

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055960	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2025
NAME OF PROVIDER OR SUPPLIER LA Crescenta Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3050 Montrose Ave LA Crescenta, CA 91214	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854</p> <p>Based on observation, interview, and record review the facility failed to follow the facility ' s policy and procedure for self-administration of medications for one out of one sampled resident (Resident 75) when:</p> <ol style="list-style-type: none"> 1. Resident 75 was not assessed prior to self-administration of medications. 2. Resident 75 was observed storing medications at the bedside. <p>This deficient practice had the potential for Resident 75 and other resident who can have access to the medications to be at risk of harm from potential side effects or adverse effect (undesired effect of medication) that the medications could pose on Resident 75.</p> <p>Findings:</p> <p>A review of Resident 75 ' s Admission Record indicated the resident was admitted on [DATE] with diagnoses that included right leg wound, left leg fracture (break in the bone), and hypertension (elevated blood pressure).</p> <p>A review of Resident 75 ' s History and Physical (H&P), dated 9/28/2024, indicated the resident does have the capacity to understand and make decisions.</p> <p>A review of Resident 75 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 4/4/2024, indicated the resident has intact cognition (the ability to process thoughts and information.) The MDS also indicated the resident is independent in self-care activities including eating, toileting, and personal hygiene.</p> <p>A record review of Resident 75 ' s physician order report for 4/2025, included orders for:</p> <p>May keep artificial tears and Flonase (a medication administered to the nose to aid in treating allergies) nasal spray at bedside in locked cabinet, ordered on 4/22/2025.</p> <p>Monitor for proper self-administration of Flonase nasal spray and artificial tears weekly, ordered on 4/22/2025.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Artificial Tears 1 (one) drop, as needed, ordered on 4/22/2025. The order included instructions, may self administer 1 drop into each eye as often as needed.</p> <p>Flonase Allergy Relief spray, 50 mcg (microgram, a unit of measurement), 1 or 2 sprays into each nostril once a day, ordered on 4/22/2025. The order included instructions, may self administer 1 or 2 sprays into each nostril once a day as needed for nasal congestion.</p> <p>During an observation and interview on 4/22/2025 at 9:23 AM inside Resident 75 ' s room, a bottle of nasal spray, labeled Saline Nasal Spray, and a bottle of eye drops without a cap labeled, Clear Eyes, were observed on Resident 75 ' s table. While the surveyor was interviewing Resident 75, the resident grabbed the bottle of nasal spray from the table, uncapped the bottle, and administered 1 spray into each nostril. Resident 75 stated he self-administers the nasal spray every 3 to 4 hours.</p> <p>During a follow-up interview on 4/22/2025 at 9:25 AM, Resident 75 stated he bought the nasal spray (spray into the nose) and eye drops himself and has been using them for more than 1 month. Resident 75 stated the facility has not conducted a meeting with him regarding the self administration of medications. Resident 75 stated he has always kept the medications on his table so that they are easily accessible.</p> <p>During a concurrent observation and interview on 4/22/2025 at 9:41 AM inside Resident 75 ' s room with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was not aware that Resident 75 was keeping medications at bedside and self-administering them. LVN 2 stated the medications must be stored inside of a locked container to prevent access to other residents who may be confused.</p> <p>During a concurrent interview and observation on 4/22/2025 at 9:44 AM with LVN 2, Resident 75 ' s medical records were reviewed. LVN 2 stated there is no record that Resident 75 was assessed for the capacity to self-administer medications. LVN 2 stated there are no records of medication administration for Resident 75 ' s nasal spray and eye drops. LVN 2 added there are no orders for Resident 75 ' s nasal spray and eye drops, and that Resident 75 may self-administer his own medications.</p> <p>During an interview on 4/22/2025 at 9:49 AM with Registered Nurse (RN) 1, RN 1 stated residents are only permitted to self-administer medications if they have been assessed and evaluated. RN 1 stated if the residents self-administer without being evaluated, they could be self-administering the medications incorrectly which could lead to overdose and interactions with their current medications. RN 1 also stated the resident ' s use of the medication must be logged and monitored.</p> <p>During a concurrent interview and record review on 4/25/2025 at 10:51 AM with the Director of Nursing (DON), the facility ' s policies and procedures (P&P) titled, Self-Administration of Medication, undated, was reviewed. The DON stated the P&P indicated residents must be assessed prior to allowing them to self-administer their own medications. The DON stated that the resident ' s self-administration of medications must also be tracked by staff by giving the resident a log to record when they self-administer their medication. The DON also stated that not following the policy puts the resident at risk for harm such as overdosing on medication. The DON added not storing the medications in a locked container could allow other residents to use the medications, which could lead to the spread of infection.</p> <p>A review of the facility ' s P&P titled, Self-Administration of Medication, undated, indicated the following:</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>If a resident desires to participate in self-administration, the interdisciplinary team will assess the ability of the resident to participate.</p> <p>The nurse will interview the resident to determine their ability to identify, prepare, secure, and administer medications.</p> <p>The nurse will obtain a physician ' s order for each resident conducting self-administration of medications.</p> <p>Storage of self-administered medications will comply with state and federal requirements for medication storage.</p> <p>A review of the facility ' s P&P titled, Bedside Medication Storage, dated 2007, indicated the following:</p> <p>The interdisciplinary team (IDT) will review and approve resident competencies and understanding prior to permission of bedside storage of medications as established in the nursing care centers policies and procedures.</p> <p>A written order for the bedside storage of medications is present in the resident ' s medical record.</p> <p>Bedside storage of medications is indicated on the resident medication administration record (MAR) for the appropriate medications.</p> <p>The manner of storage prevents access by other residents.</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882</p> <p>Based on observation, interview and record review, the facility failed to accommodate the needs two of two sampled residents (Resident 184 and 33) in accordance with the facility's policy and procedure by failing to ensure the call light (a device used by residents to signal his or her needs for assistance) was within reach (within arm's length).</p> <p>This deficient practice had the potential for Resident 184, who was at high risk of falls, and Resident 33, who has visual deficits, to not be able to call the facility staff to ask for help or assistance, especially during emergencies.</p> <p>Findings:</p> <p>1. During a review of Resident 184's Admission Record, indicated the facility originally admitted Resident 184 on 3/26/2025 and readmitted on [DATE] with diagnoses that included encephalopathy (a general term for brain disease, damage, or malfunction), disorder of bone density and structure (a condition where bones become weak and brittle, making them more prone to fractures), and atherosclerotic heart disease (thickening or hardening of the arteries).</p> <p>During a review of Resident 184's History and Physical Examination (H&P), dated 4/17/2025, indicated chief complaint was weakness and neurological physical examination was grossly intact.</p> <p>During a review of Resident 184's Minimum Data Set (MDS - a resident assessment tool), dated 3/31/2025, indicated Resident 184 was dependent (helper does all the effort) with eating, toileting and bathing, and required substantial/maximal assistance (helper does more than half the effort) with dressing and personal hygiene.</p> <p>A review of Resident 184's facility document titled, Fall Risk Data Collection dated 4/15/2025, indicated Resident 184 was high risk for fall.</p> <p>A review of Resident 184's care plan (CP) for high risk for fall that may result in physical harm due to balance problem and muscle weakness dated 4/16/2025, the CP intervention included keep call light within reach.</p> <p>During a concurrent observation and interview on 4/22/25 at 11:00 AM with Registered Nurse (RN) 1 and License Vocational Nurse (LVN) 1 in Resident 184's room. Resident 184 was lying in the bed with head of bed elevated at 30 degrees eyes closed, the call light was hanging on the left side of the bed, the button was about six inches from the floor. LVN 1 stated, the call light for Resident 184 could not be reached by Resident 184, and she was not able to use call light for assistance when she needed care. RN 1 stated, Resident 184's call light should always be within reach, so Resident 184 can ask for help especially for emergencies from accidents or fall.</p> <p>During an interview on 4/23/25 at 1:00 PM with Resident 184, Resident 184 stated that she knows how to use the call light, and she uses it if she needs assistance with the staff.</p> <p>48854</p> <p>(continued on next page)</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. A review of Resident 33's Admission Record, indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a gradual decline in mental ability usually caused by a brain disease), Parkinson's disease a brain disorder in which there is a lack of the chemical messenger dopamine, which helps control muscle movement; leads to muscle stiffness, weakness, and trembling), and osteoarthritis (inflammation of the joints due to the breakdown of the cartilage lining the bones in joints).</p> <p>A review of Resident 33's H&P, dated 11/27/2024, indicated the resident has a history of fractures (a break in a bone). The H&P also indicated the resident has a history of mental illness.</p> <p>A review of Resident 33's MDS, dated [DATE], indicated Resident 33 has severely impaired cognition (the ability to think and process information). The MDS also indicated that the resident is dependent on activities such as toileting and bathing and required substantial/maximal assistance to roll in bed from left to right.</p> <p>A review of Resident 33's care plans for visual deficit, dated 3/14/2025, included an intervention to keep call light within reach.</p> <p>During an observation and interview on 4/22/2025 at 8:58 AM inside Resident 33's room, Resident 33 was lying in bed and stated help. Resident 33's call light was observed hanging on the left side of the bed, not within reach of the resident.</p> <p>During a concurrent observation and interview on 4/22/2025 at 9:03 AM with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 33 cannot reach the call light because it is hanging on the side of the bed. CNA 1 stated Resident 33 knows how to use and uses the call light to call for help. CNA 1 stated the resident would not be able to call for help if the call light is not within reach.</p> <p>During an interview on 4/24/25 at 9:28 AM with DON (Director of Nurses), DON stated, he expects staff to answer call light promptly, and call lights should always be within the residents reach as per policy. DON stated, the call light needs to be within reach so residents can call for assistance with ADLs, and especially during an emergency from accidents or falls.</p> <p>A review of the facility's policy and procedure (P&P) titled, Fall Management, (undated), indicated; a) the staff will identify interventions related to the resident's specific risks and causes to try to reduce the risk of the resident falling, b) a fall prevention program will be developed for each resident that will provide staff with functional strategies to minimize risk for fall and c) fall risk factor includes; lower extremity weakness, functional impairments, heart failure and neurological disorders.</p> <p>A review of the facility's policy and procedure (P&P) titled, Call Lights-Answering Of, (undated), indicated; a facility staff will provide an environment that helps meet the resident's need, b) respond to resident's call light in a timely manner, and c) ensure that the call light is placed within the Resident's reach.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47467</p> <p>Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan to address Resident 32's refusal to have the long nails with fungal infection and for podiatric (a physician specialized in foot treatment) treatment on 7/13/2024, 8/24/2024, 10/24/2024 and 1/7/2025 (total 4 days).</p> <p>This deficient practice had a potential result in Resident 32's inadequate and incomplete provision of care and result in worsened foot infection and pain.</p> <p>Findings:</p> <p>During a review of Resident 32's Admission Record, indicated Resident 32 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included postherpetic trigeminal neuralgia (a condition characterized by persistent, severe facial pain that can develop after a shingles [a viral infection that causes a painful, blistering rash that typically appears on one side of the body] outbreak), secondary parkinsonism (a condition where symptoms similar to Parkinson's disease [like tremors, stiffness, and slow movements]), and peripheral autonomic neuropathy [nerve damage outside the brain and spinal cord (a column of nerve tissue that runs from the base of the skull down the center of the back)].</p> <p>During a review of Resident 32's Podiatric Evaluation and Treatment (PET), dated 7/13/2024, indicated Resident 32 was assessed with onychomycosis (a fungal infection of the nails) and left great toe ingrown nail (occurs when the side of a nail, typically a toenail, grows into the surrounding skin, causing pain, and potentially infection). The PET indicated Resident 32 refused treatment.</p> <p>During a review of Resident 32's Physician Oder Report, indicated Resident 32 had a physician order on 7/24/2024 to Podiatry services for treatment of hypertrophied (thicken) toenails and/or other foot problems needed.</p> <p>During a review of Resident 32's PET, dated 8/24/2024, 10/24/2024 and 1/7/2025, indicated Resident 32 refused to have the left great toenail treatment and toenails care during all dated visits.</p> <p>During a review of Resident 32's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 2/8/2025, indicated Resident 32's cognition (ability to think, remember, and reason with no difficulty) was moderately impaired, and was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in personal hygiene.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 4/24/2025 at 10:05 AM with Registered Nurse (RN) 2 in Resident 32's room, Resident 32's toes were about 5 millimeters (mm-a unit of measurement) in length and the resident ' s left great toe was partially black. Resident 32 stated, his left great toe had been bleeding for almost a year on and off. Resident 32 stated, he could not recall if he refused nail treatment or nail care. Resident 32 stated, if he ever refused the treatment, it was because he felt like his toenails were not taken care of enough by the doctor, which caused him pain. RN 2 stated, Resident 32's left great toe had [NAME] dry brown substance that appear like dry blood underneath the nail.</p> <p>During an interview on 4/24/2025 at 10:12 AM with RN 2, RN 2 stated, she was not aware that Resident 32 had been refusing toenails care and treatment. RN 2 stated, the podiatrist ' s assistant usually give report to the charge nurse after each doctor ' s visit. RN 2 stated, she could not recall if she got reported for Resident 32's refusal to toenails care and treatment.</p> <p>During a concurrent record review and interview on 4/24/2025 at 10:35 AM with RN 1, Resident 32 ' s PET dated 7/13/2024, 8/24/2024, 10/24/2024 and 1/7/2025, and Resident 32 ' s care plan records were reviewed. RN 1 stated, she was the RN Supervisor who was in charge of Resident 32. RN 1 stated, if Resident 32 refused toenails care and treatment, there should be a care plan to address his refusal and education for the risk of refusal to care should be provided to Resident 32. RN 1 stated, she could not find any care plan for Resident 32 ' s refusal to toenails care and treatment.</p> <p>During a concurrent record review and interview on 4/24/2025 at 10:50 AM with the Director of Nursing (DON), Resident 32 ' s medical records including Resident 32 ' s Progress Notes and Care Plans were reviewed. The DON stated, there was no care plan and any other documented evidence that Resident 32 ' s refusal to toenails care and treatment was addressed, or if alternative treatments were discussed and provided to the resident. The DON stated, there should be an interdisciplinary team (IDT, a coordinated group of experts from several different fields) meeting, and a care plan should be developed and implemented for Resident 32 ' s refusal to toenails care and treatment.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Refusal of Treatment, undated, indicated:</p> <ul style="list-style-type: none"> -Treatment is defined as care provided for purposes of maintaining/restoring health, improving functional level, or relieving symptoms. -Risks versus benefits will be discussed by the assigned staff with the resident/resident representative. -A member of the interdisciplinary team (IDT) interviews residents refusing treatment to determine what is being refused and why in order to address the resident ' s concerns. -An IDT member assesses the reasons for the resident's refusal of treatment and attempts to clarify and educate the resident and/or family as to the consequences of such refusal. -The care plan team assesses the resident ' s needs and offers the resident alternative treatments while continuing to provide all other services outlined in the care plan. <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility ' s P&P titled, Comprehensive Plan of Care, undated, indicated the comprehensive plan of care must address the resident ' individual needs, strengths, and preferences; and reflect the company ' s efforts to provide alternative methods when a resident wishes to refuse certain treatments or services.</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882</p> <p>Based on observation, interview, and record review, the facility failed to follow its policy for Medication Pass Guidelines and the professional standard of practice for one of one sampled resident (Resident 49) who received his scheduled 9 AM medications more than one hour late.</p> <p>This deficient practice had resulted in Resident 49, who also receives medication to lower blood pressure, felt frustrated, and had the potential for Resident 49 to have elevated blood pressure and not to optimize the effect of his drug therapy that could negatively affect Resident 49's quality of life</p> <p>Findings.</p> <p>A review of Resident 49's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (a condition that affects nerves in your central nervous system, causes a range of symptoms like blurred vision and problems with how we move, think and feel), hypertension (high or raised blood pressure), atrial fibrillation (an irregular and often very rapid heart rhythm), malignant neoplasm of prostate (prostate cancer) and anxiety disorder (feelings of nervousness or anxiousness and involve excessive fear or anxiety).</p> <p>During a review of Resident 49's History and Physical Examination (H&P), dated 12/12/2024, indicated Resident 49 was alert and oriented and follows simple commands.</p> <p>A review of Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/31/2025, indicated Resident 49's cognitive skills (ability to make daily decisions) was intact. The MDS indicated Resident 49 was independent with eating, supervision or touching assistance (Helper provides verbal cues and or touching steadying) with dressing, and partial/moderate assistance (helper does less than half the effort) with toileting, bathing and personal hygiene.</p> <p>A review of Resident 49's care plan (CP) for diagnosis of hypertension, dated 4/1/2025, indicated intervention include administer medications as ordered.</p> <p>A review of Resident 49's care plan (CP) for risk for constipation dated 4/1/2025, indicated intervention include administer medications as ordered.</p> <p>A review of Resident 49's care plan (CP) for cardiac function deficit due to atrial fibrillation, dated 4/1/2025, indicated intervention include administer medications as ordered.</p> <p>During a concurrent observation and interview on 4/22/2025 at 10:50 AM with Resident 49, in Resident 49's room, sitting upright in bed with head of bed elevated, Resident 49 was angry and with glaring eyes, tense jaw, and clenched fist. Resident 49 stated, he had been waiting for his medications for a while, it was late, and he was very angry and frustrated.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/22/2025 at 10:55 AM, with LVN (License Vocational Nurse) 1, in Resident 49's room, LVN 1 stated, she was aware that she had not administered Resident 49 ' s 9AM medications and will be administering the medications late because she was busy with other residents. LVN 1 stated, it was important to give the scheduled medication on time because it might affect the effectiveness of the drug therapy, such as managing his depression and discomfort from muscle spasm, and especially the medication for Resident 49 ' s hypertension. LVN 1 stated, she will inform Resident 49's Primary Medical Doctor (PMD) about the late administration of the medication today.</p> <p>A review of Resident 49's facility document titled Medication Administration History dated 4/22/2025, the document indicated the following list of medications given late:</p> <ol style="list-style-type: none"> 1. Calcium 600 mg (unit of measurement of mass) + D (3) 5 mcg (unit of measurement of mass) tablet (200 Unit) - for supplement - scheduled at 9AM administered at 11:11 AM. 2. Carisoprodol 175 mg - for muscle spasm - scheduled at 9AM administered at 11:11 AM. 3. Cranberry Tablet 450 mg - for supplement - scheduled at 9AM administered at 11:11 AM. 4. Daily Multivitamin-minerals tablet - for supplement - scheduled at 9AM administered at 11:11 AM. 5. Docusate sodium capsule 100 mg - for constipation - scheduled at 9AM administered at 11:11 AM. 6. echinacea capsule 400 mg - for supplement - scheduled at 9AM administered at 11:11 AM. 7. Eliquis 5mg - for atrial fibrillation - scheduled at 9AM administered at 11:11 AM. 8. Enalapril maleate tablet 10 mg - for hypertension - scheduled at 9AM administered at 11:11 AM. 9. ergocalciferol 50 mcg - for supplement - scheduled at 9AM administered at 11:11 AM. 10. Flecainide Tablet 100 mg - for atrial fibrillation - scheduled at 9AM administered at 11:11 AM. 11. Glucosamine sulfate 500 mg - for supplement - scheduled at 9AM administered at 11:11 AM. 12. lactulose 10 gm - for constipation - scheduled at 9AM administered at 11:11 AM. 13. magnesium citrate 200 mg - for supplement - scheduled at 9AM administered at 11:11 AM. 14. omega 3 fish oil 2000mg - for supplement - scheduled at 9AM administered at 11:11 AM. 15. Pepogest (peppermint oil) 1 capsule - for supplement - scheduled at 9AM administered at 11:11 AM. 16. PreserVision AREDS capsule - for supplement - scheduled at 9AM administered at 11:11 AM. 17. Refresh Tears 2 drops - for dry eyes - scheduled at 9AM administered at 11:11 AM. <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>18. Sertraline 50 mg - for depression manifested by social isolation - scheduled at 9AM administered at 11:11 AM.</p> <p>19. Slippery elm bark capsule 1200 mg - to soothe gastrointestinal tract - scheduled at 9AM administered at 11:11 AM.</p> <p>20. Vitamin A 10,000 units -for supplement - scheduled at 9AM administered at 11:11 AM.</p> <p>During an interview and concurrent record review Medication Administration History on 4/23/2025 at 2:30 PM with RN (Registered Nurse) 1, indicated 20 medications were given more than one hour late at 11:11 AM. RN 1 stated, she was not sure why LVN 1 was late giving the medications scheduled on 4/22/2025 at 9 AM, RN 1 stated LVN 1 Probably she got busy with other residents. RN 1 stated, administering the medication late may affect the effectiveness of the drug therapy, and the medications to lower high blood pressure if given late had the potential to cause Resident 49's blood pressure to go up.</p> <p>During an interview on 4/24/2025 at 9:30 AM, with the DON (Director of Nurses), DON stated, to optimize drug therapy, medication orders should be administered safely and timely. DON stated, scheduled medications should be administered plus/minus 60 minutes of the scheduled time. DON stated, Resident 49's medications was administered late, which had cause anger and frustration, and since he had medication to lower his blood pressure that was administered late as well, it had the potential to cause 49's blood pressure to go up.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Quality of Care, (undated), the P&P indicated; a) purpose based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, b) The facility will implement resident-directed care and treatment consistent with the resident ' s comprehensive assessment and care plan, and c) The facility will provide needed care or services (i.e., manage symptoms) for residents to improve and/or attain their highest practicable physical, mental and/or psychosocial wellbeing.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Medication pass Guidelines, (undated), the P&P indicated; a) purpose is to assure the most complete and accurate implementation of physicians medication orders and to optimize drug therapy for each resident by providing for administration of drugs in an accurate, safe and timely manner, and b) administer medications within 60 minutes of the scheduled time.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882</p> <p>Based on observation, interview, and record review, the facility failed to provide respiratory care and treatments in accordance with the professional standards of practice, care plan goals, physician's order and the facility's policy and procedure for one of one sample residents (Resident 78) who was observed without oxygen for more than 30 minutes, while pulse oximeter reading (a measure of how much oxygen is carried by red blood cells in the blood, expressed as a percentage, with a normal range being 95-100%) decreased to 85%.</p> <p>The Physician ordered Resident 78 to receive oxygen at 2 liters (standard unit used to measure the rate of oxygen flow) as needed for shortness of breath or oxygen saturation less than 93 percent.</p> <p>This deficient practice had the potential for Resident 78 to experience hypoxia (not enough oxygen is available to meet the needs of the body's cells) and/or respiratory distress (difficulty breathing), hospitalization and death.</p> <p>Findings:</p> <p>During a review of Resident 78's Admission Record, indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included peripheral autonomic neuropathy (happens when the nerves that are located outside of the brain and spinal cord are damaged, pneumonia (an infection that affects one or both lungs), and chronic kidney disease (a condition where the kidneys don't function properly over a long period).</p> <p>During a review of Resident 78's History and Physical Examination (H&P), dated 4/17/2025, indicated Resident 78 does not have the capacity to make healthcare decisions.</p> <p>A review of Resident 78's Minimum Data Set (MDS- a resident assessment tool) dated 2/20/2025, indicated Resident 78 required partial/moderate assistance (helper does less than half the effort) with eating, dressing and personal hygiene, and substantial/maximal assistance (helper does more than half the effort) with toileting.</p> <p>A review of Resident 78's facility document titled General Order (a physician order), dated 4/15/2025, indicated to provide the resident oxygen at 2 liters as needed for shortness of breath or oxygen saturation less than 93 percent, and record oxygen saturation.</p> <p>A review of Resident 78's care plan (CP) for alteration in respiratory status due to risk for legionella (severe type on pneumonia), pneumonia unspecified organism, and shortness of breath, dated 4/16/2025, intervention includes, provide oxygen at 2 liters as needed for shortness of breath or oxygen saturation less than 93 percent.</p> <p>A review of Resident 78's care plan (CP) for Anemia with risk for weakness, fatigue and shortness of breath, dated 4/19/2025, intervention includes, provide supplemental oxygen as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 4/23/2025 at 11:38 AM in Resident 78's room, Resident was in bed laying on his back with occasional cough, oxygen machine was on, connected to a nasal cannula (a device/tubing that gives you additional oxygen through the nose), which was on top of Resident 78's bed and not connected to Resident 78's nose for more than 30 minutes.</p> <p>During a concurrent observation and interview on 4/23/2025 at 11:40 AM with LVN (license Vocational Nurse) 1, CM (Case Manager) 1, and RN (Registered Nurse) 1, in Resident 78 ' s room. LVN 1 stated, Resident 78 should be getting oxygen via nasal cannula, she was not sure why it was not on the patient. CM 1 stated, pulse oximeter should have been checked prior to administering supplemental oxygen. RN 1 stated, Resident 78 not receiving oxygen can cause respiratory distress and potentially get hypoxia.</p> <p>During a concurrent interview and record review on 4/23/2025 at 11:43 AM with LVN 1, Resident 78 EHR (Electronic Health Record) dated 4/23/25 was reviewed and did not indicate pulse oximeter was checked, or supplemental oxygen was administered. LVN 1 stated, she did not remember Resident 78 ' s pulse oximeter reading at the beginning of her shift, and she forgot to record it.</p> <p>During a concurrent observation, interview on 4/23/2025 at 11:45 AM with LVN 1, CM 1 and RN1 in Resident 78' s room, Resident 78 pulse oximeter reading was low at 85 percent on room air and went up to 95 percent when supplemental oxygen at 2 liters per minute was administered via nasal cannula. LVN 1 stated, Resident 78 needed supplemental oxygen as per his pulse oximeter reading. CM 1 stated, pulse oximeter reading should have been monitored at the beginning of the shift to get a baseline and to ensure Resident 78 receives oxygen as needed. RN 1 stated, Residents 78 who had physician order for oxygen as needed, pulse oximeter reading should be done at the beginning of the shift, to ensure oxygen was administered as needed because of the potential for respiratory distress and hypoxemia.</p> <p>A review of Resident 78 ' s facility document titled Medication Administration History, dated 4/1/2025 to 4/25/2025, the document did not indicate pulse oximeter was checked, and 2 liter of oxygen was administered as needed for pulse oximeter reading less than 93 percent on 4/23/2025.</p> <p>During an interview on 4/24/2025 at 9:32 AM with DON (Director of Nurses), DON stated, Resident 78 had an order for supplemental oxygen as needed, then the pulse oximeter reading should have been done at the beginning of the shift, supplemental oxygen should have been administered as ordered and ensure it was on the patient. DON stated, a pulse oximeter reading of 85 percent and Resident 78 not receiving supplemental oxygen had the potential for respiratory distress and /or hypoxemia that can negatively affect Resident 78 ' s quality of life.</p> <p>A review of the facility ' s policy and procedure (P&P) titled, Physician Orders, (undated), indicated: physician orders are obtained to provide a clear direction in the care of the resident.</p> <p>A review of the facility ' s policy and procedure (P&P) titled, Oxygen Administration,(undated), indicated: a) a resident will need oxygen therapy when hypoxemia (low oxygen in blood) occurs, and pulse oximetry monitoring, and clinical examinations determine the adequacy of oxygen therapy, b) monitor the residents response to oxygen therapy, check pulse oximetry values during initial adjustments of oxygen flow, check pulse oximetry as indicated by the physicians order, and c) monitor the resident for signs of hypoxemia as appropriate such as pulse oximetry and breathing patterns.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854</p> <p>Based on observation, interview, and record review, the facility failed to maintain a medication error rate of five percent or (5%) or less during medication pass for two of four residents (Residents 28 and 237) in which three (3) medication errors were identified out of 30 opportunities which yielded a cumulative error rate of 10 %.</p> <p>Licensed Vocational Nurse (LVN) 1 checked the heart rate of Resident 237 prior to the administration of Hydrochlorothiazide (medication that lowers the blood pressure and heart rate) and Verapamil (medication ordered to manage hypertension [HTN- elevated blood pressure])</p> <p>LVN 1 verified the dosage of Cyanocobalamin B12 (a vitamin supplement) according to the physician's order, the Medication Administration Record (MAR) and the medication available prior to administration of to Resident 28's.</p> <p>Findings:</p> <p>1. A review of Resident 237's Admission Record indicated the resident was admitted on [DATE] with diagnoses that included heart disease (the build-up of fats, cholesterol, and other substances in and on the walls of blood vessels) and history of falls.</p> <p>A review of Resident 237's History and Physical (H&P), dated 4/17/2025, indicated the resident has a diagnosis of hypertension. The H&P also indicated the resident has the capacity to understand and make decisions.</p> <p>A review of Resident 237's Minimum Data Set (MDS- A resident assessment tool), dated 4/22/2025, indicated the resident has intact cognition (the ability to think and process information).</p> <p>A review of Resident 237's physician orders, for April 2025, included medication orders:</p> <p>1. Hydrochlorothiazide tablet; 25 mg (mg, milligram, a unit of measurement) once a day ordered on 4/16/2025. The order also included instructions to Hold [do not give the medication] if systolic blood pressure (SBP - the amount of pressure in the arteries during contraction of the heart muscle) <110 (less than 100) or HR (hear rate) <60 (less than 60).</p> <p>2. Verapamil tablet extended release; 25 mg once a day ordered on 4/16/2025. The order also included instructions to Hold if SBP <110 or HR <60.</p> <p>During a medication pass observation and concurrent interview with LVN 1 on 4/23/2025 at 8:20 AM, LVN 1 was observed checking Resident 237 ' s blood pressure. LVN 1 stated the blood pressure was 130/70, but did not mention that she checked the resident ' s heart rate. After checking Resident 237's blood pressure, LVN 1 prepared the medications Hydrochlorothiazide and Verapamil. As LVN 1 was about to administer the Hydrochlorothiazide and Verapamil, the surveyor stopped LVN 1 and asked if Resident 237 ' s heart rate was checked. LVN 2 stated that she forgot to check Resident 237's HR. LVN 1 stated the physician ' s order indicated that the resident ' s heart rate must be checked before administering the medications Hydrochlorothiazide and Verapamil.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow up interview and concurrent record review with on 4/23/2025 at 8:29 AM with LVN 1, Resident 237's physician orders were reviewed. LVN 1 stated the resident ' s blood pressure and heart rate must be checked prior to administering the resident ' s Hydrochlorothiazide and Verapamil. LVN 1 stated the resident ' s blood pressure and heart rate could potentially go down to unsafe levels if the medications are administered since the resident ' s blood pressure and heart rate were already low. LVN 1 stated Resident 237 could experience weakness, dizziness, or pass out and fall if the blood pressure and heart rate go down too low.</p> <p>2. A review of Resident 28's Admission Record indicated the resident was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included hypertension (HTN) and hyperlipidemia (elevated cholesterol).</p> <p>A review of Resident 28's H&P, dated 9/13/2025, indicated the resident has the capacity to understand and make decisions.</p> <p>A review of Resident 28's MDS, dated [DATE], indicated the resident has moderately impaired cognition.</p> <p>A review of Resident 28's physician orders, for April 2025, included a medication order for Cyanocobalamin (Vitamin B12) tablet; 500 mcg (microgram, a unit of measuring weight) by mouth daily for supplement.</p> <p>During a medication pass observation with LVN 1 on 4/23/2025 at 9:01 AM, LVN 1 was observed preparing Resident 28's medications. LVN 1 was observed putting a Cyanocobalamin 1000 mcg tablet into Resident 28 ' s medication cup.</p> <p>During a medication pass observation and concurrent interview with the LVN 1 on 4/23/2025 at 9:10 AM, before LVN 1 administered the Cyanocobalamin 1000 mcg tablet and other medications to Resident 28, the surveyor stopped LVN 1 and asked LVN 1 if the correct medication was about to be administered to Resident 28. LVN 1 stated she was about to give Cyanocobalamin 1000 mcg dosage instead of 500 mcg. LVN 1 stated she should not continue administering the medication because it was not the correct dose of the medication.</p> <p>During a follow up interview and concurrent record review with on 4/23/2025 at 9:14 AM with LVN 1, Resident 28's physician orders were reviewed. LVN 1 stated the physician ' s order indicated for Resident 28 to receive Cyanocobalamin 500 mcg, and not Cyanocobalamin 1000 mcg. LVN 1 stated administering 1000 mcg of the Cyanocobalamin was an error and could lead to overdose.</p> <p>During an interview and concurrent interview on 4/25/2025 at 11:28 AM with Director of Nursing (DON), the facility ' s policy and procedure (P&P) titled, Medication Administration dated 2007, was reviewed. DON stated the P&P indicated medications are administered accordance to the physician's orders. DON stated administering medications with parameters, such as those that affect the blood pressure and heart rate, not following the prescribed parameters could cause dizziness which could lead to accidents. DON stated if the incorrect dose of a medication/supplement is administered, the effect of the medication could be lessened or could lead to overdose.</p> <p>A review of the facility's P&P titled, Medication Administration, dated 2007, indicated:</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prior to administration, the medication and dosage schedule on the resident ' s MAR (medication administration record) is compared with the medication label.</p> <p>Medications are administered in accordance with written orders of the prescriber.</p> <p>A review of the facility's P&P titled, Medication Pass Guidelines undated, indicated:</p> <p>Verify the medication label against the medication sheet for accuracy of drug frequency, duration, strength, and route.</p> <p>If applicable and/or prescribed, take vital signs or tests prior to administration of the dose such as the heart rate or pulse and the blood pressure.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of four observed residents (Residents 237) was free from any significant medication errors when Licensed Vocational Nurse (LVN) 1 did not check the heart rate of Resident 237 prior to the administration of Hydrochlorothiazide (medication that lowers the blood pressure and heart rate) and Verapamil (medication ordered to manage hypertension [HTN- elevated blood pressure]).</p> <p>This deficient practice had the potential for the resident have dangerously decreased blood pressure and heart rate that could result in hospitalization and death.</p> <p>Findings:</p> <p>1. A review of Resident 237's Admission Record indicated the resident was admitted on [DATE] with diagnoses that included atherosclerotic heart disease (the build-up of fats, cholesterol, and other substances in and on the walls of blood vessels) and history of falls.</p> <p>A review of Resident 237's History and Physical (H&P), dated 4/17/2025, indicated the resident has a diagnosis of hypertension a (condition of having high blood pressure). The H&P also indicated Resident 237 has the capacity to understand and make decisions.</p> <p>A review of Resident 237's Minimum Data Set (MDS- A resident assessment tool), dated 4/22/2025, indicated the resident has intact cognition (the ability to think and process information).</p> <p>A review of 237's physician orders, for April 2025, included medication orders for:</p> <p>Hydrochlorothiazide tablet; 25 mg (mg, milligram, a unit of measurement) once a day ordered on 4/16/2025. The order also included instructions to Hold [do not give the medication] if systolic blood pressure (SBP - the amount of pressure in the arteries during contraction of the heart muscle) <110 (less than 100) or HR (hear rate) <60 (less than 60).</p> <p>Verapamil tablet extended release; 25 mg once a day ordered on 4/16/2025. The order also included instructions to Hold if SBP <110 or HR <60.</p> <p>During a medication pass observation and concurrent interview with LVN 1 on 4/23/2025 at 8:20 AM, LVN 1 was observed checking Resident 237 ' s blood pressure. LVN 1 stated the blood pressure was 130/70, but did not mention that she checked the resident ' s heart rate. After checking Resident 237's blood pressure, LVN 1 prepared the medications Hydrochlorothiazide and Verapamil. As LVN 1 was about to administer the Hydrochlorothiazide and Verapamil, the surveyor stopped LVN 1 and asked if Resident 237 ' s heart rate was checked. LVN 2 stated that she forgot to check Resident 237's HR. LVN 1 stated the physician's order indicated that the resident ' s heart rate must be checked before administering the medications.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow up interview and concurrent record review with on 4/23/2025 at 8:29 AM with LVN 1, Resident 237 ' s physician orders were reviewed. LVN 1 stated the resident ' s blood pressure and heart rate must be checked prior to administering the resident ' s Hydrochlorothiazide and Verapamil. LVN 1 stated the resident ' s blood pressure and heart rate could potentially go down to unsafe levels if the medications are administered and the resident ' s blood pressure and heart rate are already low. LVN 1 stated the resident could experience weakness, dizziness, or pass out and fall if the blood pressure and heart rate go down too low.</p> <p>During an interview and concurrent interview on 4/25/2025 at 11:28 AM with Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Medication Administration, dated 2007, was reviewed. DON stated the P&P indicated medications are administered accordance to the physician ' s orders. DON stated administering medications with parameters, such as those that affect the blood pressure and heart rate, not following the prescribed parameters could cause the resident to feel dizzy which could lead to accidents. DON added if the blood pressure and heart rate drastically goes down, the resident could become distressed. DON stated nurses should follow the physician ' s orders for the residents ' safety.</p> <p>A review of the facility ' s P&P titled, Medication Error Reporting and Adverse Drug Reaction Prevention and Detection, dated 2007, indicated medication error/variance shall be defined as any preventable event that may cause or lead to inappropriate medication use or harm while the medication is in the control of the health care professional.</p> <p>A review of the facility ' s P&P titled, Medication Administration, dated 2007, indicated:</p> <p>Prior to administration, the medication and dosage schedule on the resident ' s MAR (medication administration record) is compared with the medication label.</p> <p>Medications are administered in accordance with written orders of the prescriber.</p> <p>A review of the facility ' s P&P titled, Medication Pass Guidelines, undated, indicated:</p> <p>Verify the medication label against the medication sheet for accuracy of drug frequency, duration, strength, and route.</p> <p>If applicable and/or prescribed, take vital signs or tests prior to administration of the dose such as the heart rate or pulse and the blood pressure.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854</p> <p>Based on observation, interview, and record review, the facility failed to follow their policy and procedure for medication storage when one out of three medication carts was found to have 2 insulin pens (medication to control the blood sugar), belonging to Resident 72, that were not discarded within 28 days from the opened date.</p> <p>This deficient practice had the potential for staff to administer the insulin pens, which may less efficacy and could lead to the mismanagement of the blood sugar of Resident 72.</p> <p>Findings:</p> <p>A review of Resident 72's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar or blood glucose control and poor wound healing) and hyperlipidemia (elevated blood cholesterol).</p> <p>A review of Resident 72's History and Physical (H&P), dated [DATE], indicated the resident does not have the capacity to understand and make decisions. The H&P also indicated the resident has a history of mental illness.</p> <p>A review of Resident 72's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated [DATE], indicated the resident has severely impaired cognition (the ability to process thoughts and information.)</p> <p>A review of Resident 72's physician orders for ,d+[DATE], included orders for Insulin Glargine (medication used to control the blood sugar) insulin pen inject 8 units (u- a unit of measuring insulin) subcutaneously at bedtime. The physician orders did not include an order for Insulin Lispro insulin pen (an injectable medication used to control the blood sugar).</p> <p>A review of Resident 72's care plans for unstable blood glucose level, initiated on [DATE], indicated it is the facility ' s goal that Resident 72's blood glucose will remain stable. The care plan also indicated for facility staff to administer insulin as ordered.</p> <p>During a concurrent observation and interview on [DATE] at 11:46 AM with Minimum Data Set Nurse (MN), Medication Cart 1 was observed to have 2 insulin pens that were past the 28 days of their opened date. One insulin pen was Resident 72 ' s Insulin Glargine, with a written opened date of [DATE]. MN stated the Insulin Glargine should have been discarded before [DATE]. Another insulin pen was Resident 72 ' s Insulin Lispro, with a written opened date of [DATE]. MN stated the Insulin Lispro should have been discarded before [DATE].</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a follow up interview on [DATE] at 11:48 AM with MN and Licensed Vocational Nurse (LVN) 1, both MN and LVN 1 stated insulin must be discarded within 28 days of their opened date. MN stated insulin could be expired and less potent if they are past the 28 days from their opened date. MN stated staff could potentially administer the insulin to Resident 72 which could lead to the mismanagement of Resident 72 ' s DM and unstable blood sugar levels. LVN 1 added Resident 72 ' s Lispro should have been discarded because the order for Lispro was discontinued and changed to another medication.</p> <p>During an interview and concurrent interview on [DATE] at 10:51 AM with the Director of Nurses (DON), the facility's policy and procedures (P&P) were reviewed. The DON stated the P&P titled, Disposal of Medications, Syringes, and Needles (-) Disposal of Medications, dated 2007, indicated for outdated medications to be destroyed. DON added the P&P titled Medications with Shortened Expiration Dates, dated 2007, indicated insulin Lispro and Glargine expire 28 days after its first use. DON stated if insulins are used past the 28 days, they could be ineffective in controlling the resident ' s blood sugar and could lead to hyperglycemia (high blood sugar).</p> <p>A review of the facility's P&P titled, Disposal of Medications, Syringes, and Needles (-) Disposal of Medications, dated 2007, indicated for outdated medications, contaminated or deteriorated medications, and the contents of containers with no label shall be destroyed.</p> <p>A review of the facility's P&P titled, Medications with Shortened Expiration Dates, dated 2007, indicated insulin Lispro expires 28 days after first use or removal from refrigerator, whichever comes first. The P&P indicated for Lispro KwikPen, the product expires 10 days after first use or removal from refrigerator, whichever comes first. The P&P also indicated for insulin Glargine KwikPen and SoloStarPen, the product expires 28 days after first use or removal from refrigerator, whichever comes first.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854</p> <p>Based on observation, interview, and record review, the facility failed to ensure nutritional supplement and food products for two out of three stored in the medication carts were labeled with expiration date, in accordance with the facility's policy and procedure.</p> <p>This deficient practice had the potential for facility staff to administer the food products to residents, which could cause foodborne illnesses (a disease caused by consuming contaminated food or beverages. These contaminations can be from bacteria, viruses, parasites, or harmful chemicals that can cause nausea, vomiting, diarrhea, and fever).</p> <p>Findings:</p> <p>During a concurrent observation and interview on [DATE] at 11:00 AM with Minimum Data Set Nurse (MN), Medication Cart (MC) 3 was examined. The bottom drawer of MC 3 was observed to have a 237 mL carton of Ensure Plus that was opened and undated. MN stated the carton of Ensure Plus did not have any markings that indicated the date it was used and for which resident the Ensure Plus was ordered for. MN stated it must be thrown away because it could be expired, and residents could experience stomach issues if it is ingested.</p> <p>During a concurrent observation and interview on [DATE] at 11:00 AM with MN, MC 2 was examined. The bottom drawer of MC 2 was observed to have an unopened carton of Vital Cuisine Milkshake. The carton felt warm to touch and the contents were in liquid form when the carton was shaken. The carton had a written label indicating for the food item to be store[d] frozen. The carton also appeared to be bulging, and pressure was felt when the carton was slightly squeezed. MN stated the milkshake is expired because it is bulging, and it was not stored properly in an ice box. MN stated residents could get sick if they are given the milkshake.</p> <p>During a concurrent interview and record review on [DATE] at 10:51 AM with the Director of Nursing (DON), the facility ' s policy and procedure (P&P) titled, Food Storage Principles, undated, was reviewed. DON stated the P&P indicated for food to be stored properly. DON stated not storing food in the proper way could lead to food spoilage. DON stated is residents eat the spoiled food; they could get sick.</p> <p>A review of the facility's P&P titled, Food Storage Principles, undated, indicated proper food storage is essential for preserving food quality. The P&P indicated storage factors that impact the preservation of quality include holding period, temperature, and humidity. The P&P also indicated to discard leftover foods that have not been used within 48 hours of preparation.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>47467</p> <p>Based on observation, interview, and record review, the facility failed to ensure the facility's waste dumpsters cover were kept closed and not exposed to elements in the trash area.</p> <p>This failure had a potential to result in pest infestation [an increase in the numbers of a pest species (insect or small animal that is harmful, such as rats, mice, or cockroaches) in a given area], odors, unsanitary environment, and a spread of bacteria (small living things that could be dangerous and cause illnesses) and insects (small animals such as ants, and flies).</p> <p>Findings:</p> <p>During an observation on 4/22/2025 at 10:20 AM in the facility ' s trash area, the blue waste dumpster was overflowing with trash, and the lid was not closed. One of two facility ' s black waste dumpsters was not closed with lid.</p> <p>During an interview on 4/22/2025 at 2:35 PM with the Administrator (ADM), the ADM stated, she was responsible to do the facility ' s round in the trash area to make sure the facility ' s waste dumpsters were closed and the area surrounding the trash area was clean. The ADM stated, she got a report from a facility ' s staff that the dumpster was overflowing with trash and the dumpsters ' lids were not closed so she had the housekeeper come and cleaned the trash area around 11 AM on 4/22/2025. The ADM stated the facility ' s dumpsters were big and the lids were heavy, so sometimes staffs were not able to close the lids after they threw away the trash. The ADM stated, the dumpsters should always be closed to prevent pest from entering.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Pest Control, undated, indicated routine inspections are conducted at the company for evidence of pests. The P&P indicated to keep facility grounds free of trash and brush, and to keep the dumpster area clean and the lid closed.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47882</p> <p>Based on observation, interview, and record review, the facility failed to follow the facility ' s policy for Infection Control Program and Hand Hygiene for six of 16 sampled residents ' (Resident's 57, 35, 30, 66,41, and 64) during dinning observation in the Front Dining Room (FDR) by failing to ensure:</p> <ol style="list-style-type: none"> 1. The Activity Director (AD) who was observed serving, preparing food trays and touching Resident's 57, 35 and 30 without performing hand hygiene before and after direct contact. 2. Director of Staff Development (DSD) was observed serving, preparing food trays and touching Resident's 66, 41 and 64 without performing hand hygiene before and after direct contact. <p>This deficient practice had the potential to cause and/or spread infection (a process when a microorganism, such as bacteria, fungi, or a virus, enters a person's body and causes harm) in the facility.</p> <p>Finding:</p> <p>During a review of Resident 57's Admission Record, indicated the facility admitted Resident 57 on 2/18/2022 with diagnoses that included cerebral infarction (a stroke), diabetic with chronic kidney disease (the kidneys are damaged and can't filter blood as well as they should), and congestive heart failure (heart isn't pumping blood effectively enough to meet the body's needs).</p> <p>During a review of Resident 35's Admission Record, indicated the facility originally admitted Resident 35 on 2/7/2024 and was readmitted on [DATE] with diagnoses that included cerebral infarction, diabetes (blood sugar, is too high), and atherosclerotic heart disease (thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of an artery).</p> <p>During a review of Resident 30's Admission Record, indicated the facility originally admitted Resident 30 on 10/ 27/2022 and was readmitted on [DATE] with diagnoses muscle wasting and atrophy (the loss of muscle mass and strength), benign prostatic hyperplasia (enlarged prostate), and white matter disease (damage to the white matter in the brain, which is the tissue containing nerve fibers that connect different areas of the brain and spinal cord).</p> <p>During a review of Resident 66's Admission Record, indicated the facility admitted Resident 66 on 2/28/2025 with diagnoses that included diabetes, chronic kidney heart disease, and atherosclerotic heart disease.</p> <p>During a review of Resident 41's Admission Record, indicated the facility admitted Resident 41 on 8/14/2018 with diagnoses that included iron deficiency anemia (a condition in which blood lacks adequate healthy red blood cells), chronic kidney disease, and atherosclerotic heart disease.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 64's Admission Record, indicated the facility admitted Resident 64 on 1/21/2023 with diagnoses that included peripheral autonomic neuropathy (the nerves that are located outside of the brain and spinal cord (peripheral nerves) are damaged), hypertension secondary to other renal disorders (conditions that affect the kidneys, the body's filters that remove waste and excess fluid from the blood), and cardiac arrhythmias (an irregular heartbeat).</p> <p>During an observation on 4/22/2025 at 12:30 PM in the Facility ' s Dining Room (FDR), AD was serving, preparing food trays and touching Resident's 57, 35 and 30 shoulders and hands to position the Residents in front of the food tray without performing hand hygiene before and after direct contact with each resident. In a concurrent observation, the DSD was serving, preparing food trays and touching Resident ' s 66, 41 and 64 shoulders and hands to position the Residents in front the food tray without performing hand hygiene before and after direct contact.</p> <p>During an interview on 4/22/2025 at 12:45 PM with AD and DSD, AD stated, she was not aware that she had to perform hand hygiene before and after direct contact with every Residents during mealtime, and she will start doing it now that she knows. DSD stated, she thought she was only supposed to perform hand hygiene at the beginning of passing food trays and not before and after direct contact with residents, she added she will start doing it now that she knows.</p> <p>During a concurrent observation and interview on 4/22/2025 at 1 PM with RN (Registered Nurse) 1 in the FDR, RN 1 stated, currently there are 16 Residents using the front dining room, the staff who are helping pass the food trays are expected to perform hand hygiene before and after direct contact with every resident. RN 1 stated, not performing hand hygiene between Residents was an infection control issue and had the potential for cross-contamination and spread of infection.</p> <p>During an interview on 4/23/2025 at 7:36 AM with IPN (Infection Preventionist Nurse), IPN stated, the staff who are passing trays during mealtime are expected to do hand hygiene between residents. If the staff does no perform hand hygiene, it had the potential for cross contamination of infection between residents and spread of infection between residents in the facility.</p> <p>During an interview on 4/24/2025 at 9:23 AM with the DON (Director of Nurses), DON stated, during mealtime, while passing and preparing tray and taking care of residents, the staff are expected to perform hand hygiene between residents to prevent possible cross contamination which is the potential to cause and/or spread infection in the facility.</p> <p>A review of the facility ' s P&P titled, Hand Hygiene, dated 2/2017, indicated; a) the facility considers hand hygiene the primary means to prevent the spread of infection, b) all personnel shall be trained and regularly in-service on the importance of hand hygiene in preventing the transmission of healthcare- associated infections, c)all personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel , residents,, and visitors, and d) use an alcohol-based hand rub containing at least 62% alcohol or soap and water to the following situations: before and after direct contact with resident, after contact with objects in immediate vicinity of the resident, and before and after assisting a resident with meals.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's P&P titled, Infection Control Program, (undated), indicated; a)the elements of the infection prevention and control program consist of policies and procedures, outbreak management and infection prevention, b) prevention of infection includes: instituting measures to avoid complications or disseminations, educating staff and ensuring that they adhere to proper techniques and procedures and c) following established general and disease specific guidelines such those of the Center for Disease Control and Prevention (CDC) and California Department of public Health.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>47467</p> <p>Based on observation, interview, and record review, the facility failed to maintain the facility ' s dishwasher in operating condition to keep in a safe and efficient manner when the dishwasher failed the chlorine sanitizer (an effective, chlorine-based, substance or product used to reduce the number of harmful germs on all food contact surfaces to a safe level when cleaned and processed through an approved ware wash operation) test on 4/22/2025 at 9:05 AM.</p> <p>This failure had a potential to result in the facility ' s foodware (items used for containing, serving, or consuming prepared food, including cups, bowls, plates, etc.) and cookware (pots, pans, and other utensils used for cooking food) were not cleaned and sanitized, which could lead to a wide spread of foodborne illness (a condition that occurs when consuming contaminated food or beverages, which caused by the ingestion of harmful germs) within the facility ' s residents.</p> <p>Findings:</p> <p>During an observation on 4/22/2025 at 9 AM with the Dishwasher Aid (DA 1) in the kitchen, the dishwasher ' s water temperature was at 120 degrees Fahrenheit (F, unit of temperature).</p> <p>During a concurrent observation and interview on 4/22/2025 at 9:05 AM with DA 1 in the kitchen, DA 1 demonstrated how he checked the dishwasher for chlorine level to make sure the foodware was sanitized after the washing cycle. The chlorine testing strip (a narrow, elongated piece of pad which contains a chemical that reacts with chlorine in the water. The reaction causes the pad to change color that correlates to the chlorine concentration) did not change color when DA 1 dipped the testing strip in the dishwasher water to indicate the chlorine was in the correct level [50-100 PPM (or parts per million, a unit of concentration that indicates how many parts of a substance are present in one million parts of a solution)]. DA 1 completed another cycle to retest for chlorine level again, the testing strip did not change color. DA 1 stated, the testing strip should change color from white to purple that matched the reading of 50 PPM to indicate the food ware was sanitized. DA 1 stated, the dishwasher was not working appropriately. DA 1 stated the last time he checked the dishwasher ' s chlorine level was at 6 AM, about 3 hours prior to the demonstration, and the testing result was at 50 PPM.</p> <p>During an interview on 4/22/2025 at 9:15 AM with the Dietary Supervisor (DS), the DS stated, the dishwasher was supposed to be working with chlorine sanitizer at all times to make sure the facility ' s food ware were cleaned and sanitized. The DS stated food ware that had been cleaned by the dishwasher after 6 AM might still be contaminated. The DS stated, they would stop using the dishwasher and wait for maintenance to come and fix it.</p> <p>During an interview on 4/22/2025 at 9:45 AM with the Administrator (ADM), the ADM stated, the Maintenance Supervisor (MS) already came to see the dishwasher but he could not fix it, so she requested the vendor technician to come already. The ADM stated, they would use disposable foodware for lunch time while waiting for the dishwasher to be fixed.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility ' s Extra Service Request report, dated 4/22/2025, timed at 11:21 AM, the report indicated the dishwasher ' s sanitizer line was pulled up and not reaching the chlorine chemical in the bucket. The report indicated the technician had to replace the sanitizer line with a new straight line so that the sanitizer could be pumping, and the chlorine test result could get back to normal (50-100 PPM).</p> <p>During an interview with the ADM on 4/25/2025 at 2:45 PM, the ADM stated, the dishwasher supposed to be operating in a safe and efficient manner at all times to ensure the facility ' s food ware and cook ware were cleaned and sanitized to prevent a spread in foodborne illness.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Sanitation and Infection Control - Dishwashing Procedures (Dishmachine), dated 2018, indicated chemical low temperature dish-machines must maintain a water temperature of 120F-140F. Use a chemical sanitizing rinse to achieve and maintain 50-100 PPM of chlorine at the dish surface or according to manufacturer ' s specifications.</p>		