

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528</b></p> <p>Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced dignity and respect in full recognition of resident's individuality by failing to ensure that the urinary collection bag was covered with a privacy bag for two of two sampled residents (Residents 41 and 54)</p> <p>This deficient practice had the potential to affect Resident 41 and 54's self-esteem and self-worth.</p> <p>Findings:</p> <p>a. During a record review, Resident 41's Admission Record indicated the facility admitted Resident 41 on 3/20/2025 with diagnoses including acute kidney failure (AKF- a sudden and often reversible decline in kidney function), encephalopathy (a problem with the brain, affecting how it works), and hypertension (HTN - elevated blood pressure).</p> <p>During a record review, Resident 41's Minimum Data Set (MDS - a resident assessment tool) dated 3/23/2025, indicated Resident 41 was cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 41 required extensive staff assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During an observation on 5/14/2025, at 7:52 A.M., in Residents 41's room, Resident 41's urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) bag was seen hanging from the bed frame without a dignity cover.</p> <p>During a concurrent observation and interview on 5/14/2025, at 7:56 A.M., with Certified Nursing Assistant (CNA) 3, in Residents 41's room, Resident 41's urinary catheter bag was observed without a dignity bag cover. CNA 3 stated Resident 41's urinary catheter bag did not have a privacy (dignity) bag over it and needed to have one for privacy. CNA 3 stated that not having a privacy bag over Residents 41's urinary catheter bag may cause Resident 41 to feel embarrassed, uncomfortable and not feel good overall.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 5/14/2025, at 8:21 A.M., with Treatment Nurse (TN), in Residents 41's room, Resident 41's urinary catheter bag was observed without a dignity bag covering it. TN stated Resident 41's urinary catheter needed to be covered with a dignity bag for Resident 41's dignity by not having Resident 41's urine be exposed to ensure that Resident 41's dignity is maintained.</p> <p>During an interview on 5/16/2025, at 5:28 P.M., with the Director of Nursing (DON), the DON stated that catheter needed to be covered with a dignity bag to provide Resident privacy. The DON stated if there is no dignity bag on the resident's catheter, it may affect the residents' psychosocial (involving both psychological and social aspects) wellbeing.</p> <p>46843</p> <p>b. During a record review of Resident 54's admission record, indicated Resident 54 was admitted to the facility on [DATE], with diagnoses that included, pressure ulcer (also known as bedsore or pressure sore, is damage to the skin and underlying tissue caused by prolonged pressure, due to lying or sitting in one position for too long), of right heel (the back part of the foot), depression (a persistent state of sadness or lack of interest in things that you used to enjoy).</p> <p>During a record review of Resident 54's MDS, dated [DATE], indicated Resident 54's cognition (the mental ability to make decisions of daily living) was severely impaired. Resident required substantial/maximal assistance with all activities of daily living (ADLs) bed mobility, transfer, eating, toilet use and personal hygiene.</p> <p>During a record review of Resident 54's care plan regarding urinary catheter initiation date 4/22/2025 indicated indwelling foley catheter is to remain in privacy bag and catheter leg strap on at all times.</p> <p>During observation in Resident 54's room on 5/13/2025 at 9:53 AM, Resident 54's indwelling catheter bag was full of yellow urine like fluid and visible to anyone entering or passing by the door of Resident 54's room.</p> <p>During an interview on 5/13/2025 at 9:57 AM, CNA 1 (Resident 54's CNA) stated she (CNA 1) indwelling catheter should be covered for privacy and dignity. CNA 1 stated she will cover the bag right now.</p> <p>During an interview on 5/13/2025 at 8:54 AM, Director of Staff Development (DSD) stated the proper way to care for residents with indwelling catheters should have dignity bags to cover. The DSD stated the dignity bag is placed over the indwelling catheter bag to provide the resident with privacy and dignity, so that no one can tell that she has a Foley catheter inserted.</p> <p>During an interview on 05/13/25 at 8:54 AM the Director of Nursing (DON) stated the CNA should put a privacy cover over the indwelling catheter bag to protect the residents dignity.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review, the facility In-service (training) lesson plan on preserving patient dignity and privacy dated 3/25/25 at 1:30 PM, indicated: Objective Staff will be able to state the importance of providing residents with courtesy, respect, privacy and dignity at all times. Purpose To ensure that staff will provide privacy and dignity to patients and will address them appropriately. Course Contents Privacy refers to freedom from intrusion. Dignity - being worthy of respect. Respect-consideration or thoughtfulness. Patients have the right: 3. Be treated with dignity at all times like when they are in the dining room during meals time or even in the room,</p> <p>During a record review, the facility policy and procedures (P&amp;P) titled Privacy and Dignity reviewed 1/24/2025, indicated, Purpose: To ensure that care and services provided by the Facility promote and/or enhance privacy, dignity and overall quality of life. Policy: The Facility promotes resident care in a manner and an environment that maintains or enhances dignity and respect, in full recognition of each resident's individuality.</p> <p>Procedure:</p> <p>VI. The Facility respects the residents' private space and property.</p> <p>IX. The following rights to privacy are a part of the admission agreement and the resident is informed of these rights during the admission process</p> <p>A. Residents are afforded a right to privacy and confidentiality.</p> <p>X. Resident rights to privacy and confidentiality of medical information and the clinical record is outlined in HP - 01 - Form A - Notice of privacy practices.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455</b></p> <p>Based on observation, interview and record review, the facility's interdisciplinary team (IDT-- a group of health care professionals with various areas of expertise who work together toward the goals of their clients) failed to ensure one out of one sampled residents (Resident 44) was assessed determined capable to self-administer medication left at the bedside and, had a physician's order for self-administrations.</p> <p>This deficient practice had the potential for duplicity, overdose, and consumed by confused wandering resident which could lead to an adverse reactions, unnecessary hospitalization and possible poor health outcomes.</p> <p>Findings:</p> <p>During a record review, Resident 44's admission record indicated Resident 44 was admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses that include atrial fibrillation (Afib-an irregular and often very rapid heart rhythm), hypertension (a medical condition characterized by persistently elevated blood pressure), congestive heart failure (CHF- a condition where the heart cannot pump enough blood to meet the body's needs), type 2 diabetes (DM II-) and peripheral vascular disease (PVD- a slow and progressive disorder of the blood vessels).</p> <p>During a record review, Resident 44's Minimum Data Set (MDS - a resident assessment tool) dated 03/29/2025 indicated the resident 44's cognition (The mental ability to make decisions of daily living) was intact, Resident 44's required supervision or touching assistance for eating and setup partial moderate assistance for oral hygiene.</p> <p>During a facility tour on 5/13/2025 at 11:24 AM, Resident 44's bedside table was observed to have a tube of triamcinolone Acetonide cream (a topical corticosteroid medication used to treat a variety of skin conditions characterized by inflammation and itching). During a concurrent interview, Resident 44 stated she (Resident 44) uses the topical corticosteroid cream when she is itching, and that a physician prescribed the topical corticosteroid cream.</p> <p>During an interview on 5/16/2025 at 2:20 PM Resident 44 stated the resident's family member brought the topical corticosteroid cream for Resident 44 because the resident was itching.</p> <p>During an interview on 5/16/2025, at 2:22 9M, licensed vocational nurse (LVN) 7 stated LVN 7 was unaware Resident 44 had the topical corticosteroid at bedside, LVN 7 stated Resident 44 did not have a physician's order to self-administer the topical corticosteroid and the topical corticosteroid should not be left at the bedside where it is easily accessible, LVN 7 stated Resident 44 had an existing order for Fexofenadine (an oral medical used to relieve itching associated with certain allergic conditions) 180 (dose) mg (unit of measure) taken daily for itching.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/16/2025 at 2:25 PM, Director of Nursing (DON) stated Residents are only allowed to have medications (meds) at the bedside if they have been assessed to be cognitively able and physically have demonstrated that they can safely self-administer medication(s) and must have a physician approval, DON stated medication at bedside should be in a locked container. DON further stated medications should not be left at bedside, because of the risk of duplicity that can lead to an overdose. DON stated a confused wandering Resident may consume the medications which could lead to an adverse reactions, unnecessary hospitalization and possible poor health outcomes.</p> <p>During a record review, the facility policy and procedures titled Medication- Self-Administration dated 1/24/2025, indicated .Residents are provided with the opportunity to self-administer medication when determined by assessment they are capable to do so by the attending physician and the interdisciplinary team. If the resident is assessed as clinically appropriate for medication self-administration by the IDT, the licensed nurse obtains a physician's order for self-administration of selected medications. Self-administered medications will be placed in a secure drawer or cabinet that is easily accessible to the Resident.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	
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 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528</b></p> <p>Based on interview and record review, the facility failed to complete a change of condition (COC -a sudden deviation from person/patient's baseline in physical, cognitive, behavioral or function) in accordance with the facility policy and procedures (P&amp;P) titled Change of Condition Notification revised 1/24/2025 for one of three sampled residents (Resident 47).</p> <p>This deficient practice had the potential to result in the delay of necessary care for Resident 47.</p> <p>Findings:</p> <p>During a record review, Resident 47's Admission Record indicated the facility admitted Resident 47 on 7/5/2024 and was readmitted on [DATE] with diagnoses including diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), and hypertension (HTN - elevated blood pressure).</p> <p>During a record review of Resident 47's Minimum Data Set (MDS - a resident assessment tool) dated 4/30/2025, indicated Resident 47 was cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 47 required extensive staff assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a concurrent interview and record review, on 5/16/2025, at 7:20 A.M., with the Registered Nurse Supervisor (RNS) 1, Resident 47's electronic nursing progress notes dated 4/15/2025 at 9:43 P.M. was reviewed. RNS 1 stated the nursing progress notes dated 4/15/2025 at 9:43 P.M., indicated that unidentified Licensed Vocational Nurse noticed Resident 47's urine had sediments (tiny particles or matter that collect at the bottom of a urine sample. This can include things like crystals, bacteria, blood cells, or even debris from the urinary tract), was light yellow in color and had clumps (clots or sediment, which may require medical attention). RNS 1 stated the nursing progress note indicated Resident 47 had a COC, however, there was no documented evidence that a COC was completed for Residents 47. RNS 1 stated a COC is supposed to be completed at the time when the sign and symptoms of a COC is noticed/identified. RNS 1 stated the COC needs to be completed to help closely monitor how the residents is doing, if the resident is getting worse, especially specifically to the problem area that was observed or noted. RNS 1 stated not monitoring a resident's condition may lead to the resident having sepsis (a life-threatening medical emergency that occurs when the body's extreme response to an infection damages its own tissues and organs) or getting hospitalized .</p> <p>During an interview, on 5/16/2025, at 5:32 P.M., with the Director of Nursing (DON), the DON stated that a COC needs to be completed immediately a problem with a resident is identified to ensure that treatment is provided on time. The DON stated that if a COC is not done, there would be a lack of communication among the staff and the care delivery time may not be provided within the time frame which may cause further decline in the resident's emotional status and/or other health care conditions.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	
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 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review, the facility's P&amp;P, titled, Change of Condition Notification revised 1/24/2025, indicated, Purpose: To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner.</p> <p>Definition: An acute change of condition (ACOC) is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains. Clinically important means a deviation that, without intervention, may result in complications or death.</p> <p>I. Members of the interdisciplinary Teams (IDT) are expected to report and document signs and symptoms that might represent an ACOC.</p> <p>II. The facility will promptly inform the resident, consult the resident's attending physician, and notify the residents legal representative when a resident endures a significant change in their condition caused by, but not limited to:</p> <p>b. A significant change in the resident's physical, cognitive, behavioral or functional status.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	
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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48026</b></p> <p>Based on interview and record review, for one of four residents (Resident 45), the facility failed to:</p> <p>1) Complete a Preadmission Screening and Resident Review (PASRR - a screening evaluation used to determine whether placement in a long-term care facility is appropriate for the resident) Level I (a tool that helps identify possible serious mental illness and/or intellectual/development disability) assessment when Resident 45 was readmitted on [DATE].</p> <p>2) Notify the mental health agency (A mental health agency that provides and is responsible for mental health services. These services can include a range of interventions, assessments, diagnosis, treatment, and counseling, delivered in various settings to support mental health or treat mental/behavioral disorders) promptly after Resident 45 was newly diagnosed with dementia and anxiety disorder on 4/10/2025 and Alzheimer's disease on 4/18/2025.</p> <p>3) Develop a care plan after Resident 45 was diagnosed with dementia, anxiety disorders (a condition of excessive worry about daily issues and situations) and Alzheimer's disease (a common type of dementia that affects memory, thinking and behavior).</p> <p>These deficient practices of failing to complete PASRR Level I assessment, notify the mental health authority promptly and create care plans related to the diagnoses of dementia, anxiety disorder, and Alzheimer's disease for Residents 45 put Resident 45 at risk for not identifying possible serious mental illness during Resident 45's re-admission on 4/10/2025 and providing interventions tailored to Resident 45's nursing care needs.</p> <p>Findings:</p> <p>During a record review, Resident 45's face sheet (Admission Record - a document containing demographic and diagnostic information) indicated, Resident 45 was admitted to the facility on [DATE] and was readmitted on [DATE] with the following medical diagnoses: Alzheimer's disease, unspecified dementia, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder.</p> <p>During a record review, Resident 45's Minimum Data Set (MDS - a resident assessment tool) dated 4/24/2024, indicated, Resident 45 had a severely impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life).</p> <p>During a record review, Resident 45's Care Plan (a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) did not indicate any care plans were created for Resident 45 after the onset (start) of medical diagnoses of dementia, anxiety disorder, and Alzheimer's disease.</p> <p>During a record review, Resident 45's History and Physical (H&amp;P - a physician's complete patient examination) dated 4/10/2025, indicated, Resident 45 did not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	
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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review, Resident 45's Diagnosis Report (a report that contains all of patient's diagnoses, onset [start] date of diagnosis, and date when the diagnosis was resolved) indicated Resident 45's Alzheimer's diagnosis onset was on 4/18/2025, unspecified dementia on 4/10/2025, major depressive disorder on 4/10/2025, and anxiety disorder on 4/10/2025.</p> <p>During an interview and concurrent record review with Minimum Data Set Coordinator (MDSC - adequately assessing nursing home residents' needs and coordinating personalized, resident-driven care based on those assessments) nurse, MDSC-Assistant (MDSC-A) and the Director of Nursing (DON) on 5/16/2025 at 9:35 AM, MDSC stated MDSC Assistant (MDSC-A) was responsible for ensuring PASSR Level I was completed when Resident 45 was readmitted . MDSC-A stated, I have not received official responsibility to do PASRR Level I. During a record review with the DON, Resident 45's electronic health record was reviewed. The DON stated the admission nurse is responsible, but most of the PASRR Level I when not completed, the DON will complete PASSR Level 1. The DON stated, yes, it would qualify for Level I screening, but it was not done when asked if Resident 45's dementia and anxiety disorder were diagnosed on [DATE] and Alzheimer's disease diagnosed on [DATE] qualify for a PASRR Level I screening. The DON also stated, after reviewing Resident 45's with surveyor, that Resident 45 did not have care plans created for dementia, anxiety disorder nor Alzheimer's disease.</p> <p>During a record review, the facility policy and procedures (P&amp;P - explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Preadmission Screening and Resident Review revised on 7/01/2023, indicated, All individuals . must have a PASRR . prior to the facility accepting the admission. The facility ensures that PASRR Level I is completed . prior to admission to determine if they [residents] have a serious mental illness . The facility also conducts PASRR Level I screening for current residents who have a mental illness .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	
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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45528</b></p> <p>Based on interview and record review, the facility failed to develop a comprehensive care plan for one of four sampled residents (Resident 15) in accordance with the facility policy and procedures (P&amp;P) titled Care Planning revised on 1/24/2025, by failing to initiate a care plan for Resident 15's gastrostomy (g-tube -a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems).</p> <p>This deficient practice had the potential to negatively affect the delivery of necessary care and services needed for Resident 15.</p> <p>Findings:</p> <p>During a record review, Resident 15's Admission Record indicated the facility admitted Resident 15 on 9/4/2024 and was readmitted on [DATE] with diagnoses including diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), personal history of transient ischemic attack (TIA - a temporary blockage of blood flow to the brain), and dysphagia (difficulty swallowing).</p> <p>During a record review, Resident 15's history and physical (H&amp;P - a thorough assessment of a patient's health, combining a detailed conversation about their medical history and a physical examination) dated 4/30/2024, indicated . dysphagia status post g-tube</p> <p>During a record review, Resident 15's Minimum Data Set (MDS - a resident assessment tool) dated 3/9/2025, indicated Resident 15 is cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 15 required partial/moderate to dependency on staff with activities of daily living (ADL - tasks of everyday life) and was incontinent urinary and bowel.</p> <p>During a concurrent interview and record review, on 5/16/2025, at 2:24 P.M., with Registered Nurse Supervisor (RNS) 1, Resident 15's electronic chart was reviewed. RNS 1 stated Resident 15 had a g-tube. RNS 1 stated Resident 15 did not have a care plan for the g-tube feeding. RNS 1 stated Resident 15 was admitted on [DATE] with a g-tube and that a care plan for the g-tube should have been initiated upon admission so that facility staff knows what type of care the Resident should be given, and if goals have been achieved. RNS 1 stated not having a care plan, the facility staff will not have guidelines on how the resident needs to be taken care of such as monitoring for patency, aspiration precautions, infections and bloating.</p> <p>During an interview, on 5/16/2025, at 5:30 P.M., with the Director of Nursing (DON), the DON stated a care plan needs to be done when there is a problem identified, the facility needs to set a goal with proper implementations. The DON stated that care plans for the residents ensure that the residents are provided quality of care and the maximum level of care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	
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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review of the facility's P&amp;P, titled Care Planning revised on 1/24/2025 indicated, Purpose: To ensure that a comprehensive person-centered care plan is developed for each resident based on their individual assessed needs.</p> <p>1. The facility's interdisciplinary Team (IDT) will develop a baseline and/or comprehensive care plan for each resident in accordance with OBRA and MDS guidelines.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	
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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45037</b></p> <p>Based on interview and record review, the facility failed to complete annual performances evaluations (the review and evaluation of an individual's or organization's performance over a 12-month period), annual skills competencies (the measurable or observable knowledge, skills, abilities, and behaviors critical to successful job performance), and trainings for five out of five employees (Licensed Vocational Nurse 1 [LVN1], LVN2, Certified Nursing Assistant 2 [CNA2], Houskeeper, and Housekeeping Supervisor).</p> <p>These deficient practices had the potential for residents not to receive the appropriate level of care needed, affecting quality of care and potentially leading to resident harm.</p> <p>Findings:</p> <p>During an interview on [DATE] at 9:22 a.m., LVN 1 stated she did not remember the date of her last annual performance evaluation, annual skills competencies, the date of fire safety card, or the date of her last annual physical. LVN 1 stated it was very important to complete annual skills competencies so that she could remain competent with caring for residents. LVN 1 stated if annual competencies were not completed annually the nurses could forget how to properly care for the residents.</p> <p>During an interview on [DATE] at 12:17 p.m., CNA 2 stated she had been a CNA for 9 years. CNA 2 stated her last in-service for skin care was on the date of interview ([DATE]). CNA 2 stated she did not remember the date she completed sexual harassment or abuse training.</p> <p>During an interview on [DATE] at 8:24 a.m., LVN 2 stated he could not remember his last annual skills competencies, or annual performance evaluation. LVN 2 stated he gave the DSD his renewed CPR card. LVN 2 stated he could not remember the dates he completed sexual harassment training, or a background check. LVN 2 stated it was important to complete skills competencies so that he did not forget how to properly care for residents, resident safety, and to be competent with caring for all his residents.</p> <p>During an interview and concurrent record review on [DATE] at 10:08 a.m., the Housekeeping Supervisor stated she was not aware that outside contracted housekeepers were supposed to have employee files kept in the facility. A review of the Housekeeping Supervisor employee file indicated no trainings, annual competencies, or vaccination records.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	
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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 10:37 a.m., Director of Staff Development (DSD) stated sexual harassment training was renewed every two years, fire safety, and cardio-Pulmonary resuscitation (CPR - It is an emergency life-saving procedure that is done when someone's breathing or heartbeat has stopped) cards are renewed every two years. DSD stated abuse training was completed quarterly and as needed and performance evaluations annual skills competencies were completed by DSD or the Director of Nursing (DON) yearly/annually. DSD stated the outside housekeeping contractor was responsible to complete abuse and sexual harassment training for the contracted housekeeping staff. DSD stated it was very important that all employee files be kept updated to ensure all training, licenses, CPR cards, and Fire safety cards, so that the nurses and the facility complied with the requirements. DSD stated it was important for all training to be updated to ensure that the nurses could provide the best care for all the residents. DSD stated all the staff documents, including trainings, licenses, vaccination records, physicals, were supposed to be kept in the employee files.</p> <p>During a concurrent record review with DSD on [DATE] from 10:37 a.m., the employee files indicated:</p> <ol style="list-style-type: none"> <li>1. LVN 1: nurses license was expired, no annual performance evaluation, annual skills competencies in employee file, fire safety card, annual physical, TB skin test, vaccination records, or background check.</li> <li>2. LVN 2: CPR card had expired, updated sexual harassment training, expired abuse training (when was the expiration date?), and no annual performance evaluation.</li> <li>3. CNA 2: no sexual harassment training and last abuse training was on [DATE].</li> <li>4. Housekeeper: No annual competencies.</li> <li>5. Housekeeping Supervisor: No There were no trainings sexual harassment, abuse or annual competencies.</li> </ol> <p>During an interview on [DATE] at 11:48 a.m., the Administrator stated all employees working in the facility were supposed to have an employee file with all documents up to date kept in the facility. The administrator stated it was important for all employees working in the facility to have a file on hand so that the employee was identifiable if an incident happened.</p> <p>During an interview on [DATE] at 2:45 pm, the DON stated that all employee files were supposed to be updated. The DON stated if competencies were not completed annually, the nurses could forget how to complete important tasks which could harm the residents.</p> <p>During a record review, the facility policy and procedures titled Performance Evaluations dated ,d+[DATE], indicated, Employees may receive periodic performance reviews. The review will generally be conducted by their supervisor. The first performance evaluation may be conducted annually, on or around their anniversary date. The frequency of performance evaluations may vary depending upon length of service, job position, past performance, changes in job duties or recurring performance problems.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46843</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage practices in the kitchen when:</p> <ol style="list-style-type: none"> <li>1. Walk in refrigerator shelves were cracked and rusted.</li> <li>2. Food stored on rusted shelves in the walk-in refrigerator.</li> </ol> <p>These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of bacteria from one object to another) that could lead to foodborne illness medically compromised residents who receive and eat food from the kitchen.</p> <p>Findings:</p> <p>During an initial kitchen tour observation of the walk-in refrigerator on 5/13/2025 at 7:40 AM, a total of four shelves were rusted in various places on the shelves, ready to cook foods were stored on or directly under the rusted shelves.</p> <p>During an interview on 5/13/2025 at 7:42 AM, [NAME] 3 stated, the racks are rusty in the main refrigerator.</p> <p>During an interview on 5/13/2025 at 8:03 AM, [NAME] 2 stated, the racks in the refrigerator need to be replaced because they are rusty.</p> <p>During a concurrent observation and interview on 5/13/2025 at 9:14 AM, Dietary Supervisor DS stated DS's first day to work as the dietary supervisor is today (5/13/2025). DS stated DS will take action to improve the situation with the rusted racks in the refrigerator area.</p> <p>During a concurrent observation and interview on 5/15/2025 at 10:26 AM, Administrator (ADM) stated, the racks in the refrigerator need to be replaced because they are rusty.</p> <p>During a record review, the facility Policy and Procedures (P&amp;P) titled Food Storage, reviewed on 1/24/2025, indicated Food items will be stored, thawed, and prepared in accordance with good sanitary practice.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	
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 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45037</b></p> <p>Based on observation, interview, and record review the facility failed to:</p> <ol style="list-style-type: none"> <li>1. Maintain and ensure patient care bathrooms were in safe operating condition for 2 of 2 sampled bathrooms.</li> <li>2. Maintain and ensure the kitchen ice machine was in safe operating condition, two of three food preparation tables, one of four food warming trays, four of four food storage racks, and the overhead light in the walk-in freezer, were in safe operating condition.</li> </ol> <p>These deficient practices had the potential to result in staff being unable to meet the needs of residents in a timely and safe manner.</p> <p>Findings:</p> <p>1. During observation of the shared bathroom between rooms [ROOM NUMBERS] on 05/13/25 at 1:28 p.m., the maintenance aide observed with the surveyor and confirmed by stating the toilet was running constantly after flushing, and the toilet seat was very loose and broken.</p> <p>During an observation of the bathroom in room [ROOM NUMBER] on 05/13/25 at 1:44 p.m., the maintenance aide observed with the surveyor and confirmed by stating the bathroom's hot water faucet was constantly running and would not turn off and the toilet seat was discolored and broken.</p> <p>During an interview on 05/13/25 at 2:21 p.m., with Maintenance Aide. Stated he had been employed with the facility for 1 month. The maintenance aide stated he would make rounds daily to check for repairs. The maintenance aide state he did not have any documents or records to show what needed to be repaired in the facility, or documents to show which rooms he rounded on daily. The maintenance aide stated there was a maintenance repair log at each nurse's station. The maintenance aide stated if the residents continued to use the toilet with a broken toilet seat, the residents could fall and get injured.</p> <p>During a review of the maintenance repair log at nurses' stations 1 and 2 on 05/13/25 at 2:21 p.m., there were no repairrequests for the bathroom sink and toilet in room [ROOM NUMBER], or for the toilet in room [ROOM NUMBER].</p> <p>During an interview on 05/14/25 at 8:08 a.m., the housekeeper stated she had been working for the facility for 3 years. The housekeeper stated she was responsible for cleaning the patient's room and bathrooms daily in the morning and as needed. The housekeeper stated if the toilet and the sinks were broken, she would report it to the maintenance aide right away. The housekeeper stated if the residents used the broken toiled seat, it was very dangerous, and the patient could fall and get injured.</p> <p>During an interview on 05/14/25 at 10:08 a.m., the DON stated the maintenance supervisor was out on medical leave. The DON stated the maintenance aide was covering the facility for minor repairs only. The DON stated if the facility needed major repairs an outside company would be utilized.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	
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 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facilities policy titled Resident Rooms and Environment with a reviewed date of 1/24/2025, indicated: Purpose: To provide residents with a safe, clean, comfortable, and homelike environment.</p> <p>A review of the facilities policy titled Maintenance Services with a reviewed date of 1/24/25, indicated: Policy: The maintenance department maintains all areas of the building, grounds, and equipment. Procedure: I. The maintenance department is responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times.</p> <p>46843</p> <p>2. During an initial kitchen tour observation, rust was observed on four of four racks in the main refrigerator where food was stored. The ice maker was observed to be not working, one out of four of the food warmers was not working, one of three food preparation tables (the large table) were unsteady and appeared to be weak, one out of three food preparation tables was missing, and there is no light in the walk-in freezer.</p> <p>During an interview on 5/13/2025 at 7:42 AM [NAME] 3 stated the ice maker had been broken since the prior weekend (5/10/2025 and 5/11/2025). [NAME] 3 stated no ice was purchased on 5/10/2025 and 5/11/2025. [NAME] 3 stated one of four warmer trays were broken, and the warmer tray to the far left had not been working for the last four weeks. [NAME] 3 stated the four racks in the main refrigerator were rusty. [NAME] 3 stated the light in the walk-in-freezer was not working.</p> <p>During an interview on 5/13/2025 at 8:03 AM [NAME] 2 stated the ice maker had been broken over the weekend and it had been hot. [NAME] 2 stated no one bought any ice during the weekend. [NAME] 2 stated one of four food warmer trays had been broken the one to the far left does not work. It has not been working for the last four weeks. [NAME] 2 stated the racks in the refrigerator needed to be replaced because they were rusty. [NAME] 2 stated there was no light in the walk-in freezer. [NAME] 2 stated the door on the freezer would get stuck and kitchen staff would have to leave something in the doorway to stop it from closing when kitchen staff went inside to get food. [NAME] 2 stated the food preparation table was weak and could break at any moment because one of the legs of the table was loose. [NAME] 2 stated the small food preparation table broke about three weeks prior, and it had never been replaced.</p> <p>During an interview on 5/13/2025 at 8:03 AM [NAME] 1 stated the light in the walk-in freezer did not work, and the ice machine was broken. [NAME] 1 stated the food preparation tables were old and unsteady.</p> <p>During a concurrent observation in the facility kitchen and interview on 5/13/2025 at 9:14 AM, the Dietary Supervisor (DS) stated the day of interview (5/13/2025) was the DS' first day as dietary supervisor and the DS would take action to improve the situation with the rusted racks in the refrigerator area and all other broken equipment including the ice maker, the week food preparation table, the missing light in the walk-in freezer, and the missing food preparation table.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	
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 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation in the facility kitchen and interview on 5/14/2025 at 7:26 AM, the Maintenance Aide (MA) stated he was aware of the ice maker being broken since Saturday 5/10/25. The MA stated he had contacted a company to come out and service the machine to see if they could make it work. The MA stated he was aware of the table being broken, and the food warmer was mentioned to him, and was going to look at the food warmer to determine if it could be fixed. The MA stated he was also aware of the rusted racks and was waiting for approval to purchase new ones. The MA stated he did not keep a record of the reports, and would just makes notes here and there to remind him of what needed to be fixed.</p> <p>During a concurrent observation in the facility kitchen and interview on 5/15/2025 at 10:26 AM, the Administrator (ADM) stated the kitchen equipment had to be fixed or replaced. The ADM stated the ice machine was broken, one of four food warming trays was broken, the racks could not be painted because they needed to be replaced due to rust, and the food preparation tables needed to be replaced because one had already broken, and the other was weak.</p> <p>A review of the facility's Policy and Procedure (P&amp;P) titled Maintenance Services dated 1/24/2025, indicated Purpose: G. Establishing priorities in providing repair service; J. Maintaining all mechanical, electrical, and patient care equipment in safe operating condition; III. The Director of Maintenance is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.</p> <p>Equipment is repaired or replaced as necessary to ensure the safety and welfare of residents and employees. Non-critical equipment is equipment whose failure would interrupt standard operational services. Examples include the following: Dietary equipment. 1. Notify the administrator of needed routine equipment replacement or repairs. 2. For minor equipment/replacements (less than 500), contact local vendors/contractors to perform the work. Consult the regional maintenance manager or RVP with questions about equipment or repairs above \$500.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	

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 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45455</b></p> <p>Based on observation, interview and record review, the facility failed to provide at least 80 square feet (sq. ft. -unit of measure) per resident in multiple resident bedrooms for 11 out of the 39 resident rooms (Rooms 100, 102, 104, 106, 108, 115, 117, 120, 123, 134, and 135). The 11 Resident rooms consisted of 3 beds in each room.</p> <p>This deficient practice had the potential to result in inadequate useable living space for the residents and working space for the health caregivers.</p> <p>Findings:</p> <p>During a record review, the Request for Room Size Waiver letter, dated 5/16/2025, submitted by the Administrator, indicated there are 11 rooms that did not meeting the 80 square feet requirement per resident according to federal regulation. The letter indicated that the room sizes would not interfere with the daily nursing care or safety of the residents. The letter also indicated there would be enough space to provide for each resident's care, dignity and privacy in those rooms which are in accordance with the special needs of the residents. The letter indicated the spaces would not have an adverse effect on the residents' health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being.</p> <p>During a record review, the Client Accommodations Analysis submitted by the facility on 5/16/2025, indicated the following rooms with their corresponding measurements:</p> <p>Rooms # total Sq. Ft/Resident # Beds Floor Area Sq. Ft/Resident.</p> <p>room [ROOM NUMBER] is 229.3 square feet with 3 beds (76.4 square feet per resident)</p> <p>room [ROOM NUMBER] is 229.3 square feet with 3 beds (76.4 square feet per resident)</p> <p>room [ROOM NUMBER] is 229.3 square feet with 3 beds (76.4.8 square feet per resident)</p> <p>room [ROOM NUMBER] is 223.1 square feet with 3 beds (77.0 square feet per resident)</p> <p>room [ROOM NUMBER] is 239.9 square feet with 3 beds (78.9 square feet per resident)</p> <p>room [ROOM NUMBER] is 224.2 square feet with 3 beds (74.7 square feet per resident)</p> <p>room [ROOM NUMBER] is 224.2 square feet with 3 beds (74.7 square feet per resident)</p> <p>room [ROOM NUMBER] is 202.0 square feet with 3 beds (67.3 square feet per resident)</p> <p>room [ROOM NUMBER] is 221.4 square feet with 3 beds (73.8 square feet per resident)</p> <p>room [ROOM NUMBER] is 133.3 square feet with 3 beds (44.4 square feet per resident)</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2025
NAME OF PROVIDER OR SUPPLIER  Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE  1100 S. Alvarado St Los Angeles, CA 90006	
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 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>room [ROOM NUMBER] is 192.0 square feet with 3 beds (64.0 square feet per resident)</p> <p>During the general observations of the residents' rooms on 5/13/2025 to 5/16/2025, the residents had ample space to move freely inside the rooms. There were sufficient spaces to provide freedom of movement for the residents and for nursing staff to provide care to the residents. There was also sufficient space for beds, side tables and resident care equipment.</p> <p>The minimum square footage for a 2-bed room should be 160 sq. ft. per federal regulation.</p>		