STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055960	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Crescenta Healthcare Center	3050 Montrose Ave LA Crescenta, CA 91214

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview and record review, the facility failed to ensure that food brought into the facility from outside was labeled and stored appropriately for one of one sampled Resident refrigerator in accordance with the facility's policy and procedure titled Food Brought from Outside the Facility. This failure had the potential to result in residents getting a foodborne illness such as food poisoning, since the food safety, freshness and ownership cannot be verified. Findings: During a concurrent observation and interview on 5/8/2026 at 10:15 AM with the Infection Preventionist (IP) in the entero food supply room, an unlabeled white bag was in the refrigerator for Resident's personally supplied food. IP removed the bag stating there is no label identifying who the item belongs to or dates identifying when to throw the item away. During a concurrent observation and interview on 5/8/2026 at 10:15 AM with the IP in the entero food supply room: three transparent bags with fruit one plastic purple water bottle one gallon container of Neopolitan ice cream one gallon container of rocky road ice cream It was in the freezer for Resident's personally supplied food. IP stated there is no label showing who the items in the Resident's freezer belonged to. During a concurrent interview and record review on 5/8/2026 at 11:30 AM with the IP, the facility's hand out titled Food Brought from Outside the Facility, undated was reviewed. The handout indicated, containers will be labeled with the resident's name, and the use by date. The IP stated there was no labeling indicating who the food in the Resident's refrigerator belonged to. The IP further stated labelling of foods is to know who the food belongs to and when the food should be thrown away. Residents could get sick or upset that their own food was thrown away. During a review of the policy and procedure (P&P) titled, Food Brought from Outside the Facility, version RC1 0305.04, the P&P indicated food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that is clearly distinguishable from facility-prepared food.

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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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN, notice of transfer of potential financial liability usually paid by Medicare (a federal health insurance) but may not be paid for in this instance because it is not medically reasonable and necessary, or custodial care) to beneficiaries before the non-covered extended care items or services are provided by the facility for two of three sampled residents (Resident 3 and Resident 60) who were discharged from Medicare Part A and continue to live in the facility. 1.Resident 3 last covered day of Medicare Part A service was on 4/13/2026. 2. Resident 60 last covered day of Medicare Part A service was on 3/10/2026. This deficient practice had violated Resident 3 and Resident 60 and/or their responsible party (RP) the right to be informed about the right to appeal, and potentially not be aware of possible charges for services rendered that were not covered after their last Medicare Part A coverage day, which could result in financial hardship. Findings: 1.During a review of Resident 3's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebral infarction (a blockage in an artery interrupts blood flow to the brain, causing brain tissue to die from lack of oxygen and nutrients), cervical disc degeneration (the natural wear and tear of the cushioning discs in your neck), and atrial fibrillation (a steady beat, the heart quivers (fibrillates), which can cause blood to pool, increasing the risks of blood clots, stroke, and fatigue) During a review of Minimum Data Set (MDS, a resident assessment tool), dated 4/26/2026, indicated Resident 3's cognitive skills (ability to make daily decisions) was severely impaired. 2. During a review of Resident 60's admission record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebral infarction, encephalopathy (disease, damage, or malfunction of the brain and cirrhosis of liver (severe, permanent scarring of the liver caused by long-term damage). During a review of Minimum Data Set (MDS, a resident assessment tool), dated 2/26/2026, indicated Resident 60's cognitive skills (ability to make daily decisions) was severely impaired. During a concurrent interview and record review on 5/7/2026 at 3:41 PM, the MDS Nurse/Beneficiary Coordinator (MDSN/Beneficiary Coordinator 1) stated that SNF Beneficiary Protection Notification Review documents for Residents 3 and 60 indicated their Medicare Part A coverage ended on 4/13/2026 and 3/10/2026, respectively, without documentation that a required SNF Advance Beneficiary Notice (ABN) was provided to the residents or their representatives. The MDSN stated that he and the Social Services Director are responsible for issuing these notices but acknowledged he did not provide them due to misunderstanding of the CMS requirements. MDSN stated that failing to issue the SNF ABN violated resident rights. During an interview on 5/7/2026 at 4:15 PM with the Social Service Director (SSD/ Beneficiary Coordinator 2), SSD stated, herself and the MDSN are responsible for providing beneficiary notice to residents and/or RP in advance when there will be changes with their benefits. SSD stated, she did not provide SNF ABN to Resident 3, Resident 60 and/or their RP, she missed it. During a concurrent interview and record review on 5/8/2026 at 8:08 AM with the Director of Nursing (DON), the Electronic Health Records were reviewed for Residents 3 and 60 which indicated no documentation that a SNF Advance Beneficiary Notice (ABN) was provided before their Medicare Part A coverage ended on 4/3/2026 and 3/10/2026, respectively. The DON stated that both Residents 3 and 60 still reside in the facility and that failure to provide required notice of changes in benefits constituted a resident rights issue. During an interview on 5/8/2026 at 8:20 AM, the Administrator (ADM) stated that the facility follows state and federal regulations and stated that a SNF Advance Beneficiary Notice (ABN) should have been provided to Residents 3 and 60 and/or their representatives before their Medicare Part A coverage ended. The Administrator explained that both Beneficiary Coordinators missed issuing the notices to the representative or resident. He stated that providing the SNF ABN in advance ensures residents are aware of benefit (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes and their right to appeal, even if they have secondary insurance. The Administrator acknowledged that failing to provide the SNF ABN violated the residents' right to be informed. A review of the facility's policy and procedure titled, Medicare Advance Beneficiary and Medicare Non-Coverage Notice, dated 6/6/2025 indicated: Procedure under SNF ABN a) residents are informed in advance when changes will occur to their bills, b) if the benefits coordinator believes during resident stay that Medicare Part A will not pay for an otherwise covered skilled service, the resident and/or the representative is notified in writing why the services may not be covered and of the resident's potential liability for payment of non- covered services, and c) SNF ABN is issued to the beneficiary before those non-covered extended care items or services are furnished to the beneficiary. A review of the facility's policy and procedure titled, Resident Rights, dated 5/7/2026 indicated; a) the company will inform the resident both orally and in writing his or her rights as a resident, b) the facility must inform each resident during the resident stay, services available in the facility and of charges for those services, including any charges for services not covered under Medicare.

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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** Based on observation, interview and record review, the facility failed to provide oxygen therapy as ordered by the physician to one of one sampled resident (Resident 14), who was not receiving oxygen due to NC (a flexible tube with two prongs that rest in the nostrils to deliver supplemental oxygen) was in a bag attached to an oxygen concentrator (a machine that takes air from the surroundings, extract oxygen and filter it into purified oxygen). This deficient practice had the potential for Resident 14 not to receive adequate oxygenation that could lead to respiratory decompensation (when respiratory system fails to meet the body's oxygen and carbon dioxide needs, requiring immediate intervention like oxygen), shortness of breath (SOB) and respiratory distress. Findings: During a review of Resident 14's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included acute or chronic respiratory failure (the lungs cannot get enough oxygen into the blood or cannot remove carbon dioxide (a waste gas) from the blood), atherosclerotic heart disease (a condition where fat, cholesterol, and other substances build up in the walls of arteries, forming buildup that narrows the arteries restricting blood flow and potentially causing heart attacks or strokes). During a review of Minimum Data Set (MDS, a resident assessment tool), dated 2/9/2026, the MDS indicated Resident 14's cognitive skills (ability to make daily decisions) was moderately impaired. The MDS indicated, Resident 14 was dependent with all ADL's. During a review of a Physician Order Report dated 5/1/2026, the Report indicated to administer oxygen at 2 liters per minute via NC continuously to Resident 14. During a review of Resident 14's care plan (CP), revised on 5/4/2026, the Care Plan indicated, the resident had alteration in respiratory status related to respiratory failure, with the intervention to administer oxygen through a N/C continuously. During a concurrent observation and interview on 5/5/2026 at 9:30 AM with Registered Nurse (RN) 2 in Resident 14's room, Resident 14 was observed lying in bed and was not receiving oxygen for at least 10 minutes. The NC was observed stored in a bag attached to the oxygen concentrator rather than placed on Resident 14. RN 2 confirmed that Resident 14 was not receiving oxygen despite the active order for continuous oxygen at 2 liters per minute. RN 2 stated since Resident 14 was not receiving continuous oxygen, there was a potential for respiratory decompensation (inadequate oxygen), including shortness of breath and respiratory distress. During an interview on 5/6/2026 at 8AM with the Director of Nursing (DON), the DON stated staff should follow all physician orders as well as the facility's oxygen administration policy. The DON confirmed that Resident 14's physician order for continuous oxygen was not followed which compromised the respiratory need of the resident. The DON further stated since the Resident 14 not receiving oxygen for at least ten minutes had the potential to result in inadequate oxygenation, which could lead to respiratory decompensation, shortness of breath, and respiratory distress, negatively affecting the resident's quality of life. A review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 10/21/2025, indicated; a)attached the oxygen delivery device to the oxygen unit, b) turn the unit on the desired flow rate and assess equipment for proper functioning, and assist in placing oxygen delivery device on the resident and make sure it fits properly and stable. A review of the facility's P&P titled, Physician Orders, dated 6/27/2025, indicated, physician orders are obtained to provide a clear direction in the care of the resident.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide medically-related social services to one of five sampled residents (Resident 21) when the Social Service Designee (SSD) did not follow up to ensure Resident 21's Advance Directive (AD a legal document indicating resident preference on end-of-life treatment decisions) and DPOA (Durable Power of Attorney) provided by the resident's responsible party (RP) was for a health care and not for financial in accordance with the facility's policy and procedure titled Advance Directives. This failure had the potential to result in Resident 21 receiving treatment against her wishes and placing Resident 21's safety at risk. Findings: During a review of Resident 21's face sheet (front page of the chart that contains a summary of basic information about the resident), it indicated Resident 21 was admitted on [DATE] with diagnoses that included cerebral infarction (stroke - loss of blood flow to a part of the brain), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 21's history and physical (H&P) dated 2/2/2026, the H&P indicated Resident 21 does not have the mental capacity to make medical decisions. During a review of Resident 21's Social Services Assessment - Initial, dated 2/12/2024, The Social Services Assessment indicated Resident 21 has an Advance Directive, but resident representative did not bring a copy of AD for the facility. During an interview on 5/6/2026 at 2:32 PM, the SSD stated, When an Advance Directive is provided, she will copy and place it in the chart and provide a copy to the medical records person. SSD further stated she does not review the Advance Directive or compare it to the Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life). During a concurrent interview and record review on 5/7/2026 at 2:42 PM with the SSD, Resident 21's Durable Power of Attorney (DPOA - a legal document that authorizes a chosen person to manage a resident's financial, legal, or medical affairs) dated 8/25/2023 was reviewed. The DPOA indicated this document does not authorize anyone to make medical and other health-care decisions. The SSD stated the DPOA form was copied and placed in Resident 21's medical record without being reviewed by the SSD. SSD further stated she will follow up with resident representatives only if she remembers to do so. During a concurrent interview and record review on 5/7/2026 at 3:10 PM with the Administrator (ADM), the facility's Social Services Manager's job description dated 9/23/2003 was reviewed. The job description indicated one of the SSD's essential duties and responsibilities is to facilitate Advance Directive decision-making process. The ADM stated the SSD is responsible for presenting the Advance Directive received in the morning meeting for proper review. During a concurrent interview and record review on 5/7/2026 at 3:10 PM with the ADM Resident 21's DPOA dated 8/25/2023 was reviewed. The DPOA indicated this document does not authorize anyone to make medical and other health-care decisions. The ADM stated the DPOA provided by Resident 21's RP was for financial reasons and not healthcare. The ADM further stated the SSD should have done a preliminary review of the DPOA so that the SSD could have followed up with the resident representative regarding a healthcare DPOA instead of a financial DPOA. During a review of the facility's Social Services Manager's job description dated 9/23/2003, the job description indicated the SSD completes required forms and documents in accordance with company policy and state and/or federal regulations. During a review of the facility's P&P titled, Advance Directives, version OP2 0303.00, the P&P indicated, the facility reviews the Advance Directive whether it's a DPOA for healthcare or if it contains specific instructions from the resident at the end of life to make sure it coincides with the physician's orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 85) did not store at the bedside that is accessible to other residents and visitor, and self-administer Albuterol Inhaler (medication used to quickly treat or prevent bronchospasms, including asthma symptoms (wheezing, tightness) and breathing difficulties) that was observed at Resident 85's bedside table in accordance with the facility's policy and procedure Medication Storage. Resident 85 stated, the Albuterol inhaler was given by her doctor and had been using it as needed every six hours when she had trouble breathing. Resident 85 did not have a Physician Order to administer the Albuterol inhaler. Resident 85 did not have an order for self-administration of the Albuterol inhaler. This deficient practice had the potential for Resident 85 and other residents with access to the medication to have excessive dose of Albuterol inhaler that could result in tachycardia (heart rate that is too fast) that could lead to compromised health and wellbeing of the residents. Findings: During a review of Resident 85's admission record indicated the resident was admitted with diagnoses that included hypertension (high blood pressure), chronic pulmonary edema (a condition caused by too much fluid in the lungs), chronic kidney disease (a long-term condition where the kidneys are damaged and gradually lose their ability to filter waste and excess fluid from the blood), and chronic obstructive pulmonary disease (COPD) (long-term, progressive lung disease that makes it hard to breathe by damaging the airways and air sacs). During a review of Resident 85's History and Physical Examination (H&P), dated 4/29/2026, indicated Resident 85 had the capacity to make healthcare decisions. During a review of Minimum Data Set (MDS, a resident assessment tool), dated 4/29/2026, indicated Resident 85's cognitive skills (ability to make daily decisions) was intact. The MDS indicated, Resident 85 requires setup and clean-up assistance (helper sets up and cleans up; resident completes activity) with eating, and partial/moderate assistance (helper does less than half the effort) with toileting, bathing, dressing and personal hygiene. During a concurrent observation and interview on 5/5/2026 at 8:58 AM with Licensed Vocational Nurse (LVN) 1 in Resident 85's room. Resident 85 was in bed; an Albuterol Inhaler was observed on Resident 85's bedside table with other belongings. LVN 1 stated, the Albuterol inhaler should not be with Resident 85, it should be properly stored in the medication cart. LVN 1 stated, Resident 85 did not have an order for the Albuterol and to self-administer her medications. LVN 1 stated, Resident 85 able to reach and access the medication Albuterol inhaler and had the potential for overuse the medication without proper monitoring that could result in adverse effect, such as tachycardia. Resident 85 stated, the Albuterol inhaler had been her medication from her doctor, and she uses it as needed every six hours if she has trouble breathing, she did not remember when she started using it. During an interview on 5/5/2026 at 9:15 AM with Registered Nurse (RN) 2, RN 2 stated, Resident 85 did not have an order for the Albuterol Inhaler and does not have an order to self-administer her medications. RN 2 stated, the Albuterol Inhaler should have been stored properly in a lock storage and not with Resident 85 to prevent the potential for overuse that could result in adverse side effects. During a concurrent interview and record review on 5/6/2026 at 7:45 AM with the Director of Nurses (DON), Resident 85's POR - Physician Order Report dated 5/1/2026 to 5/5/2026 was reviewed. The POR indicated, the Albuterol Inhaler to be administered every six hours as needed was not ordered until 5/5/2026 (day the Surveyor found the Albuterol at Resident 85's bedside and reported it to LVN 1). DON stated, Resident 85 did not have a physician order for the Albuterol until 5/5/2026 when Surveyor found it at bedside. DON stated, even with an order, the Albuterol inhaler should not be with Resident 85. During an interview on 5/6/2026 at 8:05 AM with the DON, DON stated, medications should not be at Resident 85's bedside, it should be in a locked storage area only accessible to authorized personnel. Resident 85 should not have accessed to the Albuterol inhaler because of the potential for overuse of the medication that could (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	result in adverse effect such as tachycardia that could lead to an emergency event and negatively affect Resident 85's quality of life. A review of the facility's policy and procedure (P&P) titled, Medication Storage, dated 5/2021, indicated; a) the medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications, b) provider pharmacy dispenses medications in containers, medications are to remain in these containers , this may include medication carts, rooms and cabinets, and c) in order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications are allowed access to medication carts

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately document the code status (a medical order indicating what emergency treatments a resident wants or does not want if their heart or breathing stops) of one of five sampled residents (Resident 5) was for full code (in the event of the resident's heart stops beating or stops breathing, all life-saving measures such as CPR and intubation will be used to attempt to save a resident's life) in the resident's clinical record when Resident 5 chose selective treatments as indicated on the Physician Orders for Life-Sustaining Treatment (POLST actionable medical order signed by a doctor or medical provider that translates a seriously ill patient's end-of-life wishes). This failure had the potential to result in Resident 5 receiving treatment against her wishes. Findings: During a review of Resident 5's admission Record indicated Resident 5 was admitted on [DATE] with diagnoses that included osteoporosis (weak and brittle bones due to lack of calcium and vitamin D), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and hypertension (high blood pressure). During a review of Resident 5's History and Physical (H&P) dated [DATE], the H&P indicated Resident 5 had the mental capacity to make medical decisions. During a review of Resident 5's POLST dated [DATE], the POLST indicated Resident 5 was do not resuscitate (DNR instructs healthcare providers not to perform cardiopulmonary resuscitation [CPR -chest compressions and rescue breaths to manually keep oxygenated blood flowing to the brain and vital organs] if a patient's breathing or heartbeat stops and medical intervention was selective treatment and did not want intubation (a medical procedure where a plastic tube is inserted through the mouth or nose into the windpipe to maintain an open airway and deliver oxygen for breathing) or CPR. During a review of Resident 5's Advanced Directive (a legal document indicating resident preference on end-of-life treatment decisions) dated [DATE], the Advanced Directive indicated, Resident 5 wishes for no ventilator (a medical device to help support or replace breathing), no heroic measures, no CPR. During a concurrent interview and record review on [DATE] at 4:06 pm with the Registered Nurse Supervisor (RN) 1, the physician order report dated [DATE] was reviewed. The physician order report indicated Resident 5 was full code (a patient wants all available life-saving interventions used if their heart or breathing stops). RN 1 stated Resident 5 should not be full code since Resident 5 indicated on the POLST for DNR with selective treatment. order should show selective treatment in accordance with her advanced directive. RN1 further stated it was important to have the correct order to ensure that the correct treatment was provided. RN 1 stated if there was a medical emergency, Resident 1's wishes would not be implemented since the order indicated was inaccurate. Resident 1 and the resident that at risk of having measures she did not want. During a review of the facility's policy and procedure (P&P) titled, Charting, version OP5 0601.00, the P&P indicated all documentation shall be specific, complete, and accurate. During a review of the facility's P&P titled, Physician's Orders for Life Sustaining Treatment (POLST), version OP2 0317.01, the P&P indicated, POLST is a medical order, not merely a preference document. During a review of the facility's P&P titled, Advanced Directives, version OP2 0303.00, the P&P indicated, the facility will comply with the wishes of a resident as expressed in an Advance Directive and will not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an Advance Directive.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Registered Nurse (RN) 3 performed hand hygiene for one of one sampled resident (Resident 50) after Registered Nurse (RN) 3 administered medications to Resident 50 via gastrostomy tube (GT) (a small tube placed through the belly directly into the stomach to provide nutrition, liquids, and medicines) and then proceeded to administer eye drops (Artificial Tears) to Resident 50 on 5/7/2026. This deficient practice had the potential to transfer bacteria and/or virus (tiny germs that cause infections) from Resident 50's GT site to Resident 50's eyes.Findings: During a review of Resident 50's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing), attention to gastrostomy (a surgical procedure that creates a small, artificial opening through the abdominal wall directly into the stomach), diabetic chronic kidney disease (kidneys are damaged and gradually lose their ability to filter waste and excess fluid from the blood) and legal blindness (severe vision loss). During a review of Minimum Data Set (MDS, a resident assessment tool), dated 4/10/2026, the MDS indicated Resident 50's cognitive skills (ability to make daily decisions) was severely impaired. The MDS indicated, Resident 50 was dependent with all activities of daily living (ADL's). During a review of Resident 50's Physician Order Report dated 5/1/2026 to 5/7/2026, the Report indicated to administer crushable medications via GT, and artificial tears one drop to both eyes twice a day. During a concurrent observation and interview on 5/7/2026 at 8:36 AM with RN 3, in Resident 50's room RN 3 changed gloves after providing Resident 50 with her GT medications and prior to administering Resident 50's eye drops without performing hand hygiene. RN 3 stated, she forgot to perform hand hygiene when changing gloves. RN 3 stated, the use of gloves does not replace hand hygiene. RN 3 stated, not performing hand hygiene after administering GT medication and prior to administering Residents 50's eye drops had the potential to result Resident 50 acquiring an eye infection. During an interview on 5/7/20206 at 9:28 AM with the Director of Nurses (DON), DON stated, it was the facility's policy to prevent the spread of infections, so staff must perform hand hygiene before moving from a contaminated body site to a clean body site during resident care and the use of gloves does not replace hand hygiene. DON stated, when performing two different task such as administering GT medication and administering eyedrops, hand hygiene must be performed between changing gloves to prevent infections. DON stated, RN 3 not performing hand hygiene, had the potential to transfer bacteria and/or virus from Resident 50's GT site to Resident 50's eyes which could result in an eye infection that could negatively affect Resident 50's quality of life. A review of the facility's policy and procedure (P&P) titled, Hand Hygiene, (undated) indicated; a)facility considers hand hygiene the primary means to prevent the spread of infections, b) hand hygiene before moving from a contaminated body site to a clean body site during resident care, and c) the use of gloves does not replace hand washing/hand hygiene, integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare associated infections. A review of the facility's policy and procedure (P&P) titled, Infection Control Program, (undated) indicated; important facets of infection prevention include instituting measures to avoid complications or dissemination (spreading) and educating staff and ensuring that they adhere to proper techniques and procedures.

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	055960	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Crescenta Healthcare Center	3050 Montrose Ave LA Crescenta, CA 91214

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement an antibiotic stewardship program (a coordinated program that promotes the appropriate use of drugs used to treat infections, including antibiotics) for antibiotic use when two of five sampled residents (Residents 61 and 89) did not meet criteria for antibiotic use and facility did not report it to the attending physician. This failure had the potential to result in residents receiving unnecessary antibiotics leading to antibiotic resistance (when bacteria evolve to survive and multiply despite the presence of antibiotic drugs designed to kill them). 1. During a review of Resident 61's face sheet (front page of the chart that contains a summary of basic information about the resident), it indicated Resident 61 was admitted on [DATE] with diagnoses that included encephalopathy (any disease, damage, or malfunction that affects the brain's structure or function, resulting in an altered mental state), and chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty breathing). During a review of Resident 61's Minimum Data Set (MDS-a comprehensive assessment and screening tool) dated 3/9/2026, the MDS indicated Resident 61 has severely impaired cognitive (thought process) skills for daily decision making. Resident 61 requires a helper to do more than half the effort for roll left and right, sit to lying, lying sitting on side of bed, sit to stand and chair/bed to chair transfer. Resident 61 requires a helper to do all of the effort for toileting hygiene, shower/bathe, dressing, and tub/shower transfer. During a review of Resident 61's Medication Administration Record (MAR), dated 5/2026, the MAR indicated Resident 61 received Doxycycline hyclate (a broad-spectrum (powerful medication that act against a wide variety of disease-causing bacteria) antibiotic used to treat various bacterial infections) was given twice a day starting 5/4/2026 - 5/11/2026 for fever. During a concurrent interview and record review on 5/8/2026 at 9:30 AM with the Infection Preventionist (IP), Resident 61's urinalysis (UA - a common urine test that detects infections, kidney disease and/or diabetes) results dated 5/5/2026 at 4:01 AM was reviewed. The UA indicated there was no infection detected. The IP stated there was no documented evidence that the facility staff communicated with the physician regarding negative results of the UA. During a concurrent interview and record review on 5/8/2026 at 9:30 AM with the Infection Preventionist (IP), Resident 61's urine culture (UCX - a laboratory test that identifies bacteria or yeast in a urine sample to diagnose urinary tract infections) results dated 5/6/2026 at 8:49 PM, indicated there was no abnormal infectious organism growth seen. The IP stated the there was no documented evidence that the facility staff communicated with the physician regarding negative results of the UCX. During a concurrent interview and record review on 5/8/2026 at 9:30 AM with the Infection Preventionist (IP), Resident 61's McGeer's Criteria (a standardized surveillance tool used to identify infections in long-term care facilities to ensure consistent reporting and monitor infection rates) dated 5/6/2026 at 1:37 PM was reviewed. The McGeer's Criteria was not completed. The IP stated that the McGeer's Criteria should indicate Resident 61 did not meet the criteria for antibiotics because of negative UA and UCX results. The IP further stated there was no physician communication indicating Resident 61 does not meet criteria for antibiotic use. IP stated, it is important to make sure that the antibiotics are appropriate for the resident and to ensure they should be on the antibiotics. During an interview on 5/8/2026 at 2:46 PM with the Director of Nursing (DON), the DON stated, negative lab results or McGeer's criteria not being met should be reported to the physician so that the nurses will know whether the antibiotic should be continued or stopped. The DON further stated failure to report negative labs when on an antibiotic can lead to the resident [having] unnecessary treatment and develop resistance to antibiotics. During a review of the facility's policy and procedure (P&P) titled, General Infection Control Report Guidelines, version IC 0112.00, the P&P indicated, the IP is to review the McGeer's Criteria for accuracy, identify all symptoms present, treatment being provided, and determine if it is a true infection - will need to meet the criteria listed in the form. The P&P also indicated that all residents on an antibiotic will have (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitoring done for proper follow up with the Attending physician. During a review of the facility's P&P titled, Antibiotic Stewardship Program, version IC 0113.00, the P&P indicated, it is the policy to implement an Antibiotic Stewardship Program which will promote appropriate use of antimicrobials while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. This policy has the potential to limit antimicrobial resistance in the post-acute care setting, while improving treatment efficacy, and reducing treatment-related costs. The P&P also indicates residents receiving antibiotics will be reviewed and a separate report will be made for those that did not meet the McGeer Criteria. 2. During a review of Resident 89's face sheet (front page of the chart that contains a summary of basic information about the resident), it indicated Resident 89 was admitted on [DATE] with diagnoses that included encephalopathy (any disease, damage, or malfunction that affects the brain's structure or function, resulting in an altered mental state), pneumonia (an infection/inflammation in the lungs), and dementia (a progressive state of decline in mental abilities). During a review of Resident 89's Minimum Data Set (MDS-a comprehensive assessment and screening tool) dated 1/20/2026, the MDS indicated Resident 89 has severely impaired cognitive skills for daily decision making. Resident 89 requires a helper to do less than half the effort for toileting hygiene, upper body dressing, roll left and right, sit to lying, sit to stand, and chair/bed to chair transfer. Resident 89 requires a helper to do all of the effort for shower/bathing and toilet transfer. During a review of Resident 89's physician order report dated 1/14/2026-1/20/2026, the physician order report indicated azithromycin (a commonly prescribed antibiotic used to treat bacterial infections of the ears, lungs, sinuses, skin, and throat) was started on 1/16/2026 - 1/20/2026 for pneumonia. During a concurrent interview and record review on 5/8/2026 at 9:30 AM with the Infection Preventionist (IP), Resident 89's McGeer's Criteria (a standardized surveillance tool used to identify infections in long-term care facilities to ensure consistent reporting and monitor infection rates) dated 1/16/2026 was reviewed. The McGeer's Criteria indicated the criteria for antibiotics was not met due to Resident not having at least one of the constitutional criteria (fever, leukocytosis (high white blood cell count), change in mental status from baseline or acute functional decline). The IP stated there was no communication with the physician stating the McGeer's criteria was not met. IP stated, it is important to make sure that the antibiotics are appropriate for the resident and to ensure they should be on the antibiotics. During an interview on 5/8/2026 at 2:46 PM with the Director of Nursing (DON), the DON stated, negative lab results or McGeer's criteria not being met should be reported to the physician so that the nurses will know whether the antibiotic should be continued or stopped. The DON further stated failure to report negative labs when on an antibiotic can lead to the resident [having] unnecessary treatment and develop resistance to antibiotics. During a review of the facility's policy and procedure (P&P) titled, General Infection Control Report Guidelines, version IC 0112.00, the P&P indicated, the IP is to review the McGeer's Criteria for accuracy, identify all symptoms present, treatment being provided, and determine if it is a true infection - will need to meet the criteria listed in the form. The P&P also indicated that all residents on an antibiotic will have monitoring done for proper follow up with the Attending physician. During a review of the facility's P&P titled, Antibiotic Stewardship Program, version IC 0113.00, the P&P indicated, it is the policy to implement an Antibiotic Stewardship Program which will promote appropriate use of antimicrobials while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. This policy has the potential to limit antimicrobial resistance in the post-acute care setting, while improving treatment efficacy, and reducing treatment-related costs. The P&P also indicates residents receiving antibiotics will be reviewed and a separate report will be made for those that did not meet the McGeer Criteria.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility failed to ensure the call light was accessible and within reach for one of six sampled residents (Resident 14), who was dependent with all activities of daily living (ADL), visually impaired, and a high risk for fall as indicated in the resident's care plan and facility's policy and procedures titled Call Lights-Answering Of. This deficient practice had the potential to result in Resident 14 not able to call for assistance for ADL care, and in cases of emergency such as a fall with injury which can negatively affect Resident 14's quality of life. Findings: During a review of Resident 14's admission Record, the AR indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included acute or chronic respiratory failure (the lungs cannot get enough oxygen into the blood or cannot remove carbon dioxide (a waste gas) from the blood), atherosclerotic heart disease (a condition where fat, cholesterol, and other substances build up in the walls of arteries, forming buildup that narrows the arteries restricting blood flow and potentially causing heart attacks or strokes), weakness, and arthritis (inflammation, pain, stiffness, and swelling in one or more joints). During a review of Minimum Data Set (MDS, a resident assessment tool), dated 2/9/2026, the MDS indicated Resident 14's cognitive skills (ability to make daily decisions) was moderately impaired. The MDS indicated, Resident 14 was dependent with all ADLs. During a review of Resident 14's facility document titled Fall Risk Data Collection dated 4/3/2026, the Fall Risk Data Collection indicated Resident 14 was at high risk for fall. During a review of Resident 14's care plan (CP) dated 4/7/2026, the CP indicated the resident had moderately impaired vision with intervention that included to assist with ADL's as needed and keep call light within reach. During a review of Resident 14's CP dated 4/7/2026, the CP indicated the resident was high risk for fall related to balance problem, weakness with the intervention to keep call light within reach. During a concurrent observation and interview on 5/5/2026 at 9:30 AM with Registered Nurse (RN) 2, in Resident 14's room, Resident 14 was observed in bed with the call light hanging on the right-side of the bed. RN 2 stated, Resident 14's call light should be closer to Resident 14's and was not within Resident 14's reach. RN 2 stated, Resident 2 was able to use her call light so the call light should be accessible for Resident 14 in cases of medical emergency or for when Resident 14 needs to call for assistance from facility staff. During an interview on 5/6/20206 at 8 AM with the Director of Nurses (DON), DON stated, residents in the facility should always have the call light accessible and within reach. DON stated, Resident 14 was able to use call light for assistance and was assessed as a high risk for fall resident. The DON stated Resident 14 required assistance with her ADL's so access to her call light was very important. DON stated, Resident 14 not having access to her call light, had the potential for Resident 14 not to receive the care she needs, especially during emergency, such as a fall with injury which can negatively affect Resident 14's quality of life. A review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting, (undated), indicated, for residents who cannot independently perform ADLs, necessary services will be provided to ensure adequate nutrition, grooming, and personal hygeine. A review of the facility's policy and procedure (P&P) titled, Call Lights-Answering Of, dated 3/6/2026, indicated, ensure call light is placed within the Resident reach and maintain Resident's safety.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on interview and record review, the facility failed to post accurate nurse staffing information of actual hours worked by Registered Nurses (RN), License Vocational Nurse (LVN) and Certified Nurse Aides (CNA) per shift on 5/7/26 in accordance with the facility's policy and procedure titled Posting Direct Care Staffing Numbers. This deficient practice of posting inaccurate nurse staffing information failed to ensure that residents, their representatives, visitors, and regulatory personnel had access to correct and reliable staffing data. This had the potential to misrepresent the actual number of nursing staff available to provide resident care and could negatively affect transparency and the facility's compliance with required posting regulations. Findings: During a review of the facility's document titled Nursing Staffing Daily Posting (posting of staffing information), dated 5/7/2026, the document did not indicate the number of actual time worked per shift for each nursing category (licensed or non-licensed); instead, the document contained a combined total of projected hours of each nursing category in 24 hours. During a concurrent interview and record review on 5/7/2026 at 2:37 PM with the Staffing Coordinator (SC), the facility's Nursing Staffing Daily Posting was reviewed. The SC stated the Nursing Staffing Daily Posting contained the projected hours for the morning shift, afternoon shift, and evening shifts and calculated the number of projected hours worked in a 24-hour period for each nursing category. The SC stated the actual hours worked were kept in a binder and not posted at the nurse's station. During an interview with the Director of Staff Development (DSD) on 5/7/2026 at 2:37 PM, the DSD stated that the Nursing Staffing Daily Posting was posted for staff and visitors to see and if it was not accurate, there was a potential for poor care and confusion of actual nursing staff hours. The DSD stated it was important to post accurate and actual hours for nursing staff to ensure safe staffing and patient care. During a review of the facility's policy and procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers and dated 3/30/2022, the P&P indicated, Shift staffing information shall be recorded on the Nursing Staff Directly Responsible for Resident Care form for each shift. The information recorded on the form shall include. the actual time worked during that shift for each category and type of nursing staff.