

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Hollywood Presbyterian Medical Center D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 4636 Fountain Avenue Los Angeles, CA 90029	
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48342</p> <p>Based on interview and record review, the facility failed to report to the Department an allegation of physical abuse involving one of one sampled resident (Resident 1) when staff became aware of an alleged physical abuse involving Resident 1 and a Licensed Vocational Nurse 1 (LVN 1), who worked at the facility.</p> <p>This deficient practice had the potential for the underreporting of abuse incidents and a delay in an investigation of an abuse allegation, placing Resident 1 and other residents at risk for further potential abuse.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record, (undated), indicated Resident 1 was admitted on [DATE] with a primary diagnosis of chronic respiratory failure with hypoxia (a long-time serious condition that makes it difficult to breathe on your own without enough oxygen). Other active diagnoses include tracheostomy (helps air and oxygen reach the lungs by creating an opening from outside a person's neck), anxiety disorder (feelings of worry, nervousness, or unease), blindness (unable to see), and diabetes mellitus (abnormal break down of sugars/starch resulting in higher levels of sugar in the blood and urine).</p> <p>A review of Resident 1's Progress Notes, dated 3/25/2024 at 2:34 p.m., indicated the Interdisciplinary Team (IDT) met with Resident 1's daughter who stated that Resident 1 complained about the night Licensed Vocational Nurse (LVN) 1 punched Resident 1 on the right and left side of the face during tracheostomy care. The note also indicated IDT tried to explain to Resident 1's daughter that when tracheostomy care is performed, staff may need to turn the resident's face side to side, and that Resident 1 may have misinterpreted the procedure due to Resident 1's anxiety.</p> <p>A review of Resident 1's Progress Notes, dated 3/25/2024 at 3:02 p.m., indicated Resident 1 was Spanish speaking only and legally blind with a history of anxiety. The note further indicated Social Worker (SW) met with Resident 1's daughter who was upset and requested a meeting with the Director of Nursing (DON), Administrator, and Social Worker (SW). Staff met with Resident 1's daughter who reported that LVN 1 hit Resident 1 on the left and right side of the face during tracheostomy care.</p> <p>During an interview on 4/4/2024 at 12:07 p.m. with the Director of Nursing (DON), DON stated, Resident 1's daughter reported LVN 1 slapped or punched Resident 1's face with a closed fist.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/4/2024 at 1:15 p.m. with the Director of Nursing (DON), DON stated abuse consists of hitting, verbal insults, or withholding items (food, water, money, etc.) and should be reported within 24 hours. DON stated, following receiving reports of LVN 1 hitting Resident 1, Resident 1's daughter was specifically asked are you saying Resident 1 was abused by LVN 1 and Resident 1's daughter responded no. DON stated, that's why the facility did not report the allegations because Resident 1's daughter stated the allegation was not abuse.</p> <p>During a concurrent interview and record review with the Director of Therapy Services (DTS) on 4/4/2024 at 1:35 p.m., the facility's Abuse Policy, dated 3/22/2023, was reviewed. DTS stated, when Resident 1's daughter reported that Resident 1 was hit by LVN 1, DTS reports getting ready to call the police, Ombudsman, etc. but due to Resident 1's daughter insisting not to call, it was not reported. DTS said, based on the abuse policy, page two, letter A, under title Policy, number three indicated when an elder or dependent adult tells the reporter that he or she has experienced behavior-constituting abuse, Social Services may be called to assist with the evaluation and reporting. DTS stated this was why the SW was called to sit in on the interview with Resident 1's daughter and document the statements which was signed by Resident 1's daughter.</p> <p>During an interview with the DTS, on 4/4/2024 at 1:35 p.m., DTS stated, if a resident or family reports being hit by a staff member, DTS should report the incident to the appropriate officials immediately, suspend the employee until the investigation is completed, and check on other residents' that the suspected employee cared for.</p> <p>A review of the facility's policy and procedure (P&P) titled, Abuse or Neglect, Elder or Dependent Adult, dated 3/22/2023, page two, letter A, titled policy, indicated hospital personnel shall screen, assess, and report all suspected cases to the proper authorities.</p> <p>A review of the facility's policy and procedure (P&P) titled, Residents' Rights and Responsibilities, dated 11/28/2018, page 20, letter T, titled Resident Behavior and Facility Practices (483.13), number four, indicated the facility must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48342</p> <p>Based on interview and record review, the facility failed to ensure that an allegation of abuse was thoroughly investigated for one of one sampled resident (Resident 1), when the facility failed to obtain a statement or interview from Resident 1 as well as CNA 1, who reportedly witnessed the incident.</p> <p>This deficient practice had the potential for the facility to not appropriately determine necessary interventions that may be implemented for the protection of residents.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record, (undated), indicated Resident 1 was admitted on [DATE] with a primary diagnosis of chronic respiratory failure with hypoxia (a long-time serious condition that makes it difficult to breathe on your own without enough oxygen). Other active diagnoses include tracheostomy (helps air and oxygen reach the lungs by creating an opening from outside a person's neck), anxiety disorder (feelings of worry, nervousness, or unease), blindness (unable to see), and diabetes mellitus (abnormal break down of sugars/starch resulting in higher levels of sugar in the blood and urine).</p> <p>A review of Resident 1's Progress Notes, dated 3/25/2024 at 2:34 p.m., indicated the Interdisciplinary Team (IDT) met with Resident 1's daughter who stated that Resident 1 complained about the night Licensed Vocational Nurse (LVN) 1 punched Resident 1 on the right and left side of the face during tracheostomy care. The note also indicated IDT tried to explain to Resident 1's daughter that when tracheostomy care is performed, staff may need to turn the resident's face side to side, and that Resident 1 may have misinterpreted the procedure due to Resident 1's anxiety.</p> <p>A review of Resident 1's Progress Notes, dated 3/25/2024 at 3:02 p.m., indicated Resident 1 was Spanish speaking only and legally blind with a history of anxiety. The note further indicated Social Worker (SW) met with Resident 1's daughter who was upset and requested a meeting with the Director of Nursing (DON), Administrator, and Social Worker (SW). Staff met with Resident 1's daughter who reported that LVN 1 hit Resident 1 on the left and right side of the face during tracheostomy care.</p> <p>During an interview on 4/4/2024 at 11:30 a.m. with the Director of Therapy Services (DTS), DTS stated, Resident 1's daughter arrived on 3/25/2024 and reported that LVN 1 punched Resident 1 twice.</p> <p>During an interview on 4/4/2024 at 12:07 p.m. with the Director of Nursing (DON), the DON stated, Resident 1's daughter reported LVN 1 slapped or punched Resident 1's face with a closed fist. DON reports responding by asking Resident 1's daughter are you saying this is abuse?, to which Resident 1's daughter replied no, it's not abuse. DON stated she informed Resident 1's daughter, if this is abuse, we need to call the police and report it. DON stated, Resident 1's daughter replied no, it's not abuse. DON stated the allegation was not reported because Resident 1's daughter insisted that the reported incident of LVN 1 punching or slapping Resident 1 in the face twice was not abuse.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/4/2024 at 12:38 p.m. with the Director of Nursing (DON), the DON stated, Resident 1 was assessed with no marks, bruises, or anything. DON said, Resident 1 did not say anything about the incident. DON stated, Resident 1's daughter was in Resident 1's room holding Resident 1's hand during the assessment along with two other family members. DON said, Resident 1 was not asked about the allegations or interviewed about the incident as DON did not want to mention the incident in the presence of family.</p> <p>During an interview on 4/4/2024 at 12:38 p.m. with the Director of Nursing (DON), the DON stated she (DON) spoke with LVN 1 about the alleged abuse. DON said a written statement of events was received from LVN 1. DON stated, CNA 1 was present in Resident 1's room during the tracheostomy care and medication pass but was not interviewed about the allegation as part of the facility's internal investigation because Resident 1's daughter stated the incident was not abuse.</p> <p>A review of the facility's policy and procedure (P&P) titled Abuse or Neglect, Elder or Dependent Adult, dated 3/22/2023, page four, letter E, indicated, when a case of abuse/neglect/assault is suspected, a physician will investigate: number six indicated, get names and statements from witnesses, friends, neighbors, etc.</p> <p>A review of the facility's policy and procedure (P&P) titled, Residents' Rights and Responsibilities, dated 11/28/2018, page 20-21, letter T, heading Resident Behavior and Facility Practices (483.13), number five indicated the facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress.</p>		