

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/04/2025
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)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure proper storage and disposal of expired medications and syringe for three of four medication carts (Medication Cart 3, Medication Cart 7, Medication Cart 9) by:1. Not discarding expired medication and 10 milliliter (mil- unit of measurement) syringes timely.2. Medication that did not have opened date and expiration date on the label were disposed accordingly in Medication Cart 7.3. Unopened insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) was stored properly when found in Medication Cart 7 and not in cold storage. 4. Failing to follow facility's Policy and Procedure (P&P) for labeling and storage of pharmaceuticals and disposal of medications. These deficient practices had the potential to result in nursing staff administering expired and not properly stored medications. Findings:A. During a concurrent observation and interview on 12/3/2025 at 2:55 p.m. with Licensed Vocational Nurse 6 (LVN 6) at Medication Cart 3, an expired multiple fiber supplement (used to help with digestion) and insulin lispro (a medication used to manage blood sugar levels) vial was found. The fiber supplements expiration date indicated 11/28/2023, 4/10/2024 and 6/30/2025. The insulin vial was opened on 10/26/25 which had an expiration date of 4/17/2028 and a label that stated to discard after 28 days. LVN 6 stated that fiber supplements and expired insulin must be disposed of as it is ineffective and can cause harm.B. During a concurrent observation and interview on 12/4/2025 at 9:54 a.m. with Licensed Vocational Nurse 7 (LVN 7) at Medication Cart 9, an expired 10 ml syringe (a simple pump device with a barrel and plunger, used to remove or inject fluid) was found. The 10 ml syringe had an expiration date of 11/2025. LVN 7 stated that expired syringe should be discarded.C. During a concurrent observation and interview on 12/4/2025 at 10:19 a.m. with Licensed Vocational Nurse 3 (LVN 3) at Medication Cart 7, it was observed to [NAME]. An opened refresh eye drop (used to relieve dry eyes) without an open date label which had an expiration date of 09/2026.b. An expired prochlorperazine (medication that treat nausea, vomiting and schizophrenia- a mental illness that is characterized by disturbances in thought) which had an expiration date of 11/2025.c. Fenofibrate (medication that used to manage high cholesterol) which was filled on 11/14/2025 without an expiration date label.d. An unopened novolog (medication to manage blood sugar levels) insulin vial not properly stored in cold storage which had an expiration date of 5/31/2027. LVN 3 stated it is important not to administer expired medication because it can harm the resident. During an interview on 12/4/2025 at 11:00 a.m. with Director of Nursing (DON), DON stated that medications must be checked for expiration before administration. DON stated that expired medications should not be kept in the medication and not to be administered due to reduced effectiveness. The DON stated insulin that is not stored properly should be replaced to ensure resident safety.During a review of the facility's P&P, titled, Labeling and Storage of Pharmaceuticals revised on 9/24/2025, the P&P indicated that Expiration dates shall appear on the label whether or not they appear elsewhere on the container. Drugs are to be stored at the recommended temperatures per US Pharmacopeia recommendations. Please note that storage conditions for any medication are (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	printed on the bottle/container in accordance with the law. All multi-dose vials are to be marked with the date of expiration and discarded after 28 days or per manufacturer's recommendation (whichever is sooner). A label as such as affixed on the medication to display the expiration date. During a review of the facility's P&P, titled, Disposal of Medications revised on 9/24/2025, the P&P indicated that outdated/expired pharmaceuticals that are not scheduled/controlled substances are also returned in this manner depending on their vendor/originator. Individual items may be discarded in the pharmacy.		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observations, interviews, and record review the facility failed to ensure kitchen staff were trained and evaluated for competency skills when: 1.Food Service Worker (FSW2) did not know the proper sanitizer test strip (a small, chemically treated paper or plastic strip used to measure the concentration (strength) of a sanitizing solution) to use for the sanitizer solution (chemical mixture used after cleaning to reduce the number of harmful microorganisms, like bacteria, on food-contact surfaces to a level considered safe by public health standards) used to clean food contact surfaces. FSW2 did not follow manufactures guidance when testing the sanitizer solution used to clean food contact surfaces. 2.Cook1 and Cook2 did not follow standardized recipes when preparing the minced and moist diet (food is cut or ground into very small, soft, moist pieces [about 4mm, or the size of a fork tine gap] that are easy to mash with a fork or tongue, requiring little chewing but needing some to form a cohesive lump, preventing choking and helping residents with chewing/swallowing issues) and were not able to demonstrate the International Dysphagia (difficulty swallowing) Diet Standardization Initiative (IDDSI) fork test and the IDDSI tilt test to make sure the food is Level 5 Minced and Moist per order (IDDSI Fork Test-the lump size is 4mm which is about the gap between the prongs of standard dinner fork, IDDSI spoon tilt test-sample holds its shape on the spoon and fall off fairly easily if the spoon is tilted not firm or sticky). These deficient practices had the potential to result in unsafe and unsanitary food production that could place 6 out of 67 residents in the facility who received food from the facility's kitchen at risk for food borne illness. These deficient practices also placed the residents at risk for meal dissatisfaction, malnutrition, and choking. Findings:1. During an observation in the cold food preparation area on 12/1/2025 at 10:20AM, FSW2 was asked to test the effectiveness of the sanitizer solution in a red bucket. FSW2 looked for the test strip to use then asked Chef1 for assistance. Chef 1 provided FSW2 with the test strip to use and instructed FSW2 to immerse the test strip in the solution and compare color change on the test strip canister for color chart. FSW2 immersed the wrong end of the test strip and removed quickly then stated there was no change in color. FSW2 stated FSW2 did not test for the effectiveness of the sanitizer and relied on another staff to check the sanitizer solution. During a concurrent observation in the kitchen and interview with Chef1 and the Dietary Manager (DM) on 12/1/2025 at 10:30AM, Chef1 stated all kitchen staff had been trained to check the sanitizer solution effectiveness using the test strips provided. The DM stated kitchen staff recently had an in-service on how to test the sanitizer solutions, and it was expected for staff to know. Chef1 stated it was important for staff to know how to test the sanitizer to make sure the solution was effective in sanitizing food contact surfaces and to prevent cross contamination. Chef 1 stated the staff in-service done on sanitizers was a presentation style in-service. During a review of manufacturer instructions for testing the sanitizer indicated to dip a test strip for 5 seconds, shake excess solution off, wait 10 seconds then compare the color on the test strip with colors on the test strip canister to determine concentration, normal solution had to be between 272-700ppm. During a review of the facility training agenda and roster titled SAFE training dated 7/17/2025 indicated staff participated in the SAFE training, information was presented during the training and its staff responsibility for adhering to the procedures and controls in the programs. There was no competency evaluation checklist post training. During a review of facility Food Service Workers job description (dated 3/5/2012) indicated, adheres to all sanitation procedures; sets up and maintains assigned work area in a neat, clean manner to facilitate efficiency and ensure food safety 2.During an observation in the kitchen of the tray line service for lunch on 12/1/2025 at 11:50AM, the minced and moist turkey chili was observed to be very loose, with a pureed (food that's been blended, ground, or strained until it's a smooth, lump-free, pudding-like consistency, requiring no chewing) consistency. During the serving of the minced and moist turkey chili, the chili was poured from the serving scoop into a bowl and appeared to be a smooth (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consistency. Sous chef (chef2), chef2 stated the minced and moist was the regular turkey chili except blended so it would be smoother. Chef2 stated kitchen staff served the minced and moist turkey chili in bowls. Chef 2 stated the cooks prepared the minced and moist turkey chili. During a concurrent interview with cook1, cook2 and chef1 on 12/1/2025 at 12:30PM, cook2 stated he prepared the minced and moist turkey chili, cook2 stated the food processor was used to make the turkey chili smooth. Cook2 did not remember how long the turkey chili was in the food processor. Cook1 assisted cook 2 in preparation of the food. Cook1 stated the turkey chili was placed in the food processor and pulsed about 3 times to get a smooth consistency. Cook1 stated minced and moist food should be small enough to fit through the gaps of the fork and juices should not go through the fork. When asked to demonstrate the test to make sure the minced and moist food meets were to the specification of the minced and moist diet per the IDDSI guidelines. Cook1 stated a fork was used to press on the food to make sure it was soft and fit between the gaps of fork and there were no runny juices. Cook1 pressed on the turkey chili and removed some with fork and then stated, the turkey chili might have been pulsed a long time in the food processor, and it was more like a puree. Chef1 stated the turkey chili was already a minced product and should have not been processed a long time to keep the consistency minced and not puree like. During a review of the facility recipe for the turkey chili, it indicated for minced and moist diet to place the regular turkey chili in the food processor and pulse once or twice to achieve the minced texture. During an interview with the DM on 12/1/2025 at 12:30PM, the DM stated the cooks had to follow the recipe for minced and moist to prepare the correct texture. During a review of the IDDSI guideline website titled IDDSI and dated 7/2019, the IDSSI guideline indicated that Level 5 Minced and Moist was usually eaten with spoon or fork, for people who could not bite off pieces of food safely but had some basic chewing ability. The guideline indicated it was important that food was not sticky. The guideline indicated food was to be scooped onto a fork, with no liquid dripping and no crumbs falling off the fork. The guideline indicated the size of the food was to be 4mm, which was about the gap between the prongs of a standard dinner fork. During a review of facility cook's job description (dated 3/5/2023) indicated, Measures and mixes ingredients according to recipe.recognizes and adopts the appropriate menus and recipes to the specific needs of the patient/resident.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and distribution practices when:1. Five trays of expired raw cookie dough and four large bags of expired crumbled blue cheese were stored in the walk-in refrigerator.2. Two large boxes of raw chicken were thawing inside the walk-in refrigerator with no thaw date (date marked on frozen potentially hazardous food when it is removed from the freezer and placed under refrigeration to thaw).3. One bag of frozen mango was stored in the walk-in freezer with the bag open exposed to the freezer environment.4. Resident food was delivered from the main kitchen located in Building A to the facility located across the street in a food cart crossing through traffic and the public street. These deficiencies had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 6 out of 67 residents who received food from the facility.Findings:1. During an observation of the walk-in freezer in the kitchen located in building A on 12/1/2025 at 9:00AM, a cart was observed with uncooked cookies stored in the walk-in refrigerator with a use by date of 11/25/2025 (6 days past use by date). During a concurrent observation of the walk-in freezer in the kitchen located in building A with the Dietary Manager (DM) and executive chef (chef1) on 12/1/2025 at 9:00AM, the DM stated kitchen staff should have discarded the cookies if the cookies were not prepared. Chef1 stated staff took the cookies out of the freezer to thaw in the refrigerator and didn't use it. Chef1 said kitchen staff should have discarded the cookies per use by date because the cookies were old. Chef1 stated kitchen staff were to use all food or discard by the use by date to make sure fresh products were served. Chef1 stated when food items were beyond the use by date the food could be bad quality or have gone bad. During an observation in the kitchen's walk-in refrigerator in the facility's kitchen on 12/1/2025 at 9:15AM, four large bags of crumbled blue cheese with a use by date of 11/26/2025 were observed stored in the walk-in refrigerator for dairy products. During a concurrent observation in the kitchen's walk-in refrigerator in the facility's kitchen with the DM and Chef1 on 12/1/2025 at 9:15AM, the DM stated the four large bags of crumbled blue cheese were old and the DM was observed removing the bags to discard them. Chef1 stated the four large bags of crumbled blue cheese were old and should not have been stored in the walk-in refrigerator. Chef1 stated kitchen staff were assigned to check and discard food items that were expired. Chef 1 stated expired food should not be served because the food could have gone bad. 2. During an observation of the walk-in refrigerator for meat in the facility's kitchen on 12/1/2025 at 10:00AM, two large boxes of raw chicken were observed stored on the bottom shelf with no date. During a concurrent observation of the walk-in refrigerator for meat in the facility's kitchen and interview with Chef1 on 12/1/2025 at 10:00AM, Chef1 sated the boxes of chicken were delivered that morning (12/1/2025). Chef 1 stated it was important to label and date food and to discard expired food items for safe storage. 3. During an observation in the kitchen's walk-in freezer on 12/1/2025 at 10:15AM, one bag of mango chunks was observed stored in the walk-in freezer uncovered, with the contents exposed to freezer environment. During a concurrent interview with Chef1, Chef1 said food Had to be covered tightly to prevent cross contamination. Chef1 was observed removing the bag of mango chunks from freezer to discard. During a review of facility's policy and procedure (P&P) titled Food storage and Labeling dated 1/22/2025, the P&P indicated All TCS food we prepare or open must be labeled and used within 7 days. During a review of facility's quick standard for Food Safety titled thawing dated 5/8/2023, the quick standard indicated, Plan ahead to verify, preferred method of thawing under refrigeration is used . plan enough time to thaw large items.following the chart below: 4 to 12 pounds 1 to 3 days.Ensure all foods are labeled correctly during thawing. A review of the 2022 U.S. Food and Drug Administration Food Code titled Ready to Eat, Time/Temperature control for safety food, Date Marking Code#3-501.17, indicated, Ready to eat, time temperature control for safety food prepared and packaged by food processing (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed, sold, or discarded. A review of the 2022 U.S. Food and Drug Administration Food Code titled Food storage Code 3-305.11, indicated, Food shall be protected from contamination by storing the food: 1) in a clean, dry location; 2) Where it is not exposed to splash, dust, or other contamination; and 3) at least 6inches above the floor. A review of the 2022 U.S. Food and Drug Administration Food Code titled Miscellaneous Sources of Contamination Code 3-307.11, indicated, Food shall be protected from contamination that may result from a factor or source not specified under subparts 3-301-3-306. See next section for a list of miscellaneous sources of contamination. 4. During an observation in the facility kitchen of the tray line (a system of food preparation, in which trays move along an assembly line) service for lunch on 12/1/2025 at 12:00PM, kitchen staff were observed placing resident meal trays in a food cart. Food service worker (FSW1) was observed pushing the cart out of the kitchen and outside of building A towards the street and traffic light. FSW1 was then observed pushing the cart through the public and across the street from building A to the facility. During an interview with FSW1 on 12/1/2025 at 12:07PM, FSW1 stated during rainy weather the cart was still delivered by going through the street. FSW1 stated when it rained FSW1 would wear a rain jacket, but the cart was not covered. During the same observation, the cart was observed to have doors that were closed but not locked and there were gaps between the door and the frame of the cart resulting in lack of a seal. During an observation of resident lunch service in the facility on 12/1/2025 at 12:15PM, RN5 was observed checking the diet orders for each resident before serving the trays. Fruit cups were observed on the tray opened and tipped over spilling the fresh cut fruits on the trays. RN5 stated the fruits spilled on the tray, and RN 5 was going to leave the fruits like that because the fruits fell while in the cart. During an interview with the DM on 12/1/2025 at 1:15PM, the DM stated kitchen staff had been delivering the food to the nursing facility from Building A in the cart the same way for many years and it had not been an issue. The DM stated the cart was secured with the door but was not locked with a key. The DM stated she (DM) understood the concern with cross contamination. During a review of the 2022 California Building Code Dietetic Service Space 1224.20.2.1, the code indicated, Patient food preparation areas shall be directly accessible to the entry for the food supply deliveries and for the removal of kitchen wastes, interior transportation, storage, etc., without traversing patient or public circulation. Food preparation, service and storage shall be inaccessible to non-dietetic service staff. A review of the 2022 U.S. Food and Drug Administration Food Code titled Miscellaneous Sources of Contamination Code 3-307.11, indicated, Food shall be protected from contamination that may result from a factor or source not specified under subparts 3-301-3-306 (3-301 Preventing contamination by employees; 3-302 preventing Food and ingredient contamination; 3-303 preventing contamination from ice used as coolant; 3-304 preventing contamination from equipment, utensils and linens; 3-305 Preventing contamination from the premises; 3-306 preventing contamination by consumers).		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of eighteen sampled residents (Resident60), representatives were notified of changes in condition on 11/14/2025. This failure resulted in the resident's representative not being notified of the new skin breakdown and being unable to participate in decisions regarding necessary treatment and monitoring. Findings: During a record review of Resident 60's admission record indicated Resident 60 was admitted on [DATE] with a diagnoses of chronic respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), basal cell carcinoma of the skin (a type of skin cancer that most often develops on areas of skin exposed to the sun), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a record review of Resident 60's Minimum Data set [(MDS)] resident assessment tool, dated 11/07/25 indicated that Resident's cognitive was impaired. The MDS indicated that Resident 60's is dependent (helper does all of the efforts) Resident 60 does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) of oral hygiene, toileting hygiene, shower, upper and lower body dressing, and personal hygiene. During a record review of Resident's 60 electronic medical records progress notes on 12/02/2025 at 10:49 a.m., a review of the change of condition (COC) dated 11/14/2025 at 19:42 indicated that Resident 60 had a scratch on the left back of the neck, with recommendation to follow wound care as ordered. There was no documentation that the family had been notified. During a concurrent interview and record review on 12/03/2025 at 1:58 p.m. with Treatment Nurse 1(TX1) of Resident 60's COC, TX1 stated that Resident 60 experienced a change of condition on 11/14/2025 at 19:43, it indicated patient has a scratch on left back of the neck. TX1 stated that Resident 60's Representative was not notified of the new skin scratch. TX1 stated that she forgot to contact Resident60's representative because she was not assigned to Resident 60 and was assisting the nursing staff. During concurrent interview and record review on 12/4/2025 at 11:14 a.m. with Director of Nursing (DON) on 12/04/2025 at 11:14 a.m., the DON stated that License staff are expected to notify the resident's physician and responsible representative of all changes in condition, including new skin issues. The DON stated that the notification was not completed for Resident 60's COC initiated on 11/14/2025. DON stated that it is important to notify the residents responsible representative of any changes because representatives are responsible for participating in care decisions and have the right to know what is going on with their loved ones. A review of the facility's policy and procedure titled. Change of Condition, Notification revised on 09/10/25, indicated Notify the resident's family/caregiver of unexpected changes in resident's condition and document such communication in the medical record.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed ensure the Minimum Data Set (MDS- standardized data collection tool used to assess cognitive brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions] and functional status, and care needs) section I -Active Diagnosis (a physician-documented illness or condition that is currently impacting a patient's health status, treatment, or plan of care) was accurately documented for one of four sampled residents (Resident 2). By failing to document Resident 2's diagnosis of anxiety (a feeling of worry or fear in response to stress that becomes excessive, persistent, and interferes with daily life) in the MDS dated [DATE]. This failure had the potential for Resident 2 not to receive a care plan for behavior monitoring. Findings: During a review of Resident 2's admission Record, the admission record indicated the facility admitted the resident on 1/8/2025 with a diagnosis of major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (a progressive state of decline in mental abilities), and anxiety. During a review of Resident 2's MDS dated [DATE], the MDS indicated the resident was oriented to time but was challenged with recall. The MDS indicated the diagnosis anxiety was not triggered (documented) under section I -Active Diagnosis. During a concurrent interview and record review on 12/4/2025 at 8:39 AM with the Minimum Data Set Nurse (MDSN) 1, MDSN 1 reviewed Resident 2's MDS dated [DATE], the Medical Diagnoses on the admission Record, and the Physician's Order dated 11/24/2025. MDSN 1 reviewed Resident 2's medical diagnosis and MDS 1 confirmed the resident was diagnosed with anxiety. MDSN 1 reviewed Resident 2's Physician's Order dated 11/24/2025 and confirmed the resident was prescribed Ativan (short term management of anxiety symptoms) for anxiety. MDSN 1 reviewed Resident 2's MDS dated [DATE] and confirmed the resident had not been triggered for anxiety under Section I - Medical Diagnosis. The MDS 1 stated Resident 2 should have been triggered for anxiety because the resident was prescribed an antianxiety medication. The MDS 1 stated Resident 2 would be at risk for misdiagnosis. During an interview on 12/4/2025 at 9:24 AM with the Director of Nursing (DON), the DON stated all medications were required to have a diagnosis (to indicate why the medication was prescribed). The DON stated the MDS should have been triggered first, then a seven day look back should be seen. The DON stated Resident 2 would be at risk for not having a care plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) to monitor for side effects of anxiety medications and would be at risk for a lack of behavior monitoring. During a review of the facility's policy and procedures (P&P) titled Psychotherapeutic Medications in the Chalet, dated 3/26/2025, the P&P indicated psychotherapeutic medications included but were not limited to antipsychotic, antidepressants, antianxiety and mood stabilizing medications. The policy indicated psychotherapeutic medications were used only when indicated by assessment and medical necessity. The P&P indicated any order for psychotherapeutic medication had to include the name of drug and dosage, frequency and indication of use. During a review of the facility's P&P titled Coding Procedure, Sub Acute, dated 1/24/2024, the P&P indicated the facility would use information while the resident (unspecified) was in house to determine the diagnoses for the MDS and to be in compliance with regulatory agencies for timely completion of the medical record.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview and record review, the facility failed to ensure care planning for two of five sample residents as follows: Resident 20's care plan for right hand mitten was updated. Care plan was not initiated prior to implementation of Resident 80's side rails use. These failures had the potential for delayed provision of appropriate care and monitoring. Findings: a. During a review of Resident 20's admission Record, the admission Record indicated the facility initially admitted Resident 20 on 7/5/2023, and readmitted the resident on 01/17/2024, with the diagnosis that included chronic respiratory failure, dependence on respirator (ventilator - a medical device to help support or replace breathing), and hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following nontraumatic intracerebral hemorrhage (bleeding within the brain). During a review of the Minimum Data Set (MDS - a resident assessment) dated 10/10/2025, the MDS indicated Resident 20's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Patient 20 was dependent on staff for all activities of daily living (ADL - routine tasks/activities such as bathing, dressing, and toileting) a person performs daily to care for themselves). During an observation on 12/1/2025, at 11:18 a.m., Resident 20 was observed lying in bed with right hand mitten on. During an interview on 12/3/2025 at 11:00 a.m. with Director of Nursing (DON), DON stated care plan is created during admission and reviewed quarterly, annually and when there is a change of condition. DON stated for restraints, the care plan is updated every time there is a new order. DON stated a mitten is a restraint and care plan would need to be updated for resident with mitten on. During a concurrent interview and record review on 12/3/2025 at 11:05 a.m. with Minimum Data Set Nurse (MDS) 2 and DON of Resident 20's Care Plan dated 12/3/2025, the care plan indicated the goals and interventions for physical restraints - right hand mitten was last revised 10/10/2025 by MDS 2. The DON and MDS 2 stated the care plan were not updated. The DON stated the care plan should have indicated a review every seven days for the use of mitten to match the doctor's orders. The DON stated it is important that the care plan is updated for it to be current for nurses to know the residents' risks, problems and interventions for the residents. During a review of facility's P&P titled, Interdisciplinary Care Plan dated 1/24/2024, the P&P indicated, To ensure that all resident's care needs are identified through continuous assessments and those needs are care planned with corresponding measurable objectives and adequate interventions. All residents will have a comprehensive care plan to meet their individual needs that is prepared by an interdisciplinary team (IDT) after admission and periodically reviewed and revised after subsequent assessments or change of condition. b. During a review of Resident 80's admission Record, the admission Record indicated the facility admitted Resident 80 on 11/29/2025, with the diagnosis that included chronic respiratory failure, dependence on respirator and pleural effusion (condition in which excess fluid builds around the lungs). During a review of Resident 80's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 12/2/2025, the H&P indicated resident awake, no command following, no movements, no agitation, no confusion, no anxiety. During a review of Resident 80's Admit/Readmit Screener (clinical tool used to quickly assess resident at admission), dated 11/29/2025, the Admit/Readmit Screener indicated Resident 80's is alert, non-verbal and unresponsive. The Admit/Readmit Screener indicated Resident 80 as total dependence with bed mobility, transfer, dressing, and personal hygiene. During an observation on 12/1/2025 at 11:25 a.m., 2:03 p.m., and on 12/2/2025 at 9:03 a.m., Resident 80 was observed awake, lying in bed with 4 side rails up. During a concurrent observation and interview on 12/3/2025 at 2:38 p.m. with LVN 5, observed Resident 80's side rails x2 up. LVN 5 stated the side rails x2 are up for Resident 80 for safety and repositioning. During a concurrent interview and record review on 12/3/2025 at 2:44 p.m. with RNS, Resident 80's Physician Order dated 11/29/2025 and Care Plan dated 12/3/2025 was (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed. The Physician Order indicated, may use side rails x2 for positioning and ease of mobility as an enabler. The RNS indicated Resident 80 had an order for side rails x2, however, it is not in the Care Plan. RNS stated the side rails should be in the Care Plan. RNS stated there should be care plan for the side rails because it lets staff know the goals, interventions, and what needs to be evaluated and reported to the doctor. RNS stated a care plan is necessary to provide appropriate care. During a review of facility's P&P titled, Interdisciplinary Care Plan dated 1/24/2024, the P&P indicated, To ensure that all resident's care needs are identified though continuous assessments and those needs are care planned with corresponding measurable objectives and adequate interventions. All residents will have a comprehensive care plan to meet their individual needs that is prepared by an interdisciplinary team (IDT) after admission and periodically reviewed and revised after subsequent assessments or change of condition.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care in accordance with professional standards of practice for three of nine residents when the facility failed to: Ensure two of four residents (Resident 35, Resident 24) had physician orders for side rails (protective barrier or structural support along the edge of something, most commonly a bed to prevent falls). Release Resident 20's right hand mitten every 2 hours as indicated in the Residents care plan. These deficient practices had the potential for lack of monitoring and potential harm or injury. Findings: During a review of Resident 20's admission Record, the admission Record indicated the facility initially admitted Resident 20 on 7/5/2023, and readmitted the resident on 01/17/2024, with the diagnosis that included chronic respiratory failure, dependence on respirator (ventilator & a medical device to help support or replace breathing), and hemiplegia and hemiparesis (weakness and paralysis on one side of the body) following nontraumatic intracerebral hemorrhage (bleeding within the brain). During a review of the Minimum Data Set (MDS & a resident assessment tool) dated 10/10/2025, the MDS indicated Resident 20's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Patient 20 was dependent on staff for all activities of daily living (ADL & routine tasks/activities such as bathing, dressing, and toileting) a person performs daily to care for themselves). During an observation on 12/1/2025, at 11:18 a.m., Resident 20 was observed lying in bed with right hand mitten on. During an interview on 12/2/2025, at 3:19 p.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 stated the order is to release the mitten every 2 hours for 15 minutes to check on Resident 20's circulation and skin integrity. LVN 5 stated LVN assigned to the resident is the nurse responsible for releasing the restraint every 2 hours, check circulation and integrity. LVN 5 stated the last time she released the mitten was at 12:35 p.m. and that she was supposed to release again at 2:30p.m. LVN 5 stated it is important to release the mitten every 2 hours as ordered to check and make sure the mitten is not causing problems with circulation or skin integrity. During a concurrent interview and record review of Restraints assessment dated [DATE]-[DATE] on 12/3/2025 at 10:05 a.m. with Registered Nurse (RN) 4, the Restraints Assessment indicated the restraints were released, skin and pulse checked on: 11/30/2025 at 6:00 p.m., thereafter at 8:51 p.m. 12/1/2025 at 4:40 a.m., thereafter at 8:00 a.m. 12/2/2025 at 12:34 p.m., thereafter at 3:30 p.m. RN 4 stated Resident 20's mitten was not released and re-applied according to Physician's order of every 2 hours. RN 4 stated it is important to release the mitten timely every 2 hours to make sure the restraint is not causing circulation and skin integrity problems to the resident. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of the facility's policy and procedure (P&P) titled, Restraints & Physical: Guidelines for Use and Assessment (Sub-Acute), dated 1/14/2024, the P&P indicated All residents will be released for repositioning, checked for application, circulation, and pressure a minimum of every 2hours. The release and restraint checks will be documented on the designated nursing restraint assessment under actions taken. During a review of Resident's 35's admission Record, the admission Record indicated the facility admitted Resident 35 on 7/24/2024 with the diagnosis including epilepsy (brain disorder characterized by recurrent seizures, which are sudden surges of abnormal electrical activity in the brain) and schizophrenia (serious, chronic mental disorder that disrupts how a person thinks, feels, and behaves, causing a distorted view of reality). During a review of Resident 24's admission Record, the admission Record indicated the facility admitted Resident 24 on 7/28/2025 with diagnosis including epilepsy traumatic brain injury (damage to the brain from an external physical force), and obstructive hydrocephalus (A blockage in the brain's cerebrospinal fluid (a clear, watery fluid that surrounds and protects your brain and spinal cord) pathways. During a review of Resident 24's MDS dated [DATE], the MDS indicated the resident was impaired on both sides for the upper and lower extremities (the outermost parts of the body, specifically the arms and legs (upper and lower limbs). The MDS indicated Resident 24 was dependent on all self-care needs. The MDS indicated that bed rails were not used as a restraint. During a review of Resident 35's MDS dated [DATE], the MDS indicated the resident's cognition was severely impaired. The MDS indicated that Resident 35 was dependent on all self-care needs. The MDS indicated that bed rails were not used as a restraint. During a review of Resident 24's Care Plan Report dated 11/14/2025, the Care Plan report indicated Resident 24 had a seizure disorder at risk for injury. The Care Plan report indicated the intervention included padded side rails up times four for seizure precautions. During a review of Resident 35's Care Plan Report dated 11/15/2025, the Care Plan Report indicated Resident 35 had a risk for seizures related to motor vehicle accident with traumatic brain injury. The Care Plan Report indicated the interventions included for padded side rails up times two for seizure precautions. During an observation on 12/1/2025 at 10:36 AM in Resident 35's room, Resident 35 was lying in bed, the upper side rails were up times two, the call light was within reach. During an observation on 12/1/2025 at 10:58 AM in Resident 24's room, Resident 24 was lying in bed, the upper side rails were up two times, the call light was within reach. During a review of Resident 35's Physician order dated 12/1/2025, the Physician Order indicated padded side rails up times two for seizure precautions every shift. The Physician Order was done at 07:00 PM. During a review of Resident 24's Physician order dated 12/1/2025, the Physician Order indicated padded side rails up times two for seizure precautions every shift. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent, observation, interview and record review on 12/2/2025 at 9:16 AM with Registered Nurse (RN) 1, Resident 35's Physician's order was reviewed. The physician order indicated padded side rails up times two for seizure precautions dated 12/1/25. Resident 35 was observed to have side rails up times four. RN 1 stated there was no physician's order noted for side rails to be up times four. RN 1 stated that maybe the CNA put the side rails up times four. RN 1 stated the physician order for padded siderails to be up times two was dated 12/1/2025 at 17:22. RN 1 stated Resident 35 always had a physician's order for padded side rails to be up times two for seizure precautions. During an interview on 12/3/2025 at 1:45 PM with the Minimum Data Set Nurse (MDSN), the MDSN stated the facility had a standard order for side rails either for mobility positioning enabler (any device, equipment, or technique that helps a person with physical impairments maintain a comfortable and safe body posture or move around more easily) and for seizure diagnoses. The MDSN stated there is a specific coding for side rails in the MDS for restraints but would not be triggered. During an interview on 12/3/2025 at 1:47PM with the Director of Nursing (DON), the DON stated that they will use side rails to be up times four, for restraints or per resident request. The DON stated that assessments are done, then the MDS does an entry assessment and 7-14 days and initiate a baseline care plan. During an interview on 12/4/2025 at 8:54 AM with the Certified Nurse Assistant (CNA) 2, CNA 2 stated if residents (unspecified) are moving around in the bed then the side rails would be up times four, and if the charge nurse gave them instructions with a Physician's order. CNA 2 stated Resident 35 does not have side rails up times four. CNA 2 stated Resident 35 does not move around in bed. During an interview on 12/4/2025 at 8:59 AM with Registered Nurse (RN) 2, RN 2 stated that her superiors reminded the staff (unspecified) to check for all residents (unspecified) physician orders for padded side rails. RN 2 stated she put in the order for padded side rails up times two for Resident 35 and Resident 24. RN 1 stated there weren't any orders for side rails up times two or four for Resident 24 or Resident 35. RN 2 stated the side rails up times four would be appropriate for those residents (unspecified) who are confused and moving a lot and restless. RN 2 stated padded side rails up times two would be a standing order and does not need a consent. RN 2 stated side rails need to be padded when up times four. RN 2 stated the risk to the residents without an order for side rails up times four would be the side rails would be considered a restraint, which must have an order and monitoring for risk of falls and checking skin integrity. During an interview on 12/4/2025 at 9:12 AM with the DON, The DON stated they decided to reach out to the doctors (unspecified) and if appropriate get an order for side rails for those residents with seizure diagnosis. The DON stated in discussions with the nurses (unspecified), if residents (unspecified) had seizure diagnosis that it's appropriate to have side rails up times four. The DON stated the nurses (unspecified) had confusion which is why the physicians order for side rails up times 2 was placed. The DON stated the risk to Resident 24 and 35 without physician's order for side rails could be lack of guidance regarding resident (unspecified) safety. The DON stated at the end of the day, it's the residents (unspecified) will suffer. During a review of the facility's policy and procedures (P&P) titled, Restraints & Physical: Guidelines for use and Assessment (Sub-Acute), dated 5/14/2025, the P&P indicated all restraints will require a physician order and restraint use will be reflected in the resident's plan of care. During a review of the facility's policy and procedures (P&P) titled, Provider Orders: Inpatient and (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Outpatient, dated 8/27/2024, the P&P indicated a provider order is required to admit, place in observation, discharge, transfer and for all tests services therapies and procedures for a patient.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to provide oral care to one of five residents (Resident 8) when Resident 8 was observed with teeth covered with white secretions, and sticky matter. This failure had the potential to result in dental deterioration, aspiration, and infection. Findings: During a review of Resident 8's admission Record (Face sheet) the admission Record indicated the facility admitted Resident 8 on 1/17/2021 with diagnoses including chronic respiratory failure (a condition where your lungs gradually stop doing their main job over time), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), dependence on respirator/ventilator a medical device to help support or replace breathing). During a review of Resident 8's History and Physical (H&P), dated 9/7/2025 indicated that Resident 8 did not have the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool), dated 6/23/2025, indicated Resident 8's cognitive skills (the mental abilities your brain uses to think, process information, remember things, pay attention, and solve problems) for daily decision making was severely impaired. The MDS indicated Resident 8 had functional impairment in range of motion on both upper and lower extremities, and was dependent on staff for oral hygiene. During a review of Resident 8's care plan for self-care deficits, revised on 7/25/2025 indicated that Resident 8 required total assistance with her Activities of Daily Living (ADLs). The care plan goal indicated Resident 8 would be clean, dry and well-groomed daily. The care plan interventions included providing oral care daily and assisting as needed. During an observation on 12/01/2025 10:12 a.m., Resident 8 was observed to have dry mouth, and caked with dry white secretions. During an observation on 12/2/2025 at 10:30 a.m., in Resident 8's room, Resident 8 observed Resident 8 sitting supine at a 45-degree angle in bed. Resident 8 had a bubbling sound in her throat, indicating the presence of secretions. There was dried and sticky white secretions between and covering her entire bottom teeth and her mouth was dry and cracked. During an interview on 12/01/2025 10:12 a.m. with Certified Nursing Assistant (CNA) 3, in Resident 8's room, CNA 3 was observed inspecting Resident 8's secretions and stated the licensed nurse does oral care. During an observation and interview on 12/01/2025 10:20 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 was observed inspecting Resident 8's mouth. LVN stated if the resident has cracked lips or secretions, the resident could aspirate and can cause deterioration of teeth and decay. During a review of the facility's P&P titled, ADL (Activities of Daily Living Program), dated 2017, indicated the purposes of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth and to prevent oral infection. Activities to be included in the ADL Program are dressing, bathing, grooming and hygiene, feeding, bowel and bladder training and the use of adaptive equipment.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident60 and Resident 38) received proper care as follows: Failed to notify Resident 60's physician order of a change in condition (COC) on 11/14/2025Failed to update the care plan to reflect the change of condition on 11/14/2025 for Resident 60.Failed to monitor resident 60 every shift for 72 hours following the change in condition beginning 11/14/2024 4.Failed to implement treatment consistent with physician orders by not holding docusate sodium (a medication that helps soften the stool) oral liquid administration through gastrostomy tube ([GT] a soft tube surgically placed into the stomach to provide nutrition and medications) when loose stools are noted. These failures had the potential to contribute to deterioration of Resident 60's and Resident 38 health, delay necessary medical intervention and increase the risk of complications related to the change in condition. Findings:a. During a record review of Resident 60's admission record indicated Resident 60 was admitted on [DATE] with a diagnoses of chronic respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), basal cell carcinoma of the skin (a type of skin cancer that most often develops on areas of skin exposed to the sun), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a record review of Resident60's Minimum Data set [MDS] resident assessment tool), dated 11/07/25 indicated that Resident's cognitive was impaired. The MDS indicated that Resident 60's is dependent (helper does all of the efforts)) Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) of oral hygiene, toileting hygiene, shower, upper and lower body dressing, and personal hygiene. During a record review of electronic medical records under the Change of Condition (COC) dated 11/14/2025 at 19:42 , the record indicated that Resident 60 had a scratch on the left back of the neck, with recommendation to follow wound care as ordered. There was no documentation that the physician had been notified of the COC, no evidence that care plan, was updated and no documentation that resident 60 was monitored every shift for 72 hours following the COC. During interview and record review on 12/03/2025 at 1:58 p.m. with Treatment Nurse 1(TX1) of Resident 60's change of condition (COC) from 11/14/2025, TX1 stated that Resident 60 experienced a change in condition at on 11/14/2025 at 7:43 p.m., documented in the progress notes as patient has a scratch on the left back of the neck. TX1 acknowledged that the physician was not notified of the change in condition, explaining that she was assisting the nursing staff at the time. TX1 further stated that no documentation was entered into Resident 60's chart because the required steps had not been completed by any staff. She admitted to forgetting to initiate a care plan for Resident 60, reiterating that she was just helping, and confirmed that no care plan was completed. During concurrent interview and record review with the Director of Nurses (DON) on 12/04/2025 11:14 a.m., the DON stated that the facility's expectations for managing a COC include the following: the physician must be notified of any changes in condition; any orders given must be carried out; the resident's family must be informed, the care plan must be updated ; and residents must be monitored every shift for any adverse reaction to treatment. The DON stated that Resident 60 was not monitored for 72 following the change in condition due to lack of documentation done from staff. A review of the facility's policy and procedure titled. Change of Condition, Notification revised on 09/10/25, indicated Document physician documentation in the resident's record, including time, name of person contacted, and any orders received. Notify the residents family/caregiver of unexpected changes in resident's condition and document such communication in the medical record. b. During a review of Resident 38's admission Records, the admission Records indicated Resident 38 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure (a condition where lungs cannot move oxygen and carbon dioxide properly), type 2 Diabetes Mellitus (continued on next page)		

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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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[(DM)] - a disorder characterized by difficulty in blood sugar control and poor wound healing), anoxic brain damage (brain injury caused by lack of oxygen). During a review of Resident 38's Minimum Data Set ([MDS] a resident assessment tool) dated 6/5/2025, the MDS indicated Resident 38 was rarely/never understood. The MDS indicated that Resident 38 dependent (helper does all of the effort) with all activities of daily living (ADL).~The MDS indicated that Resident 38 is always bowel incontinent (no episodes of continent bowel movements). During a concurrent interview and record review on 12/02/2025 at 3:01 PM with Registered Nurse (RN) 3 of Resident 38's physician order dated 5/30/2025 , the order indicated that the physician ordered docusate sodium oral liquid 100 mg/10 ml, give 10 ml via GT one time a day for constipation (hold for loose stools). During a subsequent interview and record review on 12/2/2025 at 3:01 p.m. with Resident 38's Bowel and Bladder Elimination record for 11/2025 the records indicated the following: On 11/18/2025 at 6:43 AM Resident 38's bowel movement had loose consistency. On 11/18/2025 at 1:43 PM Resident 38's bowel movement had loose consistency. On 11/18/2025 at 8:41 PM Resident 38's bowel movement had loose consistency. On 11/22/2025 at 6:06 AM Resident 38's bowel movement had loose consistency. On 11/22/2025 at 1:20 PM Resident 38's bowel movement had loose consistency. On 11/23/2025 at 5:09 AM Resident 38's bowel movement had loose consistency. On 11/23/2025 at 1:24 PM Resident 38's bowel movement had loose consistency. On 11/23/2025 at 10:24 PM Resident 38's bowel movement had loose consistency. During a record review of Resident 38's Medication Administration Record (MAR) for 11/2025 revealed the following: Resident 38 received docusate sodium on 11/18/2025, 11/22/2025 and 11/23/2025 RN 3 stated that Resident 38's physician order to hold docusate sodium administration when loose stool was noted and had not been followed. RN 3 further stated that administering stool softener to a resident with loose stools can potentially lead to resident's dehydration, cause skin integrity problems, and harm the resident.^ During an interview on 12/03/2025 at 12:15 PM with Director of Nursing (DON), the DON stated when a resident is having loose stools, and the medication order indicates to hold the medication, staff must follow the physician's order. Administering a stool softener when a resident is having loose bowel movement can potentially lead to dehydration, skin breakdown, and can harm the resident.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with indwelling catheter received appropriate care and services to prevent urinary tract infections ([UTI] - an infection in the bladder/urinary tract) for one of 17 sample residents (Resident 12), by failing to employ infection prevention and control practices in managing catheter. This deficient practice had the potential for Resident 12's existing UTI to worsen due to contamination from the urinary catheter's (a hollow tube inserted into the bladder to drain or collect urine) dignity bag (a bag covering the catheter bag) contacting the floor. Findings: During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, traumatic subdural hemorrhage (when blood collects under the brain's outer covering after a head injury, causing pressure that can damage the brain), anoxic brain damage (when the brain gets zero oxygen, causing brain cells to die), urinary tract infection ([UTI] an infection in the bladder/urinary tract) and had a GT in place. During a review of Resident 12's Minimum Data Set ([MDS] a resident assessment tool) dated 11/06/2025, the MDS indicated Resident 12 was comatose. The MDS indicated that Resident 12 dependent (helper does all of the effort) with all activities of daily living (ADL). During an observation on 12/01/2025 at 11:02 AM in Resident 12's room, it was noted Resident 12's urinary catheter dignity bag was in contact with the floor. During a concurrent observation and interview on 12/3/2025 at 11:17 AM with Certified Nurse Assistant (CNA) 4, CNA stated that dignity bags covering urinary catheters must be positioned below the level of the resident but must not touch the floor. Observed Resident 12's dignity bag covering urinary catheter bag touching the floor. CNA 4 stated the dignity bag was touching the floor. During concurrent observation and interview on 12/3/2025 at 11:43 AM with Licensed Vocational Nurse (LVN) 9, LVN 9 confirmed dignity bag covering urinary catheter bag was touching the floor. LVN 9 stated that the dignity bag should not touch the floor, as this may contaminate the bag and increase the risk of UTI for the residents. During an interview on 12/3/2025 at 12:15 PM with Director of Nursing (DON), the DON stated that dignity bags covering urinary catheter bags must remain off the floor and be positioned below the level of the resident. The DON explained that when a dignity bag touches the floor, it can contaminate the urinary catheter, potentially leading to a urinary tract infection (UTI) and causing harm to the resident.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident, who was receiving feeding through a gastrostomy tube ([GT] a soft tube surgically placed into the stomach to provide nutrition and medications), did not have a significant weight loss (a weight loss greater than five percent (%) in one month, or greater than 7.5% in three months, and greater than 10% in six months) for one of 3 sampled residents (Resident #12). The facility failed to ensure: 1. The licensed nurses initiated a change of condition (COC- internal document) assessment and monitored Resident 12 for weekly weights, and signs and symptoms of malnutrition (condition that develops when the body is deprived of vitamins, minerals and other nutrients it needs to maintain healthy tissues and organ function), and dehydration (a dangerous loss of body fluid caused by illness, sweating, or inadequate intake) to address the nutritional need of Resident 12 on 11/19/2025.2. The licensed nurses notified Resident 12's responsible party (RP) of Resident 12's 8.43 percent (%) significant weight loss identified on 11/19/2025 and 11.45% weight loss identified on 11/26/2025.3. The licensed nurses notified Resident 12's Primary Physician and Registered Dietician (RD) of Resident 12's 11.45 % continued weight loss on 11/26/2025.4. The Interdisciplinary Team ([IDT] a team of different health care professionals working together to develop care interventions for a resident), including the RD met after Resident 12's significant weight loss was first identified on 11/19/2025, and then on 11/26/2025, to develop and discuss interventions to prevent further weight loss.5. The IDT developed an individualized care plan with measurable goals to address Resident 12's weight loss identified on 11/19/2025 and 11/26/2025. These deficient practices resulted in Resident 12 having a significant weight loss of 14 pounds ([lbs.] a unit of weight measurement) in 19 days which was 8.43 % of Resident 12's body weight on 11/19/2025, and 19 lbs. weight loss in 26 days on 11/26/2025 which was 11.45% of Resident 12's body weight. Findings: During a review of Resident 12's admission Records, the admission Records indicated Resident 12 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, traumatic subdural hemorrhage (when blood collects under the brain's outer covering after a head injury, causing pressure that can damage the brain) , anoxic brain damage (when the brain gets zero oxygen, causing brain cells to die), urinary tract infection ([UTI] an infection in the bladder/urinary tract) and had a GT in place. During a review of Resident 12's Minimum Data Set ([MDS] a resident assessment tool) dated 11/06/2025, the MDS indicated Resident 12 was comatose. The MDS indicated that Resident 12's current weight as of 11/12/2025 was 166 lbs. The MDS indicated Resident 12 was receiving a therapeutic (a meal plan that controls the intake of certain foods or nutrients) diet and was receiving 51% or more of his total calories through a feeding tube. During a review of Resident 12's Weight Summary, dated 10/31/2025, the Weight Summary indicated Resident 12's weight was 166 lbs. (admission weight). The Weight Summary has the following:On 11/5/2025 indicated Resident 12's weight was 166 lbs. On 11/12/2025 indicated Resident 12's weight was 162 lbs. On 11/19/2025 indicated Resident 12's weight was 152 lbs. (lost 14 lbs. from admission)On 11/26/2025 indicated Resident 12's weight was 147 lbs. (lost 19 lbs. in 26 days). During a review of Resident 12's Nutrition assessment dated [DATE], the assessment indicated the nutritional goal for Resident 12 was mild weight loss towards 150 lbs. range or stable weight and good labs.During a review of Resident 12's Progress Notes and Assessments, the Progress Notes and Assessments for the month of 11/2025 it indicated no records of COC assessment when the resident had a significant weight loss of 14 lbs. in 19 days, which was 8.43 % of Resident 12's body weight on 11/19/2025, and 19 lbs. weight loss in 26 days on 11/26/2025 which was 11.45% of Resident 12's body weight. During a review of Resident 12's Multidisciplinary Care Conference, dated 11/4/2025, the Multidisciplinary Care Conference indicated that Resident 12's desired body weight (DBW) was 124 - 136 lbs., and initial goal was 150 - 160 lbs. The Multidisciplinary Care Conference indicated weight loss history suspected by sister, saying that Resident 12 used to (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appear heavier prior to hospitalization. The Multidisciplinary Care Conference indicated Resident 12's bowel pattern was one to three times a day, mostly loose. The Multidisciplinary Care Conference indicated nutritional goal for Resident 12 was good tube feeding tolerance and adequate nutrition to be evidenced by tube feeding providing above 90% estimated kilocalorie ([kcal] measurement the energy in food) and protein needs, mild weight loss towards 150 lbs. range or stable weight and good labs. There was no other Multidisciplinary Care Conference assessment noted. During a review of Resident 12's untitled Care Plan initiated 11/21/2025, the Care Plan indicated Resident 12 had a significant weight loss suspected related to diuretic (medication that helps to remove extra fluid from the body) use and edema (swelling) upon admission. The untitled Care Plan indicated Resident 12's weight would be maintained in the 150 lbs. range or within normal limits (WNL) for DBW range, or as medically feasible. The Care Plan interventions include weighing resident weekly for four weeks and monthly after or as per medical doctor (MD) order. During a concurrent interview and record review on 12/03/2025 at 11:52 AM with Registered Nurse (RN) 3, RN 3 stated that resident weighs are checked during admission, then weekly for four weeks. After, RD evaluates resident nutritional needs and how often the residents need to be weighed. Licensed nurses record the weight results into PointClick Care ([PCC] electronic health record system used in the facility). Abnormal weights are reported to Medical Doctor (MD) and RD. RN 3 stated she was unable to locate COC assessment when Resident 12's had the significant weight loss on 11/19/2025 and on 11/26/2025. RN 3 was unable to locate RP notification of Resident 12's COC. RN 3 stated that any change in resident's condition must be communicated with MD and RP. RN 3 stated RDs document their progress notes in Paragon (electronic health record system used in hospitals but not for Skilled Nursing). RN 3 stated that care plans must be documented as soon as there is identified concern, to address resident needs as soon as possible to prevent further decline. During a concurrent interview and record review on 12/03/2025 at 12:56 PM with RD, the RD stated that when the residents experience significant weight loss, weight is rechecked for accuracy. Then RD evaluates the DBW and assesses the need for nutritional adjustment. Resident 12's Weight Summary indicated the resident had a significant weight loss of 14 lbs. in 19 days, which was 8.43 % of Resident 12's body weight on 11/19/2025, and 19 lbs. weight loss in 26 days on 11/26/2025 which was 11.45% of Resident 12's body weight. RD stated that she noted weight loss of 8.43% for Resident 12 on 11/21/25. Resident 12's weight loss was addressed to one of the RNs in the facility along with recommendations. RD stated she could not recall which RN she spoke to. RD stated that communication regarding resident's weights is done in between her and the Director of Nursing (DON). RD stated that she is in contact with DON constantly and exchanging with residents' status information almost every other day. During a review of Resident 12's Nutrition Daily assessment dated [DATE] with RD, the Nutrition Daily Assessment revealed that Resident 12 experienced significant weight loss suspected related to improving edema. The assessment revealed that the resident would benefit from having weight and additional labs checked. RD informed RN of her recommendations to check comprehensive metabolic panel ([CMP] - a blood test to assess body's chemical balance) and weight with next planned weights. RD stated that she noted and addressed Resident 12's weight loss of 11.45% documented on 11/26/2025, only on 12/1/2025 because she had been on vacation during the week of 11/26/2025. RD stated that she initiated a weight loss care plan on 12/1/25, however, she backdated the initiation date as 11/21/2025 since the first significant weight loss was discovered on 11/21/2025. The dietitian was unsure how soon the care plan needed to be initiated when a change in resident condition was noted. During a review of Resident 12's Nurses Progress Notes dated 11/21/2025, the Nurses Progress Notes revealed that Resident 12 was seen and examined by RD with recommendations, physician notified. Physician ordered Complete Blood Count ([CBC] - a blood test to measure red blood cells, white blood cells and platelets) and CMP to be completed on 11/23/2025, and check weight one time. During a concurrent interview and record review on 12/04/2025 at 11:10 AM with DON, the DON stated that expected/desired weight loss is not documented as COC, however it should reflect on IDT meetings. The DON stated if (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician order includes check weight one time, the order must be carried out and completed within 24 hours. Failure to properly complete physician orders may result in insufficient care planning and potential negative outcomes for the resident. During a review of Resident 12's Order Summary Report dated 11/22/2025 with the DON, the Order Summary Report indicated that an order to check weight one time was placed on 11/22/25. Resident 12 was weighed 4 days later on 11/26/2025 and it indicated 147 lbs. The DON stated that weight check ordered on 11/22/2025 for Resident 12 was delayed, which lead to delayed care planning, compromising Resident 12's health, causing further weight loss. During a subsequent interview on 12/4/2025 at 11:10 a.m. and record review of Resident 12's all Order Summary Reports and Progress notes for 11/2025 with the DON, the Order Summary Reports and Progress notes revealed no new orders regarding Resident 12's weight loss of 11.45% on 11/26/2025. The DON stated that Resident 12's weight loss of 11.45% on 11/26/2025 had not been reported to MD and IDT to addressed on time. The DON further added delay in assessment and implementing intervention can lead to further decline in medical needs, unmet nutritional needs, and further unintended weight loss. The DON stated that care plans must be completed within 24 hours of problem identification. Care plan initiation date must be current and cannot be backdated. The DON stated that care plan initiation for weight loss was delayed. She further stated that the care plan initiated on 12/1/2025 in not complete. She further stated that the interventions must be more specific to address resident needs. The DON stated that Multidisciplinary Care Conference meetings are held twice a week. She confirmed that the last Multidisciplinary Care Conference meeting for Resident #12 was documented on 11/4/2025. The DON was unsure if there was another Multidisciplinary Care Conference meeting after 11/4/2025. The DON was unable to locate documentation for Multidisciplinary Care Conference meetings after 11/4/25. The DON stated that Resident #12's family/responsible party had not been notified regarding resident's significant weight loss. The DON stated that failure to notify the resident's family of significant weight loss compromises the family's right to be informed of COC. During a review of the facility's (P&P) titled Standards of Nutrition Care for the Long Term Care/Sub Acute Unit reviewed in November 2023, indicated The Registered Dietitian identifies nutritional risk factors and recommends nutritional interventions, based on a resident's medical condition, nutritional needs and goals. The Dietitian monitors the resident's response to nutritional interventions and adjusts goals and nutrition plans, as needed. 1. A Care Plan is developed for each resident. The care plan is prepared by an interdisciplinary team that includes the dietitian. The care plan includes measurable objectives and specific interventions recommended to maintain adequate nutritional status, relative to condition and prognosis. 2. The dietitian will document on the appropriate care plans. The Care Plan will include information gathered from the nutrition assessment and reflect the residents' nutritional status, goals, preferences as well as the planned nutrition intervention and monitoring criteria. 3. The residents' care plans will be updated quarterly, or more often as needed; e.g., as conditions change, goals are met, or interventions are determined to be ineffective. If nutritional goals are not achieved, different or additional approaches are considered and implemented as indicated. The dietitian monitors and responds to weight changes. Significant weight changes are defined as: 1 month - 5% (significant loss), Greater than 5% (severe loss) 3 months - 7.5% (significant loss), Greater than 7.5% (severe loss) 6 months - 10% (significant loss), Greater than 10% (severe loss). The dietitian is a member of the Interdisciplinary Team. The dietitian will attend appropriate meetings and rounds and document attendance. The appropriateness of the selected residents' care plans is discussed at weekly Interdisciplinary Team meetings, with recommendations for modifications and/or changes presented and revised as needed. During a review of facility's P&P titled Nutritional Screening, Assessment and Reassessment of the Patient reviewed in September 2025, the policy indicated The RD documents on the Interdisciplinary Care Plan following the initial assessment or evaluation of a patient. During a review of facility's P&P titled Residents' Rights and Responsibilities reviewed in September 2024, the policy indicated A facility must immediately inform the resident, consult with the resident's physician; (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and if known, notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental or psychosocial status. During a review of facility's P&P titled Change of Condition, Notification revised in September 2025 the policy indicated The primary physician will be notified for unplanned loss or gain of greater than 5% of body weight within a 30-day period. Document physician notification in the resident's record, including time, name of person contacted, and any orders received. If the resident's physician cannot be reached within a reasonable amount of time, (i.e. by the end of the shift) notify the Director of Nursing and/or Medical Director. Notify the resident's family/caregiver of unexpected changes in resident's condition and document such communication in the medical record.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of eighteen sampled residents (Resident60): Failed to ensure Resident 60 were assessed for risk of entrapment from bed rails prior to installation was completed. Failed to review the risk and benefits of bed rails with the resident representative and obtain consent prior to installation. These failures had the potential to result in compromised resident safety associated with unassessed bed rail use. Findings: During a record review of Resident 60's admission record indicated Resident 60 was admitted on [DATE] with a diagnoses of chronic respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), basal cell carcinoma of the skin (a type of skin cancer that most often develops on areas of skin exposed to the sun), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a record review of Resident60's Minimum Data set [MDS] (resident assessment tool), dated 11/07/25 indicated that Resident's cognitive was impaired. The MDS indicated that Resident 60's is dependent (helper does all of the efforts) Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) of oral hygiene, toileting hygiene, shower, upper and lower body dressing, and personal hygiene. During an observation on 12/2/2025 at 2:01 p.m. in resident 60's room, resident 60 was observed lying in bed facing the doorway with elbows bend towards the chest, bilateral arms resting on chest, and both hands clenched in a fist. A white linen blanket was pulled up to resident60's waist, the bed was in the low position, bilateral SCD boots were in place with the machine on, both side rails raised. During a review of Resident60's medical record on 12/2/2025 at 12:09 p.m. revealed no documented bed rail risk assessment for entrapment, no documentation of alternatives attempted, and no evidence of the resident's or Representative's informed consent for bed rail use. There was no care plan addressing bed rail use or potential entrapment. During an interview on 12/02/2025 at 3:15p.m. with Minimal Data Set Nurse 1 (MDS 1), MDS 1 stated that the nursing staff do not assess for risk of entrapment from bed rails prior to having side rails on because all residents have standing orders from admission to have side rails for positioning and as enabler. MDS1 further stated that staff conduct bed rail assessments only for residents who are alert, and if resident is not alert, there was no need to assess them for risk of entrapment for bed rail use. During a concurrent interview and record review with RN 4 on 12/04/25 at 9:42 a.m., RN 4 stated that there was no risk assessment done for Resident 60's side rail use during admission, nor was any consent form for siderail use as an enabler obtained. RN 4 emphasized the importance of assessing residents before siderails are used for safety reasons, as some residents may be at risk of entrapment, and not all the residents can safely use siderails for mobility. Resident 60's MDS functional abilities, documented on 11/7/2025, indicated impairment (loss of function) on both sides. RN 4 stated that resident 60 cannot use the siderails due to impairment of both upper extremities (shoulder, elbow, wrist, hand). During a review of the facility's policy and procedure titled, Restraints- Physical: Guidelines for use and assessment (Sub-Acute) dated on 06/14/2025, indicated, this facility to assess resident prior to implementation of restraints to ensure appropriate protocols have been followed.		

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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 12/04/2025
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)		
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interviews and record reviews, the facility failed to ensure adequate oversight of the Food and Nutrition Services by qualified personnel, by failing to: 1. Ensure the Director of Food Services met the state and federal requirements for the position and did not have other leadership responsibilities outside of the Dietetics Services department. The Dietary Manager (DM) did not receive at least six hours of in-service training on the specific California dietary service requirements contained in CCR title 22 (health and safety code 1265.4). 2. Ensure the hours dedicated to the oversight of the Food and Nutrition Services by the Director of Food Services were adequate for the scope and complexity of the food service operation. The DM was the Director of Food Services and was also overseeing patient transport, environmental services and overhead operations. These deficient practices had the potential to compromise the safety and nutritional status of residents via cross contamination (transfer of germs and/or bacteria from one surface to another), and decreased meal satisfaction and intake. Cross Reference: F802, F812 Findings: During an interview with the Dietary Manager (DM) on 12/1/2025 at 1:00PM regarding kitchen supervision, the DM stated DM was a full-time employee overseeing food service department, patient transport, Environmental services and overhead operations. The DM stated everyday DM stopped by the kitchen to make sure everything was ok. The DM stated Chef1, and the retail manager (RM) assisted the DM with the daily operation of the kitchen. The DM stated both chef1 and RM did not have dietary manager credentials. The DM stated the DM recently received the Dietary manager certification and did not know that the DM also needed to complete required 6 hours of California State dietary service requirements. The DM stated the DM's time was split into overseeing different departments within the facility and was not always in the kitchen. The DM's office was not located in the kitchen. A review of DM's credentials on 12/1/2025 at 9:00AM, indicated the DM had a certification from an accredited certified dietary manager program effective through 8/31/2026. However, the DM did not receive at least six hours of in-service training on the specific California dietary service requirements contained in CCR title 22 (health and safety code 1265.4). During an interview with the Registered Dietitian (RD) on 12/1/2025 at 9:30AM, the RD stated RD was the clinical Nutrition Manager and supervised three full time dietitians and part time dietitians. The RD assisted with in-services for the kitchen staff and stated the DM was mainly overseeing the kitchen. During a review of facility job description for Food Service Supervisor dated 6/27/2011, the job description indicated Supervises production. observes methods of food preparation and cooking, size of portions etc. To ensure food is prepared in prescribed manner. enforces nutrition and sanitation standards for unit. During a review of the California Health and Safety Code (HSC) 1265.4, the HSC indicated, .a) A licensed health facility . shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b) to supervise dietetic service operations. (b) The dietetic services supervisor shall have completed at least one of the following educational requirements: (1) A baccalaureate degree with major studies in food and nutrition, dietetics, or food management and has one year of experience in the dietetic service of a licensed health facility. (2) A graduate of a dietetic technician training program approved by the American Dietetic Association, accredited by the Commission on Accreditation for Dietetics Education, or currently registered by the Commission on Dietetic Registration. (3) A graduate of a dietetic assistant training program approved by the American Dietetic Association. (4) Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility .		

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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. Based on observation, interview and record review, the facility failed to ensure that one of eighteen sampled residents (Resident 71) had access to a functional call light. This deficient practice had the potential to result in negative impact on Resident 71 safety. Findings: During a review of admission record, the admission Record indicated that Resident 71 was admitted initially on the facility on 08/03/2024 with diagnoses including chronic respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) with tracheostomy (a surgical opening through your neck and into your windpipe to establish a direct airway for breathing), on ventilator (a medical device to help support or replace breathing), diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), cerebral ischemic stroke (loss of blood flow to a part of the brain), muscle weakness and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of the Minimum Data Set (MDS - resident assessment tool) dated 11/07/2025, indicated Resident 71's cognitive (mental action or process of acquiring knowledge and understanding) skills suggests that the individual has a severe level of cognitive impairment. The MDS indicated Resident 71 requires maximum assistance from the staff for activities of daily living ADLs (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During the initial tour on 12/1/2025 at 9:25 a.m., Resident 71 had no call light system in place. During a concurrent observation and interview on 12/1/2025 at 9:50 a.m. with Treatment Nurse 2 (TX 2) in Resident 71's bedside, TX 2 stated there was no call light in place attached to the call system. TX 2 stated there should be a call light here but maybe they took it out. During an interview on 12/4/2025 at 08:49 a.m. with Registered Nurse 4 (RN 4), RN 4 stated that staff must always keep the call light within the resident's reach, as it is crucial for residents to request assistance and prevent falls. RN 4 stated without call light their delayed responses to residents' needs can compromise their safety. During an interview on 12/4/2025 at 11:00 a.m. with Director of Nursing (DON), DON stated the importance of providing residents with access to a call light for their safety as it allows residents to request assistance when needed. During a review of Resident 71's Order Summary Report dated 12/4/2025, the order summary indicated an order was initiated on 8/19/2025 stated appropriate call light within reach every shift for safety. During a review of Resident 71's care plan titled Care Plan Report initiated date on 08/15/2024, the resident has an ADL self-care performance deficit related to limited mobility. Interventions stated as follows: encourage the resident to use bell to call for assistance. During a review of the facility's policy and procedure (P&P), titled, Call Light System revised on 10/2024, the P&P indicated, ensure call light is within the reach of the patient/resident at all times. As soon as the request is addressed, ensure call light device is positioned and placed appropriately before leaving the bedside.		