received, the nurse follows the procedure for order documentation . 3) The nurse records the medication use from the emergency kit on the [medication/use form] and [calls the pharmacy for replacement of the kit/dose and/or flags the kit with a color-coded lock to indicate need for replacement of kit/dose] as soon as possible after the medication has been administered . 6) Before going off duty, the charge nurse indicates the opened status of the emergency kit at the shift change report, and transfers the new medication orders to oncoming staff . I. If exchanging kits, when the replacement kit arrives the receiving nurse gives the used kit to the pharmacy personnel for return to the pharmacy . K. The kits are monitored/inventoried by the [consultant pharmacist/provider pharmacy] at least [every thirty (30) days] for completeness and expiration dating of the contents. The date of inventor is noted [on the outside of the kit].

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on interview and record review, the facility failed to communicate the consultant pharmacist's recommendation, in the Medication Regimen Review (MRR), to the attending physician for two of five sampled residents (Resident 15 and 53). This deficient practice had the potential for unnecessary medication use, resulting in an adverse drug reaction to affect the health and wellbeing of Resident 15 and Resident 53. Findings: A review of Resident 15's Admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including dementia (a chronic or persistent disorder of the mental processes caused by brain disease), osteoarthritis (inflammation of the bone) and anxiety disorder. A review of Resident 15's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool) dated 3/28/2024, indicated Resident 15 had moderately intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and required moderate assistance from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). A review of Resident 15's Consultant Pharmacist's Medication Regimen Review (CPMRR) dated 3/23/2024, indicated a recommendation to re-evaluate cetirizine (antihistamine medication) and loratadine (antihistamine medication) due to a possibility of duplicate therapy. The CPMRR indicated to document rationale if medication needed to be continued. During a concurrent interview and record review with the Director of Nursing (DON) on 5/28/2024 at 2:41 p.m. , Resident 15's order summary was reviewed by the DON. The order summary indicated the resident had a physician's order for loratadine dated 5/21/2024 and cetirizine dated on 2/1/2024. The DON reviewed and confirmed Resident 15's progress notes had no documentation regarding CPMRR. The DON stated facility staff had to relay and document pharmacy recommendations to the physician. During an interview with the Nurse Practitioner 1 (NP 1) on 5/28/2024 at 4:37 p.m., NP 1 stated she (NP 1) was not aware Resident 15 was taking two different kinds of antihistamine. NP 1 stated that she was also not aware that Resident 15 had a pharmacy recommendation. NP 1 stated facility staff should have notified the physician for any pharmacy recommendations. A review of Resident 53's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and generalized muscle weakness. A review of Resident 53's MDS dated [DATE], indicated the resident had moderately intact cognition for daily decision-making and required minimal assistance from staff for ADLs. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 53's order summary report (OSR) dated 3/28/2024, indicated Resident 53 had an order for Fosamax (medication that slows bone loss and prevents fractures) 70 milligrams (mg) by mouth one time a day every Saturday on an empty stomach. The OSR indicated facility staff could crush medications and mix with apple sauce. A review of Resident 53's CPMRR, dated 4/26/2024, CPMRR indicated a recommendation by the pharmacist to add do not crush to the Fosamax order. During a concurrent interview and record review with the Director of Nursing (DON) on 5/28/2024 at 2:33 p.m. , Resident 53's medical record was reviewed. The DON confirmed by stating do not crush was missing from the active physician's orders and the pharmacist recommendation was not documented in Resident 53's progress notes. The DON stated all the licensed nurses could notify the physician regarding CPMRR recommendations and the recommendations and notification of the physician had to be documented in the progress notes. A review of a facility's policy and procedures (P&P) titled Consultant Pharmacist Reports: Medication Regimen Review, reviewed on 1/29/2024, indicated recommendations were to be acted upon and documented by the facility staff and/or the prescriber.

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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** 44252 Based on observation, interview and record review, the facility failed to provide pharmaceutical services to meet the needs of residents in the facility by failing to: 1. Ensure proper disposal of an open sterile central line (a small, soft tube called a catheter is put in a vein that leads to your heart, used for delivering fluids or medications for a longer period of time) dressing kit, and expired sterile (completely clean and free from germs) needles, alcohol pads (small gauze pads saturated with alcohol used as an disinfectant), and saliva collection kit (syringe used to collect saliva for a lab test). 2. Ensure opened medication bottles/containers for acidophilus (prebiotic medication) and bismuth subsalicylate (medication that relieves symptoms of upset stomach) were dated when opened. 3. Ensure ipratropium Bromide and albuterol sulfate solution (medication being given via inhalation [inhaling medication in the form of gas or vapor] used to treat or prevent bronchospasm [when muscles that line the airways in the lungs becomes tighten) was properly used when opened within two weeks or disposed after the timeframe per manufacturer's policy. 4. Ensure pill cutter was clean every after use. 5. Ensure medication cart was clean at all times. These deficient practices had the potential to compromise the safety and effectiveness of medications which could result in medication administration error and place residents at risk for unsafe, improper medication administration use. Findings: 1. During a concurrent observation and interview on [DATE] 10:42 a.m., with Registered Nurse 3 (RN 3), the IV (intravenous which means in the vein) medication storage closet was observed. There was one open sterile central line dressing kit, and 45 expired sterile needles (expiration date [DATE]), five expired alcohol pads (expiration date ,d+[DATE]), and one expired saliva collection kit (expiration date ,d+[DATE]). RN 3 verified the expiration dates of the supplies, gathered the supplies to throw them out and stated they (expired supplies) should not be there. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedures (P&P), titled Equipment and Supplies for Administering Medications, reviewed on [DATE], indicated, The facility maintains equipment and supplies necessary for the preparation and administration of medications to residents . A. The following equipment and supplies are acquired and maintained by the facility for proper storage, preparation and administration of mediations: 5) Oral syringes, parenteral (without passing through the digestive system, usually by injection or IV) syringes, needles, droppers . alcohol wipes, . labels for date opened/date expires . B. The charge nurse on duty ensures that equipment and supplies relating to medication administration are clean and orderly . C. The consultant pharmacist monitors medication storage conditions on a [quarterly] bases and reports any irregularities and recommendations for improvement to the [director of nursing]. 43261 2. During a concurrent observation and interview with RN 2 on [DATE] at 10:30 a.m., medication cart 1 was observed. There were opened bottles of acidophilus (prebiotic medication) and bismuth subsalicylate (medication that relieves symptoms of upset stomach) with missing date to indicate the date opened. RN 2 stated when opening a medication bottle and or container, they (nurses) have to make sure that they put the date when it was opened. A review of the facility's P&P, titled, Medication Storage in the Facility, reviewed on [DATE], indicated that when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated by placing a date opened sticker on the medication. 3. During a concurrent observation and interview with RN 2 on [DATE] at 10:34 a.m., medication cart 2 was observed. There was a fully opened foil pack of ipratropium Bromide and albuterol sulfate solution inside the opened box dated [DATE]. RN 2 validated the open foil inside the open box and stated that per manufacturer's policy, the medication was supposed to use within 2 weeks from the time package was opened. A review of the facility's P&P, titled, Medication Storage in the Facility, reviewed on [DATE], indicated that the nurse will check the expiration date of each medication before administering it. P&P also indicated that all expired medication will be removed from the active supply and destroyed in the facility. A review of the manufacturer's guidelines for ipratropium Bromide and albuterol sulfate solution, undated, indicated that the medication should be protected from light, should remain stored in the protective foil pouch at all times and once open, it should be used within two weeks. 4. During a concurrent observation and interview with RN 2 on [DATE] at 10:27 a.m., a pill cutter inside the medication cart 1 was observed with whitish and greenish particles. RN 2 stated the pill cutter should be cleaned after each use, so it does not cause of mixing with medications. During a concurrent observation and interview with the Licensed Vocational Nurse 3 (LVN 3) on [DATE] at 11:28 a.m., a pill cutter inside the medication cart 2 was observed with whitish and greenish particles. LVN 3 stated the pill cutter should be cleaned after each use since it will have some residues from other medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During a concurrent observation and interview with LVN 3 on [DATE] at 11:28 a.m., there were cluttered items including bandages, nail cutter, alcohol wipes, etc. inside the left top drawer of medication cart 2. LVN 3 stated the charge nurses was supposed to keep the medication cart clean at all times. During an interview with Infection Preventionist Nurse 1 (IPN 1) on [DATE] at 5:02 p.m., IPN 1 stated that it was the charge nurses' duty to make sure medication carts and pill cutter are being cleaned due to possible transmission of infection. A review of the facility's P&P, titled, Medication Administration-General Guidelines, reviewed on [DATE], indicated that medications are administered in accordance with good nursing principles.

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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. 38740 Based on observation, interview and record review, the facility failed to follow the menu and provide resident a variety of food options when: 1.One resident (Resident 48) who was on a renal diet (a diet aimed at keeping levels of fluids, electrolytes, and minerals balanced in the body in individuals with kidney disease or who are on dialysis) received chicken jambalaya (mixed rice, chicken, and tomato dish) instead of Baked chicken and rice per menu. 2. Residents who were on vegetarian and vegan diets (Resident 69, Resident 61 and Resident 9) complained that the menu does not have variety of vegetarian options and Resident 61 complained that last week fish sticks were served every day for lunch. This deficient practice had the potential to result in inadequate nutrition status and meal dissatisfaction when the menu is not updated to reflect the needs of the residents. Findings: According to the facility dinner menu for regular diet on 5/24/2024, the following items will be served on the regular diet: Chicken Jambalaya (a casserole type dish with mixed rice, chicken, sausage, tomato and spices) 1 cup; seasoned zucchini 1/2 cup, 1 wheat roll, margarine, applesauce and milk. Renal Diet: Baked chicken with gravy 2 ounces, brown rice with margarine 1/2 cup, seasoned zucchini 1/2 cup, 1 wheat roll, margarine, and applesauce. During a concurrent observation and interview with [NAME] 2 and Dietary Supervisor (DS) in the kitchen on 5/25/2024, at 9:45a.m., there was a medium size plastic container of red colored rice, labeled chicken jambalaya stored in the reach in refrigerator with date 5/24/24 and use by date of 5/25/24. [NAME] 2 stated chicken jambalaya was from yesterday dinner (5/24/24). [NAME] 2 stated there were rice, sausage, chicken, tomato, onions, and spices. [NAME] 2 stated for residents on renal there was baked chicken and rice with no sausage and no tomato. According to the facility lunch menu for regular diet on 5/26/2024, the following items will be served on the regular diet: Baked pork chop with gravy 3 oz, 1 baked potato, margarine, mixed vegetables 1/2 cup, wheat roll margarine. Renal diet will receive pork chop, rice 1/2 cup and mixed vegetables. A review of Resident 48's meal ticket (physician ordered diet with resident food preferences) for lunch dated 5/26/24 indicated renal diet 80 grams protein, low salt, low potassium, no coffee, no milk, no pork. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation the tray line service for lunch on 5/26/204 at 11:55 a.m., for Resident 48 who dislikes pork and is on renal diet, [NAME] 3 served regular chicken jambalaya with mixed vegetables and wheat roll instead of the baked pork chop. During a concurrent interview with [NAME] 2 and [NAME] 3, [NAME] 3 stated the chicken jambalaya was left over from previous day's dinner and is used as an alternative for residents who don't like pork. [NAME] 2 stated she prepared the chicken jambalaya on 5/24/24 for dinner. She stated the ingredients were chicken, sausage, tomatoes, onions and rice. [NAME] 2 stated the same day residents on renal diet received baked chicken and rice instead of the chicken jambalaya per menu. During a dining observation on 5/26/2024 at 12:50 p.m., Resident 48 was on her bed and lunch was set up in front of her. Resident 48 stated the food is terrible and did not want to eat it. Resident 48's family who was present stated the food looked very bad and not appropriate for the renal diet. During an interview with [NAME] 2 and DS on 5/26/2024 at 3:30p.m., [NAME] 2 stated the residents on renal diet should not get tomatoes, potatoes, spinach, beans, and milk. When asked if the chicken jambalaya had tomatoes, [NAME] 2 replied yes. During the same interview, DS stated Resident 48 does not like pork and that's why [NAME] 3 served chicken jambalaya as the alternative. DS stated the regular chicken jambalaya was not a renal diet. DS stated, we should've served something else because jambalaya was not for renal diet. DS stated renal diet is low in salt and potassium foods such tomato to maintain normal electrolyte levels. A review of the recipe for the chicken jambalaya indicated the ingredients included chicken, sausage, onion, celery, diced tomatoes with juice and rice. For Renal diet, the recipe indicted to serve baked chicken with gravy, brown rice with margarine. A review of facility policy, titled renal diet, dated 2020, indicated, this diet is used for the resident with renal insufficiency .this diet regulates the dietary intake of sodium, potassium, and protein to lighten the work of the diseased kidney. 2. During a dining observation on 5/25/2024 at 1:15p.m., Resident 69 stated he is on a vegan diet. Resident 69 stated he does not eat any meats, dairy, eggs or fish. Resident 69's tray included fish sticks, brussel sprouts and pasta. Resident 69 stated he thought all the meals that was provided for him was plant based. During a dining observation on 5/25/2024 at 1:25 p.m., Resident 9 was in her room and on her bed. Resident 9 stated she is vegetarian, does not eat any meat but eats eggs, and dairy products. Resident 9 stated the facility gives her grilled cheese sandwich, cheese quesadilla (cheese in tortilla), fruit platter and fish sticks. Resident 9 stated she refused her meal today because a visitor brought her lentil soup. She stated the vegetarian options are limited in the facility, but her friends bring her vegetarian options. (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 dining observation on 5/25/2024 at 2:00 p.m., Resident 61 was in her room on her bed. Resident 61 stated she is vegetarian, and eggs and dairy are ok. Resident 61 stated that they serve fish sticks as one of the vegetarian options. She states last week she received fish sticks every day for lunch. She stated she receives 3 fish sticks with side of vegetables and either rice, pasta, or potato. She stated there is very poor selection of vegetarian options. Resident 61 stated her family brings her vegetarian options. During an interview with DS on 5/26/2024 at 3:30 p.m., DS stated the options for vegetarian diets are grilled cheese sandwich, cheese quesadilla, salad, fruits, and fish sticks. DS stated they (facility) replace the meat with fish sticks or grilled cheese on the regular menu, but they don't have a special menu for vegetarian diet with recipes. DS stated she purchased plant-based meatballs and served as a substitute for meat and the residents did not like it. She stated she served platter of vegetables; garbanzo beans and corn and residents did not like it either. During an interview with facility administrator (ADM) on 5/26/2024 at 3:30p.m., ADM stated facility will work with the registered dietitian to evaluate and reassess residents' needs. A review of facility policy and procedure, titled, Menus dated 4/1/2014, indicated, the purpose to ensure that the facility provides meals to residents that meet the requirement of the food and nutrition board of the national research council of the national academy of sciences. the dietary manager will develop menus in collaboration with the dietitian. Menus are to be designed in consideration of resident preference, dietary department resourced .when a substation is requested, the substitute item should be compatible with the rest of the meal taking into consideration color, texture, and flavor, comparable in nutritional value taking into consideration vitamins, minerals and calories.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38740 Based on observation, interview and record review, the facility failed to ensure the residents were served the food with preferences listed on the lunch meal ticket (physician ordered diet with resident food preferences) and received substitute meal options of similar nutritive value when: 1.One resident (Resident 69) food preferences were not honored by serving fish sticks during lunch, despite Resident 69's diet order indicated Vegan. 2. Two residents (Resident 61 and Resident 9) who are vegetarians and do not eat meat, received 3 fish sticks for alternate protein choice that had lower protein content than the beef paprika (diced beef and spices) and the roasted pork chop that was on the regular menu. This deficient practice had the potential to result in decreased meal satisfaction, decreased nutritive value for the meal, which could lead weight loss and other health issues. Findings: 1. A review of Admission Record indicated Resident 69 was admitted to the facility on [DATE] with diagnoses including epidural hemorrhage without loss of consciousness (bleeding between the inside of the skull and the outer covering of the brain), dysphagia oropharyngeal phase (difficulty swallowing) and cognitive communication deficit. A review of Resident 69's meal ticket (physician ordered diet with resident food preferences) for lunch dated 5/25/24 indicated Regular texture diet and vegan (A diet based on plants such as vegetables, grains, soy products tofu, nuts and fruits, vegans do not eat foods that come from [NAME] including dairy products and eggs.) During an observation of lunch service in the kitchen on 5/25/2024 at 12:00 p.m., cook 1 served 3 fish sticks with tartar sauce, brussels sprouts, and pasta for Resident 69. During a concurrent observation and interview with [NAME] 1 and [NAME] 2 on 5/25/2024 at 12:00p.m., Cook2 stated for the vegan and vegetarian get fish instead of the beef paprika. [NAME] 2 stated resident 69 likes the fish sticks. During a dining observation on 5/25/2024 at 1:15 p.m., resident 69 was seated on wheelchair and food on the bed side table Infront of him. Resident 69 stated he has been vegan for more than 5 years. He stated he does not eat animal products including fish. When asked if the lunch is vegan, he replied yes, adding I believe it is vegan. The resident further stated that the facility knows I am vegan, and I trust everything they provide and place Infront of me is vegan. During an interview with Cook1 and Cook2 on 5/25/2024 at 1:35 p.m., Cook1 stated vegan food should not have any meats, cheese, eggs, butter, and no fish. [NAME] 1 stated Resident 69 eats the fish sticks so we serve him the fish sticks. [NAME] 2 stated vegan meatballs were served but Resident 69 refused them but then the resident eats fish sticks. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same interview with dietary supervisor (DS) on 5/25/2024 at 1:35 p.m., DS stated Resident 69 keeps asking for fish stick and that is the reason we give him fish sticks. DS stated she made vegie burger and put regular cheese on it and the resident ate the regular cheese. A review of the dietary profile for Resident 69 dated 4/10/2024 indicated the resident likes vegetables, salads, fruits, plant-based food, soy milk or almond milk and dislikes all meats, cheese, milk, and soups. A review of the same dietary profile for Resident 69 dated 4/10/2024 indicated the resident's family stated, brother is Vegan as much as possible no meats plant-based food and resident is able to tell what he likes and for snacks he likes crackers, chips, Sherbert. A review of Nutrition/Dietary Progress note for Resident 69 dated 4/29/2024 indicated the resident had a significate weight loss x 2 weeks, resident with variable intake and is likely not meeting estimated nutrient needs. Plan to add snacks TID in between meals at 10am, 2 pm and 8pm for variable intake, wound healing and wight loss. A review of the ingredients of the tartar sauce indicated the product has eggs. A review of the ingredients of the fish sticks indicated the product has [NAME] and type of fish. A review of facility policy, titled, Dietary profile and resident Preference interview revised 4/21/2022, indicated, The dietary manager will complete a dietary profile for residents to reflect current nutritional needs and food preferences. The dietary department will provide resident with meals consistent with their preferences and physician order as indicated on the tray card. If a preferred item is not available a suitable substitute should be provided. The dietary manager may update food preferences as often as necessary. A review of facility document titled Vegetarian and Vegan diet dated 2020, indicated, Vegans use vegetables, salads, legumes (beans, peas and lentils), tofu, fruits, whole grains, nuts and seeds and exclude all animal products. To maintain energy intake, increase the use of leavened bread, cereals, legumes, nuts, and seeds, use a fortified soy milk, use of green leafy vegetables, dried fruits etc. 2. A review of Resident 9's meal ticket (physician ordered diet with resident food preferences) for lunch dated 5/25/24 indicated No added salt regular texture, vegetarian, fish ok. A review of Resident 61's meal ticket for lunch dated 5/25/24 indicated CCHO diet (diet for individuals who have high blood sugar), regular texture and vegetarian (Diet consists of no meats and fish, vegetables, nuts, seeds, and fruits and sometimes eggs and dairy are included). During a concurrent observation and interview on 5/25/2024 at 12:00 p.m., [NAME] 1 served 3 fish sticks for residents 9 and resident 61 who were on vegetarian diet. [NAME] 1 stated the vegetarians like the fish stick and instead of the 3 ounces (oz.) beef paprika (diced beef with spices) vegetarians will get 3 fish sticks (frozen fish product breaded and shaped into sticks). Cook1 stated 3 fish sticks is 3 ounces of protein and usually for lunch it's 3 ounces of protein. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the nutritional information on the packaging of the frozen fish sticks used as an alternative meal for the vegetarians indicated 4 fish sticks provide 12 grams of protein and facility served only 3 fish sticks even less protein. A review of the United States Department of Agriculture (USDA) USDA National Nutrient Database for Standard Reference Legacy dated (2018) Nutrients: Protein (g), The protein content of 3 ounces (oz) of cooked beef is 21-25 grams of protein. https://www.nal.usda.gov/sites/default/files/page-files/Protein.pdf The vegetarian alternative 3 fish sticks provided significantly less protein than the 3 ounces of the beef paprika (diced beef with spices) served on the regular menu. During a concurrent observation and interview on 5/26/2024 at 11:55 a.m., Cook3 served 3 fish sticks for residents 9 and resident 61 who were on vegetarian diet as an alternative meal for the boneless baked pork chop served on the regular menu. The protein content of the 3 ounces boneless pork chop is 20-25 grams and according to the nutrition information on the package of the frozen fish sticks, 4 fish sticks provide 12 grams of protein which is less than the pork chops. Cook3 stated the vegetarians like the fish sticks. Cook3 doesn't know how much protein fish sticks have. During a dining observation on 5/25/2024 at 1:25 p.m., Resident 9 was in her room and on her bed. Resident 9 stated that she is vegetarian, does not eat any meat but eats eggs, and dairy products. Resident 9 stated the facility gives her grilled cheese sandwich, cheese quesadilla (cheese in tortilla), fruit platter and fish sticks. Resident 9 stated she refused her meal today because a visitor brought lentil soup. She stated the vegetarian options are limited in the facility, but her friends bring her vegetarian options. During a dining observation on 5/25/2024 at 2:00 p.m., Resident 61 was in her room on her bed. Resident 61 stated she is vegetarian, and eggs and dairy are ok. Resident 61 stated that they serve fish sticks as one of the vegetarian options. She states last week she received fish sticks every day for lunch. She stated she receives 3 fish sticks with side of vegetables and either rice, pasta, or potato. She stated there is very poor selection of vegetarian options. Resident 61 stated her family brings her vegetarian options. During an interview with Dietary supervisor (DS) on 5/26/2024 at 3:30 p.m., DS stated the options for vegetarian diets are grilled cheese sandwich, cheese quesadilla, salad, fruits, and fish sticks. DS stated the facility replaced the meat with fish sticks or grilled cheese, but they (facility) did not have a set menu for vegetarian diet. DS stated the facility serves 3 fish sticks for 3 ounces of meat. During the same interview, DS stated the regular diet on 5/26/24 was 3 ounces of boneless baked pork chop and the vegetarians received 3 fish sticks. A concurrent review of the nutritional information on the package of the frozen and breaded fish sticks indicated 4 fish sticks is 4 ounces and provided 12 grams of protein. The nutrition content of 3 ounces of boneless baked pork chop is 20-25grams of proteins. DS stated if residents did not receive comparable amount of protein and calories, they would receive less nutrition and would have weight loss. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with facility administrator (ADM) on 5/26/2024 at 3:30p.m., ADM stated 3oz of pork or meat provides anywhere between 21-27 grams of protein per information available on the internet, more protein than the 3 fish sticks. A review of Resident 9's diet order dated 4/29/2024 indicated No added salt diet, regular texture, low fat milk, vegetarian ok with fish. A review of Resident 61's diet order dated 5/10/2024 indicated CCHO regular texture (diabetic diet), vegetarian. A review of Resident 61's Dietary Profile dated 3/21/2024 indicated per residents (family) prefer vegetarian food, per family for snacks likes fresh fruits, apples, pears, oranges, watermelon, carrots celery, peanut butter. For main meal likes lentil soup, fresh vegetables, fruits hard boiled eggs or scrambled eggs and fish sticks are ok. Resident dislikes carbohydrates, cereal, pasta, bread, meats, spinach kale, fish fillet, turkey, and chicken. Family will also bring food. A review of the recipe for the beef paprika indicted portion size is (3 oz of beef and 1 oz of sauce). A review of the recipe for the baked pork chop indicated portion size is 1 pork chop boneless 3 ounces. A review of the nutrition information for Oven ready par fried whole grain breaded [NAME] sticks, indicated 4 fish sticks are 4 ounces and provide 12 grams of protein. A review of facility policy titled Vegetarian and Vegan diet (dated 2020) indicated, nutrition breakdown for protein 78-85 grams of protein per day. Vegetarians use vegetables, salads, legumes, tofu fruits, whole grains, nuts, and seeds and sometimes will use dairy item and eggs. A review of facility policy and procedures, titled, Menus dated 4/1/2014 indicated, the dietary manager will develop menus in collaboration with the dietitian. Menus are to be designed in consideration of resident preference, dietary department resourced .when a substation is requested, the substitute item should be compatible with the rest of the meal taking into consideration color, texture, and flavor, comparable in nutritional value taking into consideration vitamins, minerals and calories.

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F 0808

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.

38740

Based on observation, interview, and record review, the facility failed to provide fortified diet (diet enhanced to increase caloric content) as ordered by the physician to one of 21 sampled residents (Resident 36) who was on a kosher (food that complies with a strict set of dietary rules in the Jewish religion) and fortified diet.

This deficient practice had the potential to result in decreased caloric intake and lead to undesirable weight loss for the resident.

Findings:

During an observation of lunch service in the kitchen on 5/25/2024 at 12:00 p.m., residents who were kosher diet received prepacked kosher meal. The prepackaged kosher meal was heated for 2 minutes in the microwave and then placed on resident tray.

During the same observation and interview in the kitchen with [NAME] 1 and [NAME] 2, [NAME] 2 was communicating the fortified diet orders written on the resident's meal tickets during tray line for lunch service and [NAME] 1 was adding butter on the vegetables for residents on fortified diet. [NAME] 1 stated fortified diet means add butter for more calories. A review of resident 36's tray or meal tickets on the cart indicated the orders for fortified diets. However, [NAME] 2 did not read out loud the fortified diet and [NAME] 1 did not add butter on Resident 36's food.

During an observation on 5/25/2024 at 1:00 p.m., Resident 36's tray on the bedside table had sliced roasted turkey, sweet potato, peas in a disposable plastic container that was opened and a cup of nutrition supplement. There was no butter on the tray or on the food.

During a concurrent interview with Resident 36 on 5/25/2024 at 1:00p.m, the resident stated she eats kosher food, and the food comes prepackaged and sealed and the nurse assists in removing the cover.

During an observation of lunch service in the kitchen on 5/25/2024 at 11:55 a.m., Resident 36 prepacked kosher food was heated in the microwave then placed on the tray.

During the same observation [NAME] 2 did not communicate the fortified diet for resident 36 and [NAME] 1 did not add any butter on Resident 36's tray.

During an observation on 5/25/2024 at 1:00 p.m., Resident 36's tray on the bedside table had spaghetti and meatballs and peas. Resident only ate the meatballs. There was no butter on the tray or on the food.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Dietary Supervisor (DS) on 5/26/2024 at 3:30 p.m., DS stated fortified diet orders are for residents who are losing weight or have decreased intake. DS stated for during lunch meal, butter is added on vegetables to add extra calories. DS stated when residents did not get the fortified diet then they did not receive the extra calories. DS stated they did not add butter to Resident 36's food. DS stated the food comes in prepackaged and sealed container and they don't open it because it is Kosher. DS stated they could not add butter on the food because it was sealed. DS said Resident 36 did not get the extra calories from fortified diet as ordered. A review of the Order Summary Report for Resident 36 indicated diet order: Fortified Diet regular texture for weight loss start date 4/30/2024. A review of the Dietary Profile dated 3/6/2024 indicated diet order is regular texture fortified food, resident likes kosher food and dislikes pork. A review of facility policy and procedures titled Therapeutic Diets (Revised 6/1/2014) indicated, Therapeutic diets are diets that deviate from the regular diet and require a physician order. Per the physician order, therapeutic diets are planned, prepared, and served in consultation with the Dietitian. A review of facility policy and procedures titled Fortified Diet (dated 2020) indicated, fortified diet is designed for residents who cannot consume adequate amounts of calories and or protein to maintain their weight or nutritional status .the goal is to increase calorie for the foods .calorie increase should be approximately 300-400per day .examples adding extra margarine or butter to food, extra gravy etc.

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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** 38740 Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and food preparation when: Food brought to resident from outside of the facility, including leftovers stored in the resident food refrigerator were not dated. There was no monitoring system for the refrigerator temperatures and expired food was not discarded. This deficient practice 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 food borne illness in 67 out of 70 residents who received food from facility including the residents who had their food stored in the resident refrigerator. Findings: During an observation in the resident refrigerator located in a room in the common hallway on [DATE] at 11:00 a.m., there was no thermometer inside the freezer, no refrigerator/freezer temperature documentation log. There were three plastic bags containing food with no date. There was one large brown bag with food for a resident with no date. There was one lunch box with no label or date. One plastic to-go food container with date [DATE] and another container of food for resident with date [DATE] exceeded storage period for outside food. There was one small container of leftover strawberry flavor yogurt with no open date and one glass food storage container with white soupy food item with no label or date. The freezer contained frozen dinner boxes with no date, one large plastic cup of leftover coffee color drink with no label and date, one open leftover of chocolate bar with no label. During the same observation and interview with Dietary Supervisor (DS) and Administrator (ADM) on [DATE] at 11:00 a.m., DS stated the nursing staff are responsible to check the food label and date. ADM stated everyone is responsible for maintaining the food in the refrigerator and to discard expired products. ADM stated when family brings food from outside, nurses should label and date the food item before storing in the refrigerator to know when to discard. ADM and DS didn't explain why there was no thermometer in the freezer. ADM stated they (facility) will make sure the refrigerator is organized, food is dated and expired items are discarded. A review of facility policy titled Food Brought in by Visitors (revised [DATE]) indicated, When food is brought into a nursing home prepared by others, the nursing home is responsible for ensuring that the food container is clearly labeled with the resident's name and date received and stored in a refrigerator .perishable food requiring refrigeration will be discarded after two (2) hours at bedside, and if refrigerated it will then be labeled, dated, and discarded after 48 hours.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review the facility failed to ensure the facility's Administrator (ADM) who was responsible for providing effective leadership, oversight, safe access to residents, staff, and visitors, policies, and procedures throughout the recertification process-maintained professionalism and appropriate behavior. This deficient practice impeded the completion of an investigation, placing facility residents at risk for the spread of infections, delays in care, and had the potential to make residents, visitors, and staff feel threatened. Findings: A review of Resident 278 admission record indicated the resident was initially admitted to the facility on [DATE] with diagnoses that included chronic kidney disease stage 4 (kidneys are moderately or severely damaged and are not working as well as they should to filter waste from your blood. Waste products may build up in your blood and cause other health problems), type 2 diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), and chronic obstructive disease (COPD- is a common lung disease causing restricted airflow and breathing problems). A review of Resident 278's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 5/9/24 indicated, Resident 278 was moderately impaired cognitively (ability to think, read, learn, remember, reason, express thoughts, and make decisions) and required supervision and/or touching assistance to setup or clean-up assistance for activities of daily living (ADL's: activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating). A review of the care plan titled At risk for MDRO and other transmissible infectious pathogens due to peripherally inserted central catheter (PICC line -presence of a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart), history of MRSA (Methicillin-resistant Staphylococcus aureus is an infection of Staphylococcus (staph) bacteria. This germ is resistant to some antibiotics. It can spread in hospitals, other healthcare facilities, and in the community), ESBL (Extended-spectrum beta-lactamases are enzymes that confer resistance to most beta-lactam antibiotics, including penicillin, cephalosporins, and the monobactam aztreonam. Infections with ESBL-producing organisms have been associated with poor outcomes), and VRE (Vancomycin-resistant Enterococci are bacteria (germs) that commonly live in the gastrointestinal tract (bowels) of most people [colonization] can be spread from person to person through direct contact with an infected or colonized person), was initiated on 5/25/24 with interventions which included to educate resident, and resident family/representatives regarding the purpose of Enhanced Standard Precaution (ESP-transmission based precaution that refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). A review of Resident 278's physician order summary report (POSR) as of 5/27/202, indicated there was no physician's order for ESP. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation of Resident 278's room and interview on 5/27/2024 at 5:15 p.m., Resident 278's room door was observed to have signage indicating the resident was on Enhanced Standard Precaution (ESP-transmission based precaution that refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). Visitors/family were observed entering Resident 278's room without putting on the indicated Personal protective equipment (PPE: specialized gowns, gloves, masks, or equipment worn to create a barrier between the wearer and germs, reducing the chance of exposure and spread of infections). The visitors/family were then observed hugging and kissing Resident 278 with no PPE on. Registered Nurse 4 (RN4) was asked if resident family members and visitors were educated regarding ESP, PPE, and the importance of protecting residents who were on ESP. RN 4 stated that visitors were notified over the phone before visiting the facility regarding isolations/precautions and what type of PPE to wear. RN 4 stated all visitors were re-educated when arriving to the facility's lobby to ensure understanding and were then directed to go to the nursing station to collect the required PPE for infection control. During the same concurrent observation of Resident 278's room and interview 5/27/2024 at 5:15 p.m., the ADM approached the surveyor in the hallway and started talking loudly over the surveyor, not allowing the surveyor to speak, while vigorously pointing out at a paper with facility policies. The ADM held the paper within 4-5 inched of the surveyor's face, with the level of voice getting louder, in front of facility staff, residents, and visitors. The ADM stated, where in our policy does it state that touching is included in the isolation?. The surveyor kindly informed the ADM that she (the surveyor) was unable to speak with the ADM at that moment as the surveyor was in the middle of the interview. The ADM walked away angrily. Visitor 1 (V1) for Resident 278 then approached the surveyor angrily yelling at the surveyor asking why the surveyor was trying to prevent the visitors/family from visiting with the resident. V1 stated no one in the facility had spoken to her (V1) about the type of precautions Resident 278 was on. V1 stated she (V1) was not happy that the facility had not even placed any type of container by Resident 278's room containing PPE which would serve as a cue for anyone entering the room. V1 stated placing the PPE at the nursing station where guests had no access was unacceptable and denied V1 and others the opportunity to put on PPE. The surveyor was unable to continue the investigation as the surveyor felt threaten and left the facility. During a telephone interview on 5/28/2024 at 9:31am, the district office supervision (DOS) called the ADM and [NAME] President of Operations (VPO) to ensure the recertification process could continue safely. The ADM continuously interrupted the DOS in a loud voice throughout the call stating she (ADM) was very passionate. The ADM was asked if professionalism and respect could be maintained, the ADM agreed. During the formal exit conference on 5/28/2024 at 7:29 p.m., with the ADM, [NAME] President of Operations (VPO), Director of Nursing (DON), and Regional Quality Management Consultant 1 (RQMC1), the ADM was observed entering the conference wearing a blue overall onesie in a monster ([NAME]/[NAME]) character. During the required reading of the exit conference script reading, the surveyor was interrupted by ADM who sarcastically declared and uttered, that's an understatement, after reading the script paragraph, we understand that the survey process can be stressful. The surveyor had to stop throughout the exit as the ADM was constantly interrupting. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the policy and procedures (P&P) titled Enhanced Standard Precautions revised 1/29/24 indicated, the facility will reduce the potential for transmissions of pathogens including MDROs and viruses through the use of enhanced standard and transmission-based precautions. The same P&P indicated the purpose was to provide guidelines for infection control practices to reduce the potential for transmission of pathogens including MDROs and viruses which included: MRSA, VRE, ESBL, any infection when the organism is sensitive to two or fewer antibiotics. Under admission and placement, the P&P indicated to ensure that the appropriate instructions (signage) are communicated to staff, visitors and others entering the facility. A review of the facility's job description, titled, Administrator, undated, it indicated that principal responsibilities and duties (of ADM) includes maintaining strong positive relationships with resident, families, personnel, physicians, and the community . Maintain neat, well-groomed, and professional appearance.

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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** 43261 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program to implement their infection control policy and procedures (P&P) for five of 19 by failing to: 1. Don (put on) appropriate personal protective equipment (PPE) when disconnecting Resident 3 from the gastrostomy tube (GT- a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration) and while assisting Resident 3. 2. Don appropriate PPE when Certified Nursing Assistant 4 (CNA 4) was assisting Resident 178 during basic care. Enhanced Standard Precaution (ESP-transmission based precaution that refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) signage was not updated in Resident 178's door. 3. Provide education about ESP and offer PPE use to the visitors of Resident 278. 4. Ensure hemodialysis (HD-filtering the blood of a person whose kidneys are not working normally) residents with indwelling catheter were placed in ESP for Residents 48, and 62. 5. Ensure medication cart and pill cutters were clean at all times. 6. Ensure RN 1 donned (put on) gown before providing peripherally inserted central catheter (PICC, a thin, soft tube inserted into a vein in the arm, leg, or neck for long-term intravenous antibiotics [medication to fight bacterial infections]) care for Resident 278. These deficient practices had the potential to cross contamination and the spread of infection to the residents, visitors, and the community. Findings: 1a. A review of Resident 3 admission record indicated the resident was initially admitted to the facility on [DATE] with diagnoses that included hemiplegia (loss of strength in the arm, leg, and sometimes the face on one side of the body) and hemiparesis (loss of use in the arm, leg, and sometimes the face on one side of the body) following cerebral infarction (stroke), encounter for attention to gastrostomy and essential hypertension (elevated high blood pressure not caused by another disease). A review of Resident 3's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 2/16/24 indicated, Resident 3 was moderately impaired cognitively (relating to mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 3 was dependent for all activities of daily living (ADLs- bed mobility, transfer, dressing, and toilet use). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the care plan titled At risk for MDRO (multidrug resistant organism [MDRO] is a germ that is resistant to many antibiotics. If a germ is resistant to an antibiotic, it means that certain treatments will not work or may be less effective), and other transmissible infectious pathogens due to: Presence of Gtube, initiated 5/25/24. The interventions included to educate staff regarding the use and purpose of ESP. During a concurrent observation and interview with Licensed Vocational Nurse (LVN) 1 on 5/26/24 at 12 p.m. , LVN 1 was observed wearing gloves without gown while disconnecting Resident 3 from the Gtube who was on ESP. LVN 1 was unable to verbalize the reason why it was important to include an isolation gown while working with a resident who had an indwelling medical device. During an interview with Infection Preventionist Nurse 2 (IPN 2), IPN 2 stated that when providing care such as connecting or disconnecting a Gtube, staff must don a gown and gloves for infection prevention. 1b. A review of Resident 3's Physician Order Summary Report (POSR), as of 5/27/2024, indicated there was no physician's order for ESP. During an observation Certified Nursing Assistant 2 (CNA 2) on 5/24/2024 at 6:33 p.m., Resident 3 was observed with an ESP signage posted outside the door with no PPE and PPE cart provided. CNA 2 went inside Resident 3's room and pull up Resident 3's gown to access Resident 3's g-tube catheter. CNA2 did not perform hand hygiene and did not don gown and gloves before touching Resident 3. CNA 2 did not do any hand hygiene after leaving Resident 3's room. During a follow-up interview with CNA 2 on 5/24/2024 at 6:39 p.m., CNA 2 stated Resident 3 was on ESP according to the signage posted outside the door. CNA 2 acknowledged she did not put on PPE such as gown and gloves before touching Resident 3 which put residents at risk of acquiring infection. CNA 2 further stated they(staff) got their PPE from the linen cart which is down in the basement, and it was hard for them to use PPE because PPE was not readily available for them to use if needed. During an interview with Infection Preventionist Nurse 1 (IPN 1) on 5/27/2024 at 4:56 p.m., IPN1 stated staff are to don PPE if doing high-contact care with residents. IPN1 stated, if staff pulled up resident's gown to access a g-tube, that did not mean it was a high-contact activity. When asked if staff should wear gloves and do hand hygiene before and after touching resident, IPN answered yes. IPN 1 stated, placing residents on ESP is a nursing scope of practice and does not need a physician's order. IPN1 further stated, they are in process of learning what an ESP is. 2. A review of Resident 178's Admission Record indicated Resident 178 was originally admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses including diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), end stage renal failure (ESRD-a medical condition in which a person's kidney [organ in the body that lifters waste and excess fluid from the blood] function stop functioning on a permanent basis), hemodialysis dependence and generalized muscle weakness. A review of Resident 178's MDS dated [DATE], indicated Resident 178's skills for daily decision-making were moderately impaired. Resident 178 required maximal assistance from staff for activities of daily living (ADLs-bed mobility, transfer, dressing, and toilet use). MDS also indicated Resident 178 was on hemodialysis since admission. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 178's POSR, as of 5/27/2024, indicated no orders for enhanced standard precaution. A review of Resident 178's care plan, created on 5/25/2024, indicted Resident 178 was at risk for MDRO with interventions to initiate enhance standard precautions and educate staff regarding the use and purpose of the precaution. During an observation on 5/25/2024 at 12:49 p.m., transmission-based precaution signage and PPE cart were not observed to be provided for Resident 178. During an observation on 5/26/2024 at 10:04 a.m., Certified Nursing Assistant 4 (CNA 4) did not wear any PPE while providing Resident 178's basic care. CNA 4 stated Resident 178 was not on a transmission-based precaution, therefore no PPE was needed or required. During a concurrent observation and interview with Licensed Vocational Nurse 3 (LVN 3) on 5/27/2024 at 11:41 a.m., there was no signage to indicate Resident 178 was on enhanced standard precaution. LVN 3 stated Resident 178 was supposed to be on enhanced standard precaution since re-admission on 5/21/2024 and staff should wear proper PPE when caring for the resident. During an interview with IPN 1, on 5/27/2024 at 4:56 p.m., IPN 1 stated that Resident 178 was supposed to be on enhanced standard precaution since re-admission, dated 5/21/2024. IPN 1 stated the signage was not updated and that Resident 178 was at risk for infection if staff was not wearing proper PPE when caring for the resident. 45524 3. A review of Resident 278 admission record indicated the resident was initially admitted to the facility on [DATE] with diagnoses that included chronic kidney disease stage 4 (kidneys are moderately or severely damaged and are not working as well as they should to filter waste from your blood. Waste products may build up in your blood and cause other health problems), type 2 diabetes mellitus, and chronic obstructive disease (COPD- is a common lung disease causing restricted airflow and breathing problems). A review of Resident 278's MDS dated [DATE] indicated Resident 278 was moderately impaired cognitively and required between supervision or touching assistance to setup or clean-up assistance for ADLs. A review of the care plan titled At risk for MDRO and other transmissible infectious pathogens due to: Presence of PICC line, history of MRSA (Methicillin-resistant Staphylococcus aureus is an infection of Staphylococcus (staph) bacteria. This germ is resistant to some antibiotics. It can spread in hospitals, other healthcare facilities, and in the community), ESBL (Extended-spectrum beta-lactamases are enzymes that confer resistance to most beta-lactam antibiotics, including penicillin, cephalosporins, and the monobactam aztreonam. Infections with ESBL-producing organisms have been associated with poor outcomes), and VRE (Vancomycin-resistant Enterococci are bacteria (germs) that commonly live in the gastrointestinal tract (bowels) of most people [colonization] can be spread from person to person through direct contact with an infected or colonized person), initiated on 5/25/24, indicated interventions which included to educate resident, and resident family/representatives regarding the purpose of ESP. (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 with Registered Nurse (RN) 4 on 5/27/24 at 5:15 p.m., two visitors (V1 and V2) went into Resident 278's room without receiving education regarding the type of precaution the resident was on and any offer for PPE. RN 4 stated that guests were notified over the phone before they visited the facility regarding isolations/precautions and what type of PPE to don. RN 4 stated that all visitors should be re-educated at the lobby to ensure understanding and directed to go to the nursing station to collect the required PPE for infection control. During an interview with V1 on 5/27/24 at 5:18 p.m., at the nurse's station, V1 stated that no one in the facility had spoken to her about the type of precautions Resident 278 was on. V 1 stated that she was not happy that the facility had not placed any type of container by Resident 278's room containing PPE which would serve as a cue for anyone entering the room. V1 stated that placing the PPE at the nursing station where guests had no access was unacceptable because it denied herself and others from being offered the opportunity. A review of the P&P titled Enhanced Standard Precautions, revised 1/29/24, indicated, the facility will reduce the potential for transmissions of pathogens including MDROs and viruses through the use of enhanced standard and transmission-based precautions. The same P&P indicated the purpose was to provide guidelines for infection control practices to reduce the potential for transmission of pathogens including MDROs and viruses which included: MRSA, VRE, ESBL, any infection when the organism is sensitive to two or fewer antibiotics. Under admission and placement, the P&P indicated to ensure that the appropriate instructions (signage) are communicated to staff, visitors and others entering the facility. 43454 4a. A review of Resident 48's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), bloodstream infection (an infection caused by bacteria entering the bloodstream) due to central venous catheter (a long, flexible tube your inserted into a vein in the neck, chest, arm or groin), acute respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), pneumonia (lung infection that inflames air sacs with fluid or pus) and dependence on renal dialysis (a treatment for people whose kidneys are failing). A review of the MDS dated [DATE], indicated Resident 48's cognitive skills for daily decision-making were moderately impaired and required maximal to total dependence from staff for ADLs-eating, toileting hygiene, shower/bathing self, upper and lower body dressing, and personal hygiene. A review of Resident 48's POSR, as of 5/27/2024 indicated, there was no order for ESP. During a concurrent observation and interview with Resident 48 on 5/26/2024 at 11:16 a.m., Resident 48's did not have any ESP signages posted outside the door and there were no PPE carts available upon exiting Resident 48's room. Resident 48 stated she was just hospitalized because of an infection and blockage of her dialysis access (Permacath - a central line catheter used for hemodialysis [HD-a process of filtering the blood of a person whose kidneys are not working normally]). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: West Hollywood Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE: 855 North Fairfax Avenue Los Angeles, CA 90046	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Infection Preventionist Nurse 1 (IPN 1) on 5/27/2024 at 4:56 p.m., IPN1 stated they did not access Resident 48's Permacath, therefore the resident did not need to be on ESP. IPN1 stated Resident 48's dialysis Permacath is an indwelling catheter. IPN1 further stated they are in process of learning what an ESP is. During an interview with Medical Director (MD) on 5/28/2024 at 5:24 p.m., MD stated, a Permacath for the resident on HD is considered an indwelling catheter. MD stated he thinks it's important to ensure these residents are protected from infection and Resident 48 should be placed in an ESP. MD stated he was not aware of who were the residents placed in ESP, but physicians should be notified when residents are to be placed in ESP as a physician's order could help implement the process. During a follow-up interview with MD on 5/28/2024 at 7:20 p.m., MD stated that he wanted to correct himself to the surveyor to clarify that it is not necessary to have a physician's order to place resident for ESP. A review of the facility's P&P titled, Resident Isolation - Categories of Transmission-Based Precautions, reviewed on 1/29/2024, indicated that transmission-based precautions are used accordingly when caring for residents who are documented or are suspected of having communicable diseases or infection that can be transmitted to others. A review of the facility's P&P titled, Compliance with Laws and Professionals Standards, reviewed on 1/29/2024, indicated that facility policies and procedures are developed and maintained in accordance with local, state, and federal laws and with currently accepted professional standards and principles that apply to professionals providing services in a skilled nursing facility. A. Policies and procedures are reviewed at least annually and updated as necessary. B. Facility staff perform their duties in accordance with the policies and procedures adopted by the Facility. A review of Centers for Medicare & Medicaid Services (CMS), Quality, Safety & Oversight (QSO - oversight for compliance with the Medicare health and safety standards for laboratories, acute and continuing care providers [including hospitals, nursing homes, home health agencies (HHAs), end-stage renal disease (ESRD) facilities, hospices, and other facilities serving Medicare and Medicaid beneficiaries], made available to beneficiaries, providers/suppliers, researchers and State surveyors information about these activities), reference letter: QSO-24-08-NH, dated 3/20/2024 indicated that in July 2022, the Centers for Disease Control and Prevention (CDC - serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and health education activities designed to improve the health of the people of the United States) released updated EBP recommendations for Implementation of PPE Use in nursing homes to prevent spread of MDROs, and therefore, CMS is updating its infection prevention and control guidance accordingly. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status. Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the CDC's Implementation of PPE in Nursing Homes to prevent spread of MDROs, updated 7/12/2022, indicated that Enhanced Barrier Precautions expand the use of PPE and refer 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. When implementing Contact Precautions or Enhanced Barrier Precautions, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this: . make PPE, including gowns and gloves, available immediately outside of the resident room . Provide education to residents and visitors. 4b. A review of Resident 62's Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction (stroke), DM and dependence on renal dialysis. A review of Resident 62's MDS dated [DATE], indicated the Resident 62 was moderately impaired (a slight decline in cognitive function, such as memory, language, and thinking) and required between supervision or touching assistance to setup or clean-up assistance for ADL- Eating, oral hygiene, toileting hygiene, personal hygiene, shower/bathe self, upper and lower body dressing. A review of Resident 62's orders dated 3/29/24 indicated, (to) observe Permacath (a special catheter used for short-term dialysis treatment) site right chest for redness, vascular access, tenderness, bleeding, and drainage every shift. During a concurrent observation and interview of Resident 62's room with IPN2 on 5/26/24 at 10:38 a.m., there was no signage at the door to indicate type of isolation. The IPN2 stated that Resident 62 should be on isolation given the fact that he had a central line. IPN2 stated that any type of opening in the body is a possible portal for infection. IPN2 also stated that Resident 62 should have been on isolation for that reason. 5a. During a concurrent observation and interview with RN 2 on 5/26/2024 at 10:27 a.m., the pill cutter inside the medication cart 1, was observed with whitish and greenish particles. RN 2 stated the pill cutter should be cleaned after each use, so it does not mix with any other medications left on the cutter. During a concurrent observation and interview with LVN 3 on 5/27/2024 at 11:28 a.m., the pill cutter inside the medication cart 2, was observed with whitish and greenish particles. LVN 3 stated the pill cutter should be cleaned after each use since it would have some residues from other medications. 5b. During a concurrent observation and interview with LVN 3 on 5/27/2024 at 11:28 a.m., cluttered items such as bandages, nail cutter, alcohol wipes, etc. were observed inside the left top drawer of medication cart 2. LVN 3 stated that the charge nurses were supposed to keep the medication cart clean at all times. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with IPN 1 on 5/27/2024 at 5:02 p.m., IPN 1 stated that it is the charge nurses' duty to make sure medication carts and pill cutter are being cleaned due to possible transmission of infection. A review of facility's P&P, titled, Medication Administration-General Guidelines, reviewed on 1/29/2024, indicated that medications are administered in accordance with good nursing principles. A review of facility's P&P, titled, Infection Control, reviewed on 1/29/2024, indicated that facility will provide infection control policies and procedures required for a safe and sanitary environment. 44252 6. A review of Resident 278's Admission Record indicated Resident 278 was originally admitted to the facility on [DATE], with diagnoses including diabetes mellitus, muscle weakness, discitis (inflammation of the intervertebral [area between bones of the spine] disc space) lumbar (lower back) region, and malignant neoplasm (cancerous tumor) of the breast. A review of Resident 278's MDS, dated [DATE], indicated Resident 278 had moderate cognitive impairment and required supervision or touching assistance from staff for toileting, bathing, dressing and personal hygiene. The same MDS further indicated Resident 278 was on intravenous (IV, medical technique that administers fluids, medications, and nutrients directly into a person's vein) antibiotic therapy and had a PICC. A review of Resident 278's physician order summary report (POSR), dated 5/27/2024, indicated Resident 278 had an order dated 5/8/2024 of PICC line: change dressing and cap every day shift every seven days until 6/20/2024. During an observation with concurrent interview with Registered Nurse 1 (RN 1) on 5/26/2024 at 9:48 a.m., RN 1 was observed providing PICC line care for Resident 278 without donning (putting on) a gown as indicated on the Enhanced Standard Precautions (a resident-centered and activity-based approach of care for preventing multi drug resistant organisms [MDRO, germs that are not ablet be treated with the majority of the medications available] transmission in skilled nursing facilities) sign posted outside the residents room door. RN 1 stated she was supposed to have donned a gown along with gloves while providing PICC care. RN 1 also stated the dressing should be labeled with the time changed, not just the date and initials. During an interview with concurrent record review with RN 1 on 5/26/2024 at 10:05 a.m., the Enhanced Standard Precautions sign, dated September 2021, and posted outside the resident's room door was reviewed. The sign indicated providers and staff must clean hands-on room entry and when exiting, and wear gloves and gown for the high-contact resident care activities . Caring for devices and giving medical treatments. RN 1 stated she should have put on a gown when caring for the resident's PICC. A review of the facility's policy and procedures titled Central Venous Catheter Dressing Changes, dated May 2022, indicated, To apply sterile dressing . 6. Apply sterile transparent dressing (no gauze) to area, making sure to center the dressing over the insertion site . Label with initials, date and time.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on interview and record review, the facility failed to implement facility's protocol for Antibiotic Stewardship (the effort to measure and improve how antibiotics are prescribed by clinicians and used by patients/resident) for three of three sampled residents (Resident 13, 178, and 278). This deficient practice had the potential for Resident 13, 178, and 278, to develop antibiotic resistance (not effective to treat infection) from unnecessary or inappropriate antibiotic use, which could lead to adverse events including allergic reactions. Findings: 1. A review of Resident 178's Admission Record indicated Resident 178 was originally admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses including diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), end stage renal failure (ESRD-a medical condition in which a person's kidney [organ in the body that lifters waste and excess fluid from the blood] function stop functioning on a permanent basis), hemodialysis (HD-filtering the blood of a person whose kidneys are not working normally) dependence and generalized muscle weakness. A review of Resident 178's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/9/2024, indicated Resident 178's cognitive (relating to mental action or process of acquiring knowledge and understanding) skills for daily decision-making was moderately impaired. Resident 178 required maximal assistance from staff for activities of daily living (ADLs- bed mobility, transfer, dressing, and toilet use). MDS also indicated Resident 178 was on hemodialysis since admission. A review of Resident 178's Physician Order Summary Report (POSR), dated 5/21/2024, indicated that Resident 178 was prescribed with ceftriaxone sodium (antibiotic [antibiotic] medication) 2 grams (GM) intravenously (IV-administering fluid medication through a needle or tube inserted into a vein) every 24 hours for osteomyelitis (bone infection). POSR also indicated daptomycin (antibiotic medication) 350 milligrams (mg) via IV every 2 days for osteomyelitis was also ordered on 5/22/2024. A review of Resident 178's Infection Screening Evaluation (ISE), dated 5/21/2024, indicated missing infection analysis result of that if ceftriaxone sodium was met or not met antibiotic usage criteria. A review of Resident 178's ISE, dated 5/4/2024, indicated missing infection analysis result of that if daptomycin was met or not met antibiotic usage criteria. During a concurrent interview and record review with the Infection Preventionist Nurse 1 (IPN 1) on 5/28/2024 at 2:10 p.m., Resident 178's antibiotic orders and ISE were reviewed. IPN 1 stated that Resident 178's ISE for both antibiotic medications were not acceptable due to missing infection analysis result to indicate if antibiotic usage criteria were met. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 5/28/2024 at 2:25 p.m., DON stated that it is important to have a correct and complete system for antibiotic stewardship to minimize and prevent antibiotic resistant to all residents. 45524 2. A review of Resident 278's Admission Record indicated Resident 278 was originally admitted to the facility on [DATE], with diagnoses including diabetes mellitus, muscle weakness, discitis (inflammation of the intervertebral [area between bones of the spine] disc space) lumbar (lower back) region, and malignant neoplasm (cancerous tumor) of the breast. A review of Resident 278's MDS, dated [DATE], indicated Resident 278 had moderate cognitive impairment and required supervision or touching assistance from staff for toileting, bathing, dressing and personal hygiene. The same MDS further indicated Resident 278 was on IV antibiotic therapy and had a peripherally inserted central catheter (PICC, a thin, soft tube inserted into a vein in the arm, leg, or neck for long-term intravenous antibiotics). A review of Resident 278's POSR, dated 5/27/2024, the POSR indicated, Resident 278 was prescribed daptomycin intravenous solution 500 mg IV every two days for spinal abscess (buildup of pus) on 5/2/2024 until 6/20/2024. A review of Resident 278's ISE, dated 5/2/2024, the ISE indicated missing infection analysis result of that if antibiotic usage criteria was met. During a concurrent interview and record review with IPN 1 on 5/28/2024 at 2:10 p.m., Resident 278's daptomycin order and ISE were reviewed. IPN 1 stated Resident 278's ISE for the daptomycin medication was not acceptable due to missing infection analysis result indicating whether the antibiotic usage criteria were met or not met. 43261 3. A review of Resident 13's Admission Record indicated Resident 13 was originally admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses including diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and essential hypertension (elevated blood pressure not caused by another disease). A review of Resident 13's MDS dated [DATE], indicated Resident 13's cognitive skills for daily decision-making were severely impaired, requiring maximal assistance from staff for ADLs. A review of the Change in Condition Evaluation dated 5/16/2023 at 4:10 pm indicated, Resident 13 was noted to be difficult to arouse but responsive to stimuli. A urine sample was collected as ordered to check for a Urinary Tract Infection (UTI- when bacteria get into your urine and travels up to your bladder). A review of physician's orders dated 5/17/2024, indicated Ciprofloxacin (Cipro-type of antibiotics) 250 mg tablets, take 1 tablet by mouth twice a day for 5 days for UTI. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of Resident 13's medical record with IPN 1 on 5/28/2024 at 2:10 p.m., IPN 1 stated Resident 13's ISE for the Cipro medication was not acceptable due to missing infection analysis result indicating whether the antibiotic usage criteria was met or not met. A review of facility's policy and procedures (P&P), titled, Antibiotic Stewardship, reviewed on 1/29/2024, indicated that the facility will implement an Antibiotic Stewardship Program (ASP) to promote appropriate use of antibiotics optimizing the treatment of infection, reducing the threat of antibiotic resistance, reducing adverse events associated with antibiotic use and improve outcomes for Residents. P&P also indicated that IPN is responsible for tracking the following antibiotic stewardship processes by whether or not the Resident's condition met McGeer's Criteria (clinical criteria used to inform resident care decisions regarding initiation of antibiotics) when the antibiotic was ordered.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation and interview, the facility failed to maintain patient care equipment in safe working condition when one of six sampled residents (Resident 3) had an uncovered overhead light with exposed bulb. This deficient practice had a potential to cause incidental accidents to the resident, which could result in injuries. Findings: A review of Resident 3's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (loss of the ability to move in one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting right dominant side, Parkinson's disease (a disorder in the brain that affects movement, often including tremors), dysphagia (difficulty swallowing food or liquid), and Alzheimer's disease (a progressing brain disorder that destroys memory and other important mental function). A review of the Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 2/16/2024, indicated Resident 3's cognitive (relating to mental action or process of acquiring knowledge and understanding) skills for daily decision-making were moderately impaired. Resident 3 required total dependence from staff for activities of daily livings (ADLs-eating, toileting hygiene, shower/bathing self, upper and lower body dressing, repositioning from sit to lying and sit to lying). During an observation in Resident 3's room on 5/25/2024 at 11:03 a.m., Resident 3's overhead light with no cover and a long light bulb was exposed. During a concurrent interview and observation of Resident 3 with Maintenance Supervisor 1 (MS1) on 5/25/2024 at 7:11 p.m., MS1 stated and confirmed Resident 3's overhead light did not have a cover. MS1 stated the overhead light should always have a protective cover; if not, it may cause an avoidable electrical accident as the lightbulb might fall on resident's head. A review of the facility's policy and procedures (P&P) titled, Resident Rooms and Environment reviewed on 1/29/2024, indicated that the facility provides comfortable and adequate lighting throughout the facility to promote a safe, comfortable, and homelike environment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454 Based on observation, interview, and record review, the facility failed to ensure that 13 out of 34 rooms (room [ROOM NUMBER], 4, 8, 9, 11, 14, 15, 16, 17, 18, 20, 22, and 33) met the 80 square feet (sq. ft.) per resident in multiple resident rooms. This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for the residents. Findings: On 5/27/2024, Maintenance Supervisor 1 (MS1) and Director of Business Development (DBD) provided a copy of the Client Accommodation Analysis and a facility letter requesting for a room waiver. A review of the Client Accommodation Analysis indicated 13 of 34 rooms do not have at least 80 sq. ft. per resident. The room waiver request and Client Accommodation analysis indicated the following: RM# RM. Size (sq.ft) #of Res sq.ft SQ.FT/Resident 3 209 3 69.7 4 209 3 69.7 8 220 3 73.3 9 220 3 73.3 11 220 3 73.3 14 220 3 73.3 15 220 3 73.3 16 216.66 3 72.2 17 209 3 69.7 18 209 3 69.7 20 209 3 69.7 22 209 3 69.7 33 220 3 73.3 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	The minimum requirement for a three bedroom should be at least 240 sq. ft. During general observations from 5/25/2024 to 5/28/2024, both residents and staff had enough space to move about freely inside the rooms. The nursing staff had adequate space to safely provide care to the residents with the side tables, dressers, and resident care equipment in rooms. The Department is recommending continuation of the Room Waiver Request.