STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview and record review, the facility failed to ensure the residents' right to a dignified existence by failing to ensure an indwelling urinary catheter (a flexible tube inserted into the bladder and left in place to continuously drain urine) collection bag (attached to the catheter tube for the purpose of collecting urine) had a dignity cover (privacy cover, a manner of concealing urine in the collection bag) for two of two sampled residents (Resident 328 and 12) reviewed under the dignity care area. This deficient practice had the potential to cause emotional distress, affect residents' self-esteem, and a decline in psychosocial wellbeing when the residents' body fluids were visible to other residents, staff, and visitors. Findings: a.A review of Resident 328's Admission Record indicated the facility admitted the resident on 6/5/2024 and readmitted the resident on 6/20/2024 with diagnoses that included end stage renal disease (the kidneys cease functioning on a permanent basis), anemia (condition in which the body does not get enough oxygen-rich blood) in chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), and acquired absence of kidney, A review of Resident 328's Minimum Data Set (MDS - an assessment and care screening tool) dated 6/26/2024, indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident required substantial/maximal assistance from staff for oral hygiene, toileting, bathing, and dressing. The MDS indicated the resident had an indwelling catheter. A review of Resident 328's physician orders indicated an order for an indwelling catheter size 16 French (measurement of the diameter of the catheter) with balloon (an inflatable plastic part of the catheter used to hold it in place) via gravity drainage (uses body position in relation to the catheter to remove urine from the bladder), dated 6/21/2024. During a concurrent observation and interview on 6/25/2024 at 11:40 a.m., Resident 328 standing in his room. Observe the resident's indwelling catheter drainage bag hanging from door facing side of the resident's bed with clear yellow urine visible from the hallway. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/25/2024 at 11:48 a.m. with Certified Nursing Assistant 4 (CNA 4), CNA 4 exited Resident 328's room and stated Resident 328 had a catheter and the urine in the drainage bag was visible from the hallway while the resident was standing at bedside. CNA 4 stated the catheter drainage bags usually have a dignity cover, but Resident 328's did not have one. CNA 4 stated dignity covers cover the urine in the drainage bag for the privacy of the resident. During an interview on 6/26/2024 at 1:41 p.m., with Minimum Data Set Coordinator 1 (MDSC 1), MDSC 1 stated Resident 328 was newly admitted with a catheter. MDSC 1 stated the facility provides privacy covers for catheter drainage bags and the resident should have been provided one at the time of admission. MDSC 1 stated the catheter cover is provided for dignity to give the resident privacy, so their urine is not visible by other residents or visitors. MDSC 1 stated when the resident's urine is visible it could possibly lead to feelings of embarrassment and affect the resident socially. During an interview and record review on 6/27/2024 at 11 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedure regarding catheters and resident rights. The DON stated the dignity cover is for the privacy of the resident and their urine output. The DON stated when urine is visible it could embarrass the resident. The DON stated other people would be able to see the resident's health status potentially leading to emotional distress in the resident. The DON stated the facility policies were not followed when Resident 328's catheter drainage bag was not covered for privacy. A review of the facility provided policy and procedure titled, Resident Rights, last reviewed 5/23/2024, indicated the purpose of the policy was to promote and protect the rights of residents at the facility. Employees are to treat all residents with dignity. State and federal laws guarantee certain basic rights to all residents of the facility. These rights include a resident's right to privacy. A review of the facility provided policy and procedure titled, Resident Rights, Quality of Life, last reviewed 5/23/2024, indicated each resident shall be cared for in a manner that promotes and enhances their quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being. Demeaning practices and standards of care that compromise dignity are prohibited. Facility staff promote dignity and assist residents as needed by helping the resident to keep urinary catheter bags covered. A review of the facility provided policy and procedure titled, Catheter - Care of, last reviewed 5/23/2024, indicated the resident's privacy and dignity will be protected by placing a cover over drainage bag when the resident is out of bed. 44376 b. A review of Resident 12's Admission Record indicated the facility admitted the resident on 1/24/2023, with diagnoses including benign prostatic hyperplasia (a benign [not cancer] condition in which the prostate gland is larger than normal) without lower urinary tract symptoms, retention of urine (a condition in which the body is unable to empty all the urine from the bladder), major depressive disorder (a constant feeling of sadness and loss of interest, which stops the individual from doing normal activities) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 12's History & Physical (H&P), dated 9/20/2023, indicated the resident can make needs known but cannot make medical decisions. A review of Resident 12's MDS, dated [DATE], indicated the resident had the ability to make self-understood and understand others. A review of Resident 12's Order Summary Report, dated 3/28/2024, indicated an order for: -3/28/2023 Indwelling foley catheter 16 French with 10 cubic centimeter (cc, a unit of volume) balloon via gravity drainage. -3/28/2024 Indwelling foley catheter is in privacy bag and catheter leg strap (a retaining strap which secures the leg bag tubing or catheter firmly) on at all times. Every Shift. During a concurrent observation and interview on 6/25/2024, at 2:10 p.m., with Licensed Vocational Nurse 2 (LVN 2), inside Resident 12's room, observed Resident 12's urinary catheter drainage bag hanging on the bed frame, without a dignity bag (privacy bag), and was visible from the hallway. LVN 2 stated the urinary catheter drainage bag should be covered with a dignity bag to honor the resident's right to a dignified existence. During an interview on 6/28/2024, at 4:35 p.m., with the DON, the DON stated the staff should have provided a dignity bag for Resident 1's urinary catheter drainage bag to promote privacy and avoid embarrassment to the resident. A review of the facility's recent policy and procedure titled, Catheter- Care of, last reviewed on 5/23/2024, indicated the resident's privacy and dignity will be protected by placing a cover over drainage bag when the resident is out of bed. A review of the facility's recent policy and procedure titled, Resident Rights- Quality of Life, last reviewed on 5/23/2024, indicated demeaning practices and standards of care that compromise dignity is prohibited. Facility Staff promote dignity and assist residents as needed by: A.Helping the resident to keep urinary catheter bags covered. A review of the facility's recent policy and procedure titled, Resident Rights, last reviewed on 5/23/2024, indicated residents of skilled nursing facilities have a number of rights under state and federal law. The Facility will promote and protect the rights. Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of resident's rights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) was within reach for four of nine residents (Resident 52, 8, 179, and 14) investigated during review of the environment task. This deficient practice had the potential to result in the delay of care and services and possible injury to residents when they are unable to ask assistance from facility staff. Findings: a. A review of Resident 52's Admission Record indicated the facility admitted the resident on 11/4/2023 with diagnoses that included end stage renal disease (the kidneys cease functioning on a permanent basis), cerebrovascular disease (damage to tissues in the brain due to a loss of oxygen to the area), aphasia (a language disorder that affects a person's ability to communicate), and muscle weakness. A review of Resident 52's Minimum Data Set (MDS - an assessment and care screening tool) dated 5/13/2024, indicated the resident usually was able to understand others and usually was able to make himself understood. The MDS further indicated the resident was dependent on staff for toileting, putting on and taking off footwear, and transferring from chair to bed. The MDS indicated the resident had impairments on one side of his upper and lower extremities. A review of Resident 52's Care Plan (CP) titled, Resident is at risk for falls related to muscle weakness, difficulty walking, anxiety (feeling of worry, nervousness, or restlessness [uneasiness]), depression (a constant feeling of sadness and loss of interest, which stops the individual from doing normal activities), use of opioid (a class of drugs used to treat pain), escitalopram (a medication to treat depression and anxiety), buspirone (a medication to treat anxiety), hypertension (high blood pressure) medications, initiated 11/29/2023, indicated the resident needs a safe environment. The CP included interventions that included anticipate and meet the resident's needs, and to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. During a concurrent observation and interview on 6/25/2024 at 11 a.m., Resident 52 was lying in bed, observed the resident's right arm was contracted (abnormal shortening of muscle tissue resulting in decreased mobility). Observed the call light clipped to Resident 52's bed sheet at the resident's right shoulder area. Resident 52 was asked if he could reach the call light and the resident stated no and pointed with his left hand to his right contracted arm. Observed Resident 52 reach his left arm across his body toward the call light and observe the call light was not within reach. During a concurrent observation and interview on 6/25/2024 at 11:05 a.m., with Certified Nursing Assistant 5 (CNA 5), CNA 5 entered Resident 52's room. CNA 5 stated the call light was placed on the right side of the resident. CNA 5 moved the call light to the left side of Resident 52's bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview on 6/25/2024 at 11:10 a.m., CNA 5 exited Resident 52's room and stated she never leaves the call light on the right side of the resident's bed because he cannot use the right arm. CNA 5 stated it was important to have Resident 52's call light on the left side of the bed because the resident does not communicate well, is fully dependent on staff, and he may need assistance for staff to help him. During an interview on 6/26/2024 at 2 p.m., the Minimum Data Set Coordinator 1 (MDSC 1), MDSC 1 stated the call light should be placed on the side of the extremity that the resident can use. MDSC 1 stated if a resident can only use the left arm, then the call light should be on the left. MDSC 1 stated when a resident is not able to get ahold of the call light to call for assistance it could result in a delay of care and possibly affect the resident causing frustration. During an interview and record review on 6/27/2024 at 11 a.m., with the Director of Nursing reviewed the facility policy call lights. The DON stated Resident 52 had a history of right sided hemiparesis (weakness on one side of the body) and the call light should be placed on the resident's left side so the resident can ask for assistance at any time. The DON stated the facility policy indicates to have the call light within reach. The DON stated the policy was not followed and could potentially result in the resident not being able to call for assistance during an emergency resulting in a delay of care. A review of the facility provided policy and procedure titled, Communication - Call System, last reviewed 5/23/2024, indicated the purpose of the policy was to provide a mechanism for residents to promptly communicate with nursing staff. The facility provides a call system to enable residents to alert the nursing staff from their rooms. Call cords will be placed within the residents reach in the resident's room. 43418 b. A review of Resident 8's Admission Record indicated the facility originally admitted Resident 8 on 12/20/2011 and readmitted the resident on 9/19/2018 with diagnoses including, but not limited to, difficulty walking, unsteadiness on feet, and cognitive communication deficit (trouble participating in conversations). A review of Resident 8's MDS, dated [DATE], indicated Resident 8 has severely impaired vision, has severe impaired cognition (difficulty understanding and making decisions), required supervision to moderate assistance with activities of daily living including eating, hygiene, mobility, toileting, and surface-to-surface transfers. A review of Resident 8's History and Physical (H&P), dated 1/23/2024, indicated Resident 8 does not have the capacity to understand and make decision. A review of Resident 8's Care Plan, revised 3/3/2024, indicated a focus on fall prevention and management with potential for further injury related to fall risk as evidenced by presence of fall risk factors including, but not limited to, visual impairment. The care plan further indicated interventions included to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview with Certified Nursing Assistant (CNA) 6, on 6/25/2024, at 8:51 a.m., inside Resident 8's room, Resident 8's call light was on the floor, next to the head of the bed, and unclipped to the bed sheets. CNA 6 confirmed Resident 8's call light was on the floor and unclipped to the bed and stated the resident likes to play with his call light and it ends up on the floor. CNA 6 stated if the call light is not within reach, the resident would not be able to call for help. c. A review of Resident 179's Admission Record indicated the facility admitted Resident 179 on 6/20/2024 with diagnoses including, but not limited to, unsteadiness on feet and generalized muscle weakness. A review of Resident 179's H&P, dated 6/21/2024, indicated Resident 179 has the capacity to understand and make decisions. A review of Resident 179's Physical Therapy (PT) Evaluation & Plan of Treatment, dated 6/21/2024, indicated Resident 179 required supervision or touching assistance with bed mobility, such as rolling left and right, sit to lying, lying to sitting on the side of the bed. A review of Resident 179's Care Plan, dated 6/20/2024, indicated an accommodation of needs plan related to Resident 179's preference to lay her head down at the foot of the bed with interventions including, but not limited to, incorporate preferences to daily care and schedule of resident while in the facility and provide assistance with daily care to meet accommodation request and needs. During a concurrent observation and interview with Resident 179, on 6/26/2024, at 1:26 p.m., inside Resident 179's room, Resident 179 was lying down in bed with her head at the foot of the bed, next to the doorway. Resident 179's call light was located at Resident 179's head of bed next to her feet. Resident 179 stated she wants to sit up to eat her meal and she needs help to sit up. Resident 179 stated she cannot call for help because she does not know where her call light is. During a concurrent observation and interview with CNA 7, on 6/26/2024, at 1:31 p.m., inside Resident 179's room, CNA 7 assisted Resident 179 to sit at the edge of her bed and placed the resident's call light from the head of the bed to the right of the resident. CNA 7 stated prior to assisting Resident 179, the resident's call light was at the resident's head of the bed, next to her feet, and was not within the resident's reach. CNA 7 stated it is important for the resident's call light to be within reach so that they can call for help. CNA 7 further stated if the call light is not within reach, the resident would not be able to call for help. During an interview with the DON, on 6/28/2024, at 4:36 p.m., the DON stated call lights should be within reach of the resident and should be able to call for help or assistance, especially in case of an emergency. The DON further stated if residents are not able to call for assistance, their needs would not be met. A review of the facility's policy and procedure (P&P) titled, Communication - Call System, last reviewed 5/23/2024, indicated call cords will be placed within the resident's reach in the resident's room. 43988 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. A review of Resident 14's Admission Record indicated the facility admitted the resident on 1/26/2023 and readmitted the resident on 3/24/2023 with diagnoses including generalized muscle weakness, lack of coordination, and vascular dementia (refers to changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain). A review of Resident 14's History and Physical (H&P) dated 12/28/2023, indicated the resident can make her needs known but cannot make medical decisions. A review of Resident 14's MDS dated [DATE], indicated the resident was able to understand and make her needs known and had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 14 required supervision with eating; dependent on staff with toileting, bathing, and lower body dressing, and substantial/maximal assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). A review of Resident 14's Fall Risk Assessment forms dated 6/7/2024 and 6/20/2024 indicated the resident was a high risk for falls. A review of Resident 14's care plan on potential for injury related to fall risk factors such a poor safety judgement, pain medications, cognitive deficit, and impulsive behavior initiated 3/21/2023 last revised on 12/26/2023, indicated a goal to minimize risk for and provide safe environment. The care plan indicated the following interventions: -Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. -Low bed with floor mat for safety due to poor safety awareness, During an observation and interview on 6/25/2024 at 9:45 a.m., with Certified Nursing Assistant 2 (CNA 2), observed Resident 14 asleep in bed with the call light hanging on the right side of the bed rails. The call light touching the floor and not within the resident's reach. Certified Nursing Assistant 2 (CNA 2) stated the call light was on the floor and not within Resident 14's reach. CNA 2 stated the call light should be within reach of the resident so the resident will be able to call for assistance if needed. During an interview on 6/28/2024 at 4:45 p.m., with the DON, the DON stated the call light should have been within Resident 14's reach so the resident will be able to ask for assistance. The DON stated not being to call for assistance had the potential for the resident needs not be met and compromise their health resulting from accidents or injuries. A review of the facility's policy and procedure titled, Communication - Call System, last reviewed 5/23/2024, indicated the facility provides a mechanism for residents to promptly communicate with staff. The policy indicated call cords will be placed within resident's reach in the resident's room and nursing staff will answer call bells promptly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43418 Based on observation, interview, and record review the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior for two of nine sampled residents reviewed under the Environment care area (Resident 8 and 109) when the facility failed to: 1. Maintain the cleanliness of Resident 8's floor. 2. Ensure the bathroom faucet fixture did not develop calcium deposits and rust for Resident 109. These deficient practices had the potential to spread infection and negatively affects the resident's psychosocial wellbeing and violated the resident's rights to a safe, clean, sanitary, and homelike environment. Findings: 1. A review of Resident 8's Admission Record indicated the facility originally admitted Resident 8 on 12/20/2011 and readmitted [DATE] with diagnoses including, but not limited to, difficulty walking, unsteadiness on feet, and cognitive communication deficit (trouble participating in conversations). A review of Resident 8's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/17/2024, indicated Resident 8 has severely impaired vision, has severe impaired cognition (difficulty understanding and making decisions), required supervision to moderate assistance with activities of daily living including eating, hygiene, mobility, toileting, and surface-to-surface transfers. A review of Resident 8's History and Physical (H&P), dated 1/23/2024, indicated Resident 8 does not have the capacity to understand and make decision. During a concurrent observation and interview with Certified Nursing Assistant (CNA) 6, on 6/25/2024, at 8:51 a.m., inside Resident 8's room, CNA 6 stated the floor between Resident 8's and his roommate's bed had brown stains. The floor felt sticky after walking around the area where the stain was. CNA 6 stated the housekeeper might have already visited the room earlier because the residents' trash bins were emptied. The trash bin next to Resident 8's bed appeared empty. CNA 6 stated it is important to keep resident rooms clean for infection control and to maintain a homelike environment. CNA 6 further stated a dirty floor can be a source of infection and potentially cause residents to feel disrespected. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with Housekeeper (HK) 1, on 6/26/2024, at 3:17 p.m., inside Resident 8's room, HK 1 confirmed Resident 8's floor was sticky. HK 1 stated her routine when she comes onto her shift includes mopping the floor in the morning and in the afternoon. HK 1 stated she is not typically assigned to Resident 8's room and is covering the other HK because she left for the day. HK 1 stated she does not know if Resident 8's assigned HK cleaned the resident's room enough. HK 1 stated if there is something difficult to clean or remove, she would use a different cleaning solution to clean. HK 1 further stated it is important to clean the rooms properly for the residents' health, to prevent bacteria growth, provide a homelike environment so that the residents feel happy, and to provide a safe environment to prevent falls. During an interview with the Director of Nursing (DON), on 6/28/2024, at 4:36 p.m., the DON stated it is important to maintain the cleanliness of resident's rooms for infection control. A review the facility's policy and procedure (P&P) titled, Cleaning & Disinfection of Environmental Surfaces, last reviewed 5/23/2024, indicated housekeeping surfaces (e.g., floors, tabletops) are cleaned on a regular basis, when spills occur, and when the surfaces are visibly soiled. A review of the facility's P&P titled, Resident Rooms and Environment, last reviewed 5/23/2024, indicated facility staff aim to create a personalized, homelike atmosphere, paying close attention to cleanliness and order. 44376 2. A review of Resident 109's Admission Record indicated the facility admitted the resident on 4/13/2024, with diagnoses including dysphagia (difficulty swallowing), gastro-esophageal reflux disease (GERD, a common condition in which the stomach contents move up into the esophagus), and anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). A review of Resident 109's H&P, dated 4/15/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 109's MDS, dated [DATE], indicated the resident had the ability to make self-understood and understand others. During a concurrent observation and interview on 6/25/2024, at 11:20 a.m., with Family Member 1 (FM 1), inside Resident 109's room, observed the bathroom faucet fixture with white deposits on the handles and grayish, greenish discoloration around the fixture. FM 1 stated the faucet fixture is unhygienic (unsanitary) for Resident 109. During a concurrent observation and interview on 6/26/2024, at 12:46 p.m., with the Maintenance Director (MD), inside Resident 109's room, observed the bathroom faucet fixture and the MD stated the faucet had rust and calcium buildup. The MD stated the bathroom fixtures should be free from rust and calcium buildup to prevent the resident from ingesting them when they brush their teeth. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/28/2024, at 4:35 p.m., with the Director of Nursing (DON), the DON stated Resident 109's faucet had a mildew residue and should have been reported to the Maintenance Department so the faucet can be replaced. The DON stated a faucet with mildew residue can be a source of infection to residents. A review of the facility's recent policy and procedure titled, Maintenance Service, last reviewed on 5/23/2024, indicated the Maintenance Department maintains all areas of the building, grounds, and equipment. The Director of Maintenance is responsible for developing and maintaining schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 44376 Based on observation, interview, and record review the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) to two of two sampled residents (Residents 118 and 378) investigated during review of physical restraints care area by failing to ensure Resident 118 and Resident 378 were properly assessed for risk for entrapment on the use of bed rails and placement of bed against the wall, ensure Residents 118 and 378 or their representative were educated with the risks and benefits of bed rails and placement of bed against the wall, ensure an informed consent was obtained from Residents 118 and 378 or their representative, ensure there was a physician order for Resident 118 and 378's use of bed rails and placement of bed against the wall, and ensure an informed consent was obtained from Residents 118 and 378 or their representative prior to installation of bed rails and placement of bed against the wall. These deficient practices had the potential to result in the restriction of residents' freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment, and death of residents. Cross reference to F700. Findings: 1. A review of Resident 118's Admission Record indicated the facility admitted the resident on 5/14/2024, with diagnoses including surgical amputation (the loss or removal of a body part) of the right foot 5th digit, muscle weakness, and unsteadiness of the feet. A review of Resident 118's History and Physical (H&P), dated 5/18/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 118's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/21/2024, indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident required supervision on mobility and activities of daily living (ADLs, tasks of everyday life). A review of Resident 118's Bed Rail Assessment, dated 5/14/2024, indicated the following: -Side Rails/Assist Bar are indicated and serve as an enabler to promote independence. -Side Rails/Assist Bar are not indicated at this time. A review of Resident 118's Fall Risk Evaluation, dated 5/14/2024, indicated the resident was high risk for potential falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 118's Care Plan titled, The resident is at risk for falls related to right ankle/foot osteomyelitis (an inflammation or swelling of bone tissue that is usually the result of an infection), status post (s/p) surgical amputation right 5th digit, impaired mobility, unsteadiness on feet, last revised on 6/19/2024, indicated interventions including the resident needs a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, handrails on walls, personal items within reach. During a concurrent observation, interview, and record review on 6/25/2024, at 2:31 p.m., with Registered Nurse 2 (RN 2) and the Assistant Director of Nursing (ADON), inside Resident 118's room, observed Resident 118's both upper bed rails up, and the bed was placed against the wall. Resident 118's Order Summary Report, Bed Rail Assessment, and consents were reviewed with RN 2. RN 2 stated there was no physician order for bed rail use and placement of bed against the wall and the assessment for bed rail use indicated contradictory recommendations (side rail use was indicated, and side rail use was not indicated). RN 2 stated there was no safety assessment conducted for placement of bed against the wall, no informed consent and documentation the resident and their representative were educated on the risk and benefits of bed rail use and placement of bed against the wall and prior to use. During an interview on 6/26/2024, at 1:09 p.m., with Registered Nurse 1 (RN 1), RN 1 stated prior to installing bed rails and placing the bed against the wall there should be a physician order, a risk for entrapment assessment, an informed consent from the resident or representative and documentation the resident or representative were educated on the risk and benefits of bed rail use and placement of bed against the wall to prevent injuries to the resident. During an interview on 6/28/2024, at 4:35 p.m., with the Director of Nursing (DON), the DON stated before applying restraints to residents such as bed rails and placement of bed against the wall there should be a risk for entrapment assessment, a physician order and an informed consent from the resident or their representative to ensure resident safety. A review of the facility's recent policy and procedure titled, Restraints, last reviewed on 5/23/2024, indicated to ensure that all restraints are used properly and only, when necessary, on residents at the facility. The facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. Restraints require a physician order and are used as a last resort measure to be used only when deemed necessary by the interdisciplinary Team (IDT) and in accordance with the resident's assessment and Plan of Care. Before any type of restraint is used, the License Nurse will verify that informed consent was obtained from the resident and has been documented in the resident's medical record. Physical restraint means the use of a manual hold to restrict freedom of movement of all or part of a resident's body, or to restrict normal access to the person's body, and that is used as a behavioral restraint. All use of restraints must conform to the manufacturer's instructions. Before applying the restraint, a Licensed Nurse will explain the risks and benefits of restraints, alternatives to restraints, how the restraint will treat the resident's medical condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility provided Owner's Manual titled, Bed Frame 1 (BF 1), last revised on 4/1/2018, indicated mattress must fit bed frame and assist rail snugly to help prevent patient entrapment. Patient entrapment with assist rail may cause injury or death. Please follow the manufacturer's instructions and monitor patient frequently. Assist rails/bars are intended only to assist the resident during bed entry and exit. These devices are not side rails, nor are they intended to be used in a manner that makes user entry and exit more difficult. Accurate assessment of the resident and monitoring of correct maintenance and equipment use are required to prevent entrapment. On March 10, 2006, the U.S. Food and Drug Administration (FDA) released guidelines for reducing the risk of hospital bed entrapment entitled; Hospital bed System Dimensional and Assessment Guidance to reduce Entrapment. This guidance document identifies potential entrapment areas within the bed frame, rails and mattress and identifies those body parts most at risk for entrapment. Potential risks of bed rails may include: -Strangling, suffocating, body injury or death when patients or part of their body are caught between rails or between the bed rails and mattress. -More serious injuries from falls when patients climb over rails. -Skin bruising, cuts, and scrapes. -Inducing agitated behavior when bed rails are used as a restraint. -Feeling isolated or unnecessarily restricted. -Preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet. 2. A review of Resident 378's Admission Record indicated the facility admitted the resident on 6/18/2024, with diagnoses including hepatic encephalopathy (a decline in brain function that occurs as a result of severe liver disease), seizures, and muscle weakness. A review of Resident 378's H&P, dated 6/21/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 378's Fall Risk Evaluation, dated 6/18/2024, indicated the resident was high risk for potential falls. During a concurrent observation, interview, and record review on 6/25/2024, at 2:31 p.m., with Registered Nurse 2 (RN 2) and the Assistant Director of Nursing (ADON), inside Resident 378's room, observed Resident 378's both upper bed rails up, and the bed was placed against the wall. Resident 378's Order Summary Report, Bed Rail Assessment, and consents were reviewed with RN 2. RN 2 stated there was no physician order for bed rail use and placement of bed against the wall. RN 2 stated there was no safety assessment conducted for bed rail use and placement of bed against the wall, no informed consent and documentation the resident and their representative were educated on the risk and benefits of bed rail use and placement of bed against the wall and prior to use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/28/2024, at 4:35 p.m., with the Director of Nursing (DON), the DON stated before applying restraints to residents such as bed rails and placement of bed against the wall there should be a risk for entrapment assessment, a physician order and an informed consent from the resident or their representative to ensure resident safety. A review of the facility's recent policy and procedure titled, Restraints, last reviewed on 5/23/2024, indicated to ensure that all restraints are used properly and only, when necessary, on residents at the facility. The facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. Restraints require a physician order and are used as a last resort measure to be used only when deemed necessary by the interdisciplinary Team (IDT) and in accordance with the resident's assessment and Plan of Care. Before any type of restraint is used, the License Nurse will verify that informed consent was obtained from the resident and has been documented in the resident's medical record. Physical restraint means the use of a manual hold to restrict freedom of movement of all or part of a resident's body, or to restrict normal access to the person's body, and that is used as a behavioral restraint. All use of restraints must conform to the manufacturer's instructions. Before applying the restraint, a Licensed Nurse will explain the risks and benefits of restraints, alternatives to restraints, how the restraint will treat the resident's medical condition. A review of the facility provided Owner's Manual titled, BF 1, last revised on 4/1/2018, indicated mattress must fit bed frame and assist rail snugly to help prevent patient entrapment. Patient entrapment with assist rail may cause injury or death. Please follow the manufacturer's instructions and monitor patient frequently. Assist rails/bars are intended only to assist the resident during bed entry and exit. These devices are not side rails, nor are they intended to be used in a manner that makes user entry and exit more difficult. Accurate assessment of the resident and monitoring of correct maintenance and equipment use are required to prevent entrapment. On March 10, 2006, the U.S. Food and Drug Administration (FDA) released guidelines for reducing the risk of hospital bed entrapment entitled; Hospital bed System Dimensional and Assessment Guidance to reduce Entrapment. This guidance document identifies potential entrapment areas within the bed frame, rails and mattress and identifies those body parts most at risk for entrapment. Potential risks of bed rails may include: -Strangling, suffocating, body injury or death when patients or part of their body are caught between rails or between the bed rails and mattress. -More serious injuries from falls when patients climb over rails. -Skin bruising, cuts, and scrapes. -Inducing agitated behavior when bed rails are used as a restraint. -Feeling isolated or unnecessarily restricted. -Preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43418 Based on interview and record review, the facility failed to ensure a resident's transfer was documented in the resident's medical record for one of three sampled residents reviewed under the hospitalization care area (Resident 64) when the reason for transfer was not indicated in Resident 64's Notice of Proposed Transfer/Discharge, dated 6/12/2024. This deficient practice had the potential for the resident and their representative and the ombudsman (a resident advocate) to not know the reason for the transfer and to not determine if the reason for transfer was appropriate. Findings: A review of Resident 64's Admission Record indicated the facility originally admitted Resident 64 on 11/5/2022 and was readmitted on [DATE] with diagnoses including, but not limited to, metabolic encephalopathy (a problem in the brain caused by chemical imbalances in the blood). The admission record further indicated Resident 64 was discharged to the general acute care hospital (GACH) on 6/19/2024. A review of Resident 64's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/20/2024, indicated Resident 64 had moderate cognitive impairment (difficulty understanding and making decisions), required supervision with eating, and required moderate assistance or was totally dependent on facility staff for activities of daily living, including hygiene, mobility, toileting, and surface-to-surface transfers. A review of Resident 64's Order Summary Report, dated 6/12/2024, indicated to transfer Resident 64 to the GACH for further evaluation and bed hold for seven days, A review of Resident 64's Alert Note, dated 6/12/2024, indicated Resident 64 and the resident's family member would like to transfer to the GACH due to the resident's fever. The alert note indicated the physician was made aware and the facility obtained an order to transfer to GACH for further evaluation. A review of Resident 64's Notice of Proposed Transfer and Discharge, dated 6/12/2024, indicated Resident 64 was discharged to the GACH on 6/12/2024. The notice did not indicate the reason for the discharge. During a concurrent interview and record review with the Assistant Director of Nursing (ADON), on 6/26/2024, at 4:31 p.m., Resident 64's Notice of Proposed Transfer Discharge, dated 6/12/2024, was reviewed and the ADON confirmed the notice did not indicate a reason for transfer or discharge. The ADON further stated it is important to indicate a reason for transfer or discharge so that the resident, resident representative, and the ombudsman area aware of the reason for transfer or discharge. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON), on 6/28/2024, at 4:36 p.m., the DON stated it is important to indicate a reason for transfer or discharge on the notice of proposed transfer and discharge form so that the facility will know the reason, check for trends, see if interventions are effective, and see if it is a proper transfer. The DON stated the notice is sent to the resident, the resident representative, and the ombudsman. The DON further stated if the notice does not indicate the reason for transfer or discharge, the ombudsman would not know if the transfer or discharge was appropriate. A review of the facility's policy and procedure (P&P) titled, Notice of Transfer/Discharge, last reviewed 5/23/2024, indicated before the transfer or discharge occurs, the facility must notify the resident, and if known, the responsible party, and ombudsman of the transfer and the reason for transfer, and document in the resident's clinical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43418 Based on interview and record review, the facility failed to ensure residents were made aware of the facility's bed-hold policy upon transfer to a general acute care hospital (GACH) for one of three sampled residents reviewed under the hospitalization care area (Resident 42) when the facility failed to complete and provide the seven (7) day bed hold agreement to Resident 42. This deficient practice had the potential for the resident and/or the resident's resident representatives to not know if the resident have a room to return to after going to the GACH. Findings: A review of Resident 42's Admission Record indicated the facility originally admitted Resident 42 on 7/26/2023 and readmitted to the facility on [DATE] with diagnoses including, but not limited to, hypertension (high blood pressure) and difficulty walking. A review of Resident 42's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/22/2024, indicated Resident 42 had severe cognitive impairment (difficulty understanding and making decisions) and had reentered the facility from the general acute care hospital (GACH) on 5/15/2024. The MDS further indicated Resident 42 required supervision or was dependent on facility staff for activities of daily living, including eating, hygiene, mobility, toileting, and surface-to-surface transfers. A review of Resident 42's Progress Note, dated 5/20/2024, indicated Resident 42 does not have the capacity to understand and make decisions. A review of Resident 42's Order Summary Report, dated 5/11/2024, indicated Resident 42 may transfer out to the general acute care hospital for further evaluation related to fall and postural hypotension (when blood pressure drops when changing position from lying down to sitting up, or from sitting to standing). A review of Resident 42's Notice of Proposed Transfer and Discharge, dated 5/11/2024, indicated Resident 42 was transferred to the GACH on 5/11/2024 because the discharge was necessary for the resident's welfare and the needs could not be met in the facility. A review of Resident 42's Bed Hold Agreement, dated 11/19/2023, indicated Resident 42 was informed of the right to request that the facility hold the bed for seven days should the resident be transferred to the GACH or go on therapeutic leave. The bed hold agreement further indicated the section of the form titled, Notification of Bed Hold option upon transfer/therapeutic leave was not completed. A review of Resident 42's Bed Hold Agreement, dated 5/16/2024, indicated Resident 42's representative provided phone consent and was informed of the right to request that the facility hold the bed for seven days should the resident be transferred to the GACH or go on therapeutic leave. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the Assistant Director of Nursing (ADON), on 6/27/2024, at 1:54 p.m., Resident 42's Bed Hold Agreement, dated 11/8/2023, was reviewed and the ADON confirmed the section of the form titled, Notification of Bed Hold option upon transfer/therapeutic leave was not completed on 5/11/2024. The ADON stated Resident 42 was hospitalized on [DATE]. The ADON further stated the Bed Hold Agreement form should have been filled out and if the resident or resident representative were not made aware of the bed hold, the resident would potentially not know if they had a place to return to after their stay in the GACH and the resident can potentially feel sad if they did not know if they had a place to return to. During an interview with the Director of Nursing (DON), on 6/28/2024, at 4:36 p.m., the DON stated it is important to notify the resident or resident representative of the bed hold agreement upon transfer to the GACH so that the resident does not have to worry about having a place to return to. The DON further stated some residents worry that they do not have a place to return to when they go to the GACH. A review of the facility's policy and procedure (P&P) titled, Bed Hold, last reviewed 5/23/2024, indicated upon admission, the facility informs the resident and or representative in writing of the facility's bed hold policy and how to exercise the right to a bed hold and the facility notifies the resident and or representative, in writing, of the bed hold option, any time the resident is transferred to an acute care hospital or requests therapeutic leave.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview, and record review, the facility failed to ensure the assessment reflected the current resident's status to two out of three randomly selected closed records (Resident 123 and 72) by: 1. Failing to accurately code the Minimum Data Set (MDS, a standardized assessment and care screening tool) of a planned resident discharge. This deficient practice had the potential to result in an accurate assessment and had the potential for the facility to not provide the appropriate services for the resident's discharge. 2. Failing to ensure Resident 72's MDS was coded as Resident 72 was receiving an antiplatelet (a type of medication that prevent blood clots from forming which can cause heart attacks and strokes) instead of an anticoagulant (a type of medication that thins the blood to prevent or reduce clotting of blood). This deficient practice had the potential to result in an accurate assessment and had the potential for the facility to provide the wrong interventions related to the resident's anticoagulant use. Findings: 1. A review of Resident 123's Admission Record indicated the facility admitted the resident on 1/19/2024, with diagnoses including atherosclerotic heart disease (thickening or hardening of the arteries) and cognitive communication deficit (difficulty with any aspect of communication). A review of Resident 123's History and Physical (H&P), dated 1/28/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 123's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/29/2024, indicated the facility discharged the resident on 3/29/2024 to home/community and coded the type of discharge as unplanned. A review of Resident 123's Order Summary Report, dated 3/28/2024, indicated the following orders: - May discharge on 3/29/2024, to Independent Living 1 (IL 1) with (w/) home health (HH, a wide range of health care services that can be given in the home), physical therapy (PT)/occupational therapy (OT)/registered nurse (RN), durable medical equipment (DME, equipment and supplies ordered by a healthcare provider for everyday or extended use)-front wheel walker (FWW, a mobility aid that helps provide stability and balance while walking). A review of Resident 123's Notice of Proposed Transfer and Discharge, dated 3/29/2024, indicated the resident was discharged to IL. The discharge reason indicated the discharge was appropriate because the resident's health has improved sufficiently so that the resident no longer required services provided by the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During a concurrent interview and record review on 6/27/2024, at 10:55 a.m., with the Minimum Data Set Coordinator 1 (MDSC 1), reviewed Resident 123's MDS dated [DATE]. The MDSC 1 stated Resident 123's discharge was planned and should have been coded as planned. The MDS stated it was important to code the resident's assessment accurately for recording and tracking purposes, and to ensure the resident will be provided with the necessary care and services. During an interview on 6/28/2024, at 4:35 p.m., with the Director of Nursing (DON), the DON stated MDSC 1 should have coded Resident 123's MDS accurately to ensure safe a discharge. A review of the facility's recent policy and procedure titled, RAI Process- MDS Assessments, Processing and Documentation, last reviewed on 5/23/2024, indicated to provide resident assessments that accurately depict and identify resident-specific issues and objectives as required, while meeting state and federal data submission requirements. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident's functional capacity and health status (As outlines in the CMS RAI MDS 3.0 Manual). 43988 2. A review of Resident 72's Admission Record indicated the facility admitted the resident on 2/9/2023 with diagnoses including right leg below knee amputation (refers to the loss or removal of a body part such as a finger, toe, hand, foot, arm or leg), peripheral vascular disease (PVD - a condition that refers to a reduced circulation of blood to a body part, other than the brain or heart, due to a narrowed or blocked blood vessel), and lack of coordination. A review of Resident 72's History and Physical, dated 3/3/2023, indicated the resident had the capacity to understand and make decisions. A review of Resident 72's MDS assessment dated [DATE] indicated the resident received an anticoagulant and not antiplatelet. A review of Resident 72's Order Summary Report indicated an order for Plavix (an antiplatelet drug that keeps platelets [in the blood from coming together and making clots) oral tablet 75 milligrams (mg - a unit of measurement) one tablet daily for diagnosis of PVD. During a concurrent interview and record review on 6/27/2024 at 11:01 a.m. with MDSC 1, reviewed Resident 72's Order Summary Report for 6/2024 and MDS quarterly assessment dated [DATE]. MDSC stated Resident 72 had a physician's order for Plavix dated 2/9/2023. The MDSC stated Resident 72's MDS quarterly assessment dated [DATE] indicated the resident's MDS was coded as receiving anticoagulant instead of antiplatelet. MDSC 1 stated the assessment should have been coded Resident 72 received antiplatelet and not an anticoagulant. The MDSC stated she should have coded the MDS assessment accurately for tracking purposes and continuity of care and to prevent delay in providing the necessary care and services needed by the resident. During an interview on 6/28/2024 at 4:40 p.m., the DON stated she signs the MDS assessments for accuracy. The DON Resident 72's MDS assessment should have been coded accurately to ensure the resident needs are met. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	A review of the facility's policy and procedure titled, RAI Process - MDS Assessments, Processing, Documentation, last reviewed 5/23/2024, indicated the following: -Provide resident assessments that accurately depict and identify resident-specific issues and objectives as required. -The facility will utilize the Resident Assessment Instrument (RAI) process as the basis for the accurate assessment of each resident's functional capacity and health status. -The RAI process includes but not limited to an accurate reflection of the resident's status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan (a document outlining a detailed approach to care customized to an individual resident's need) for: 1. Two out of two sampled residents (Residents 118 and 378) investigated during review of physical restraints (devices that limits a patient's movement) use (bed rails (metal rails that normally hang on the side of the patient's bed) use and placement of bed against the wall). 2. One (1) out of 1 sampled resident (Resident 79) who received vancomycin hydrochloride (a type of medication used in the treatment of serious bacterial infections), investigated during review of infection control task on the use of These deficient practices had the potential to result in failure in the delivery of necessary care and services. 3. One of three residents reviewed for unnecessary medications (Resident 67) that included: -measurable goals for monitoring delusions (false beliefs or judgments about external reality,) and Risperdal (an antipsychotic [a medication used to treat mental illness such as schizophrenia which is characterized by disordered thinking, behaviors, and emotions that impairs daily functioning,]) -non-pharmacological (that do not involve medications or drugs) interventions (therapies) for delusions. As a result, Residents 67 did not have identified goals, outcomes, and alternative therapies to medications, for the delusions, and did not have monitoring for the effectiveness and side effects (also known as adverse effects - unwanted, uncomfortable, or dangerous effects that a drug may have) of Risperdal, from 3/27/2024 to 5/6/2024. This deficient practice had the potential to cause Resident 67 to receive suboptimal (less than the highest standard or quality) care, for the facility to not know how to manage and care for delusions, or how effective Risperdal was for delusions, leading to the use of unnecessary medications causing potential side effects such as akathisia (inability to hold still), tardive dyskinesia (uncontrolled face muscle movements), tremors, dizziness, sedation and an overall negative impact on their physical, mental, and psychosocial well-being. Cross reference with F758. Findings: 1.a A review of Resident 118's Admission Record indicated the facility admitted the resident on 5/14/2024, with diagnoses of surgical amputation (the loss or removal of a body part) of the right foot 5th digit, muscle weakness, and unsteadiness of the feet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 118's History and Physical (H&P), dated 5/18/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 118's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/21/2024, indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident required supervision on mobility and activities of daily living (ADLs). A review of Resident 118's Bed Rail Assessment, dated 5/14/2024, indicated the following: -Side Rails/Assist Bar are indicated and serve as an enabler to promote independence. -Side Rails/Assist Bar are not indicated at this time. A review of Resident 118's Fall Risk Evaluation, dated 5/14/2024, indicated the resident was high risk for potential falls. During a concurrent observation, interview, and record review on 6/25/2024, at 2:31 p.m., with Registered Nurse 2 (RN 2) and the Assistant Director of Nursing (ADON), inside Resident 118's room, observed Resident 118's both upper bed rails up, and the bed was placed against the wall. Resident 118's care plans were reviewed with RN 2. RN 2 stated there was no care plan addressing restraints, bed rails and placement of bed against the wall. RN 2 stated the care plan serves as a communication tool to all care givers to standardize care. During an interview on 6/26/2024, at 1:09 p.m., with Registered Nurse 1 (RN 1), RN 1 a care plan should be developed on bed rail use and placement of bed against the wall to reflect the goals of the care plan and to ensure the interventions are implemented. During an interview on 6/28/2024, at 4:35 p.m., with the Director of Nursing (DON), the DON stated a person-centered care plan should be developed and implemented for resident using restraints to ensure resident safety and to provide quality care to residents. A review of the facility's recent policy and procedure titled, Comprehensive Person-Centered Care Planning, last reviewed on 5/23/2024, indicated within 7 days from the completion of the comprehensive MDS assessment, the comprehensive care plan will be developed. All goals, objectives, interventions, etc. from the current baseline care plan will be included in the resident's comprehensive care plan. 1.b A review of Resident 378's Admission Record indicated the facility admitted the resident on 6/18/2024, with diagnoses including hepatic encephalopathy (a decline in brain function that occurs as a result of severe liver disease), seizures, and muscle weakness. A review of Resident 378's H&P, dated 6/21/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 378's Fall Risk Evaluation, dated 6/18/2024, indicated the resident was high risk for potential falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation, interview, and record review on 6/25/2024, at 2:31 p.m., with Registered Nurse 2 (RN 2) and the Assistant Director of Nursing (ADON), inside Resident 378's room, observed Resident 378's both upper bed rails up, and the bed was placed against the wall. Resident 378's care plans were reviewed with RN 2. RN 2 stated there was no care plan addressing restraints, bed rails and placement of bed against the wall. RN 2 stated the care plan serves as a communication tool to all care givers to standardize care. During an interview on 6/28/2024, at 4:35 p.m., with the Director of Nursing (DON), the DON stated a person-centered care plan should be developed and implemented for resident using restraints to ensure resident safety and to provide quality care to residents. A review of the facility's recent policy and procedure titled, Comprehensive Person-Centered Care Planning, last reviewed on 5/23/2024, indicated within 7 days from the completion of the comprehensive MDS assessment, the comprehensive care plan will be developed. All goals, objectives, interventions, etc. from the current baseline care plan will be included in the resident's comprehensive care plan. 43988 2. A review of Resident 79's Admission Record indicated the facility admitted the resident on 10/23/2023 with diagnoses including pressure ulcer (PU) stage four (a sore that extend below the subcutaneous fat into the deep tissues, including muscle, tendons, and ligaments) of the sacral region (refers to bottom of the spine), and congestive heart failure (a condition in which the heart has trouble pumping blood through the body). A review of Resident 79's History and Physical, dated 4/22/2024, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 79's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 5/1/2024, indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and required partial/moderate assistance from staff with most activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated the resident had stage four (4) PU. A review of Resident 79's Wound Assessment form by Wound Care Specialist (WCS) dated 6/24/2024 indicated the resident's right foot has increased edema (the medical term for swelling) and pain with recommendation for IV antibiotic per primary care physician (PCP). A review of Resident 79's Order Summary Report indicated the following physician orders: -6/24/2024 vancomycin hydrochloride (a type of medication used in the treatment of serious bacterial infections) for two (2) weeks. Pharmacy to dose. -6/27/2024 vancomycin hydrochloride IV solution use 1 gram (gm - a unit of measurement) intravenously one time a day for right foot cellulitis until 7/10/2024 for 2 weeks. Pharmacy to dose. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/26/2024 at 3:00 p.m., with MDS Coordinator 1 (MDSC 1), Resident 79's care plan, wound assessment form, and physician's orders were reviewed. MDSC 1 stated there was no care plan developed for the use of vancomycin hydrochloride. MDSC 1 stated it is important to create a care plan to ensure staff are aware of the resident's plan of care and to prevent delay in meeting the resident's needs. During an interview on 6/28/2024 at 4:42 p.m., with the Director of Nursing (DON), the DON stated the care plan should have been developed the same time the order for the antibiotic was received. The DON stated it is important to create individualized care plan to meet the resident's needs. A review of the facility's policy and procedure titled, Comprehensive Person-Centered Care Plan, last reviewed 5/23/2024, indicated the following: -Comprehensive care plan will be developed within seven days from the completion of the comprehensive MDS assessment. The policy indicated all goals, objectives, interventions, etc. from the current baseline care plan will be included in the resident's comprehensive care plan. -Additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident. -Comprehensive care plan will be reviewed and revised at the following times: * Onset of new problems. * Change of condition * In preparation for discharge * To address changes in behavior and care; and * Other times as appropriate or necessary. 43455 3. During a review of Resident 67's Admission Record (a document containing demographic and diagnostic information,) dated 06/26/2024, the Admission Record indicated Resident 67 was originally admitted to the facility on [DATE] with diagnosis including dementia (loss of memory and other mental abilities severe enough to interfere with daily life.) During a review of Resident 67's Minimum Data Set (MDS - a comprehensive resident assessment tool), dated 02/1/2024, indicated resident was moderately impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 67 had no mood and no behavioral symptoms, including no delusions. The MDS indicated Resident 67 received antipsychotics on a routine basis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 67's Medication Administration Record ([MAR] - a record of mediations administered to residents) for March through May 2024, the MAR indicated Resident 67 was prescribed Risperdal 0.5 milligram ([mg] - a unit of measure of mass) to give one tablet by mouth twice a day for delusions, from 03/27/2024 to 05/06/2024. The MAR contained no documentation for monitoring the occurrence of delusions, adverse effects of Risperdal, or use of alternative therapies to Risperdal. During an interview on 06/26/2024 at 2:32 PM, with Licensed Vocational Nurse (2), LVN 2 stated that Resident 67's clinical record does not include monitoring for the specific occurrences of delusions by tally marks on the MAR, does not include monitoring for the side effects of Risperdal, and does not include alternate therapies to the use of Risperdal. LVN 2 stated without monitoring specific occurrences of delusions it will be unknown if Risperdal was effective in reducing the target behavior for Resident 67, without adequate side effect monitoring of Risperdal it may harm Resident 67 by causing dizziness and sedation, and without alternate therapies Risperdal maybe used unnecessarily further causing harm by negatively affecting the physical and psychosocial well-being of Resident 67. During an interview on 06/28/2024 at 10:37 AM, with the Director of Nursing (DON,) the DON stated that after a thorough search of Resident 67's clinical record the DON is unable to locate the care plan for the specific occurrences of delusions, the monitoring of side effects of Risperdal, and non-pharmacological (that do not involve medications or drugs) interventions (therapies) to the use of Risperdal. The DON also stated that the DON is unable to locate the monitoring of the specific occurrences of delusions and side effects on the MAR. The DON stated that monitoring for specific occurrences of delusions was important to measure effectiveness of Risperdal and when to make medication changes, such as lowering the dose or discontinuing. The DON stated that monitoring for side effects of Risperdal was important to ensure Resident 67 did not have unnecessary side effects such as tardive dyskinesia, akathisia, tremors, dizziness, sedation causing negative impact on their health and well-being. The DON stated the facility failed to include specific target behaviors for the use of Risperdal, monitor the specific occurrences of delusions, side effects of Risperdal, and use of alternate therapies, and overlooked and failed to initiate a care plan with measurable goals and outcomes for delusions and Risperdal for Resident 67. Review of the facility's Policies and Procedures (P&P,) titled Comprehensive Person-Centered Care Planning, dated November 2018, the P&P indicated that: It is the policy of the Facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being. I. Baseline Care Plan a. It should address resident-specific health and safety concerns to prevent decline or injury, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. III. Baseline Care Plan Summary (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. If the comprehensive assessment and the comprehensive care plan identified a change in the resident's goals, or physical, mental or psychosocial functioning, which was not previously identified on the problem specific care plans used for the baseline care plan, those changes must be updated on each specific care plan used and incorporated, as applicable, into the initial and/or updated care plan summary(ies.) IV. Comprehensive Care Plan a. Within 7 days from the completion of the comprehensive MDS assessment, the comprehensive care plan will be developed. All goals, objectives, interventions, etc. from the current baseline care plan will be included in the resident's comprehensive care plan. b. Additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident. c. The comprehensive care plan will be periodically reviewed and revised by IDT after each assessment . In addition, the comprehensive care plan will also be reviewed and revised at the following times: i. Onset of new problems iv. To address changes in behavior and care. Review of the facility's P&P, titled Admission Assessment, dated 08/212020, the P&P indicated: To identify the Resident's needs and accordingly develop plan of care. II. The admission assessment will be included in the Resident's medical record and will be used to create appropriate care plans for the Resident. Review of the facility's P&P, titled Behavior/Psychoactive Drug Management, dated November 2018, the P&P indicated: It is the policy of the Facility to provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being. I. Assessment A. Upon admission, quarterly, annually, and upon change of condition, the interdisciplinary Team (IDT) will collect and assess information about the resident including but not limited to past life experiences, description of behaviors, preferences .cognitive status and related abilities and medications. II. Interventions A. Non-pharmacological interventions i. Upon identification of factors that may contribute to a resident's mood or behavior symptoms, the Licensed Nurse shall initiate .Behavior Log with Non-pharmacological interventions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ii. The Licensed Nurse will notify and collaborate with the Attending Physician/Prescriber, family, resident, Responsible Party, and/or IDT members regarding the identified contributing factors to the resident's mood/behavior problems and the non-drug interventions taken to address the problems, as well as to evaluate the effectiveness of the non-drug interventions for further recommendations. iii. The Licensed Nurse will document the interventions taken and recommendations in the resident's Care Plan. F. Any order for psychoactive medications must include: v. Specific behavior manifested. I. Monitoring for Side Effects i. Depending on the specific classification of psychoactive mediation the resident should be observed and/or monitored for side effects and adverse consequences. ii. General/anticholinergic: constipation, blurred vision, dry mouth, urinary retention, sedation v. Neurologic: Akathisia, dystonia, extrapyramidal effects, akinesia; or tardive dyskinesia, stroke or TIA III. Evaluation A. Following admission, completion of MDS, quarterly, annually and upon significant change of condition, the IDT will review the following and make recommendations based on the resident's need: i. The effectiveness of non-drug interventions ii. Possible alternatives to use of psychotropic medications D. Documentation Requirements: ii. The Care Plan reflects the non-drug interventions prior to drug treatment, use of psychoactive medications, adverse reactions to psychoactive medications . iv. Occurrences of behaviors for which psychoactive medications are in use will be entered with hash marks (#) on the MAR every shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview and record review, the facility failed to provide care in accordance with professional standards to three out of three sampled residents (Residents 7, 118, and 109) investigated during review of insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin administration sites. The deficient practice had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross reference F760. Findings: a. A review of Resident 7's Admission Record indicated the facility admitted the resident on 1/19/2024, with diagnoses including type 2 diabetes mellitus (a disease in which the body does not control the amount of glucose [a type of sugar] in the blood) with diabetic chronic kidney disease (a decrease in kidney function that occurs in some residents who have diabetes) and diabetic peripheral neuropathy (a type of nerve damage that can occur with diabetes). A review of Resident 7's History and Physical (H&P), dated 4/26/2023, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 7's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/1/2024, indicated the resident had the ability to make self-understood and understand others. The MDS indicate the resident was receiving high-risk drug class hypoglycemic medication (a group of drugs used to help reduce the amount of sugar present in the body). A review of Resident 7's Order Summary Report indicated the following orders: -5/5/2024 Insulin Aspart Injection Solution 100 units per milliliters (unit/ml, a standardized way to quantify the effect of the medication) (Insulin Aspart). Inject as per sliding scale (varies the dose of insulin based on blood sugar level): if 70-149= 0 units; hypoglycemia (low blood sugar) protocol if blood glucose (BG) less than or equal to 70 mg/dl; 150-199= 2 units; 200-249= 3 units; 250-299= 5 units; 300-349= 7 units. Greater than 349 milligrams per deciliter (mg/dl, a milligram is one-thousandth of a gram), administer 10 units and inform MD immediately, subcutaneously before meals and at bedtime for diabetes mellitus (DM). Rotate injection sites. -6/22/2024 Insulin Detemir Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Detemir). Inject 16 unit subcutaneously one time a day for DM. A review of Resident 7's Location of Administration of insulin for 4/2024 to 6/2024, indicated the insulin was administered on: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Insulin Detemir Subcutaneous Solution Pen-Injector 100 unit/ml 4/28/2024 at 9:18 a.m. Arm-left 4/29/2024 at 8:07 a.m. Arm-left -Insulin Glargine Solution 100 unit/ml 4/8/2024 at 6 p.m. Abdomen-Left Upper Quadrant (LUQ) 4/8/2024 at 8:55 p.m. Abdomen-LUQ 4/12/2024 at 9:42 a.m. Arm-left 4/13/2024 at 8:38 a.m. Arm-left Insulin Aspart Injection Solution 100 unit/ml 4/25/2024 at 7:23 a.m. Arm-left 4/25/2024 at 2:34 p.m. Arm-left 4/26/2024 at 6:47 a.m. Arm-right 4/26/2024 at 1:14 p.m. Arm-right 4/26/2024 at 3:31 p.m. Arm-left 4/26/2024 at 9:27 p.m. Arm-left 4/28/2024 at 6:37 p.m. Arm-right 4/28/2024 at 9:21 p.m. Arm-right 4/29/2024 at 4:41 p.m. Abdomen-Left Lower Quadrant (LLQ) 4/29/2024 at 10:40 p.m. Abdomen-LLQ 5/1/2024 at 6:27 p.m. Arm-right 5/1/2024 at 9:36 p.m. Arm-right 5/3/2024 at 4:41 p.m. Arm-right 5/3/2024 at 9:42 p.m. Arm-right 5/4/2024 at 4:55 p.m. Arm-right (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/4/2024 at 9:40 p.m. Arm-right 5/24/2024 at 5:50 p.m. Arm-right 5/24/2024 at 8:58 p.m. Arm-right 5/25/2024 at 6:44 a.m. Arm-right 5/25/2024 at 6:36 p.m. Abdomen-LLQ 5/25/2024 at 6:31 p.m. Abdomen-LLQ During a concurrent interview and record review on 6/26/2024, at 1:24 p.m., with Registered Nurse 2 (RN 2), reviewed Resident 7's Order Summary Report and the Location of Administration of insulin from 4/2024 to 6/2024. RN 2 stated there were multiple instances that the sites of insulin administration of insulin were not rotated. RN 2 stated insulin administration sites should be rotated to prevent lipodystrophy and bruising and hardening of the tissues. During an interview on 6/28/2024, at 4:35 p.m., with the DON, the DON stated it is important to rotate insulin administration sites to prevent phlebitis (inflammation of a vein) and lipodystrophy. A review of the facility provided Highlights of Prescribing Information titled, Insulin Aspart Injection, for subcutaneous or intravenous use, with initial U.S. Approval in 2000, indicated to rotate injection sites within the same region for one injection to the next to reduce risk of lipodystrophy and localized cutaneous amyloidosis. A review of the facility provided Highlights of Prescribing Information titled, Levemir (insulin detemir injection), for subcutaneous use, with initial U.S. Approval in 2005, indicated to rotate injection sites within an injection area (abdomen, thigh, or deltoid) to reduce the risk of lipodystrophy. b. A review of Resident 118's Admission Record indicated the facility admitted the resident on 5/14/2024, with diagnoses including type 2 diabetes mellitus and obesity (abnormal or excessive fat accumulation that presents a risk to health). A review of Resident 118's H&P, dated 5/18/2024, indicated the resident had the capacity to understand and make decisions. The MDS indicated the resident had the ability to make self-understood and understand others. The MDS indicate the resident was on a high-risk drug class hypoglycemic medication. A review of Resident 118's Order Summary Report indicated the following orders: -5/15/2024 Insulin Lispro Injection Solution 100 unit/ml (Insulin Lispro). Inject as per sliding scale: if 0-149= 0 units. If less than or equal to 70 mg/dl- hypoglycemia protocol; 150-199= 3 units; 200-249= 4 units; 250-299= 7 units; 300-349= 10 units; 350-399= 12 units. 399 or more- call doctor, subcutaneously before meals and at bedtime for type 2 DM. Rotate injection sites. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-5/15/2024 Novolog Mix 70/30 FlexPen Subcutaneous Suspension Pen-injector (70-30) 100 unit/ml (Insulin Aspart Protamine & Aspart [Human]). Inject 8 unit subcutaneously two times a day for type 2 DM. Rotate injection sites. A review of Resident 118's Location of Administration of insulin for 5/2024 to 6/2024, indicated insulin was administered on: -Insulin Lispro Injection Solution 100 unit/ml 5/17/2024 at 5:19 p.m. Abdomen-LLQ 5/17/2024 at 9:04 p.m. Abdomen-LLQ 5/18/2024 at 5:21 p.m. Abdomen-LLQ 6/2/2024 at 6:09 a.m. Arm-left 6/2/2024 at 5:26 a.m. Arm-left 6/4/2024 at 9:22 p.m. Abdomen-Right Lower Quadrant (RLQ) 6/6/2024 at 6:11 p.m. Abdomen-RLQ 6/6/2024 at 4:53 p.m. Abdomen-RLQ 6/7/2024 at 6:54 p.m. Abdomen-RLQ 6/12/2024 at 10:11 p.m. Abdomen-RLQ 6/13/2024 at 5:28 p.m. Abdomen-RLQ 6/16/2024 at 5:57 a.m. Abdomen-LLQ 6/16/2024 at 7:32 a.m. Abdomen-LLQ 6/17/2024 at 5:39 a.m. Abdomen-LLQ 6/18/2024 at 5:47 p.m. Abdomen-RLQ 6/19/2024 at 6:22 a.m. Abdomen-RLQ 6/27/2024 at 8:14 p.m. Abdomen-RLQ 6/28/2024 at 10:30 a.m. Abdomen-RLQ -Novolog Mix 70/30 FlexPen Subcutaneous Suspension Pen-Injector (70/30) 100 unit/ml 6/2/2024 at 6:09 a.m. Arm-left (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/2/2024 at 5:26 p.m. Arm-left 6/6/2024 at 4:56 p.m. Abdomen-RLQ 6/7/2024 at 6:54 a.m. Abdomen-RLQ 6/16/2024 at 5:57 p.m. Abdomen-LLQ 6/16/2024 at 7:32 p.m. Abdomen-LLQ 6/17/2024 at 5:39 a.m. Abdomen-LLQ During a concurrent interview and record review on 6/26/2024, at 1:24 p.m., with RN 2, reviewed Resident 118's Order Summary Report and the Location of Administration of Insulin from 5/2024 to 6/2024. RN 2 stated there were multiple instances that the sites of insulin administration of insulin were not rotated. RN 2 stated insulin administration sites should be rotated to prevent lipodystrophy and bruising and hardening of the tissues. During an interview on 6/28/2024, at 4:35 p.m., with the DON, the DON stated it is important to rotate insulin administration sites to prevent phlebitis (inflammation of a vein) and lipodystrophy. A review of the facility provided Highlights of Prescribing Information titled, Humalog (insulin lispro) injection, for subcutaneous or intravenous use, with initial U.S. Approval in 1996, indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. A review of the facility provided Highlights of Prescribing Information titled, Humulin 70/30 (70% human insulin isophane suspension and 30% human insulin injection [rDNA origin]) injectable suspension, for subcutaneous use, with initial U.S. Approval in 1989, indicated Humulin 70/30 should only be administered subcutaneously. Administer in the subcutaneous tissue of the abdominal wall, thigh, upper arm, or buttocks. To reduce the risk of lipodystrophy, rotate the injection site within the same region from one injection to the next. c. A review of Resident 109's Admission Record indicated the facility admitted the resident on 4/13/2024, with diagnoses including type 2 diabetes mellitus, dysphagia (difficulty swallowing), and gastro-esophageal reflux disease (GERD, a common condition in which the stomach contents move up into the esophagus). A review of Resident 109's H&P, dated 4/15/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 109's MDS, dated [DATE], indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident was receiving high-risk drug class hypoglycemic medication. A review of Resident 109's Order Summary Report indicated the following orders: -6/11/2024 Insulin Glargine Subcutaneous Solution 100 unit/ml (Insulin Glargine). Inject 20 unit subcutaneously at bedtime for DM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-4/13/2024 Insulin Lispro Injection Solution 100 unit/ml (Insulin Lispro). Inject as per sliding scale: if 0-149= 0 units; 150-199= 1 unit; 200-249= 2 units; 250-299= 3 units; 300-349= 4 units; 350-399= 5 units; 400-999= 6 units, subcutaneously before meals and at bedtime for DM. A review of Resident 109's Location of Administration of insulin for 4/2024 to 6/2024, indicated the insulin was administered on: -Insulin Lispro Injection Solution 100 unit/ml 4/17/2024 at 11:39 a.m. Arm-right 4/17/2024 at 8:40 p.m. Arm-right 4/22/2024 at 9:04 a.m. Abdomen-LUQ 4/23/2024 at 6:12 p.m. Abdomen-LUQ 4/23/2024 at 10:05 a.m. Abdomen-LUQ 5/1/2024 at 9:13 p.m. Abdomen-Right Upper Quadrant (RUQ) 5/2/2024 at 4:42 p.m. Abdomen-RUQ 5/3/2024 at 7:04 p.m. Arm-right 5/5/2024 at 5:34 a.m. Arm-right 5/10/2024 at 8:21 p.m. Abdomen-LUQ 5/12/2024 at 4:19 p.m. Abdomen-LUQ 5/24/2024 at 8:37 p.m. Abdomen-LUQ 5/25/2024 at 5:01 p.m. Abdomen-LUQ 6/13/204 at 11:39 a.m. Abdomen-RLQ 6/13/2024 at 8:47 p.m. Abdomen-RLQ 6/14/2024 at 8:52 p.m. Abdomen-LUQ 6/15/2024 at 4:53 p.m. Abdomen-LUQ 6/21/2024 at 6:33 p.m. Abdomen RLQ 6/21/2024 at 9:58 p.m. Abdomen-RLQ 6/23/2024 at 9:52 p.m. Abdomen-LUQ (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/24/2024 at 11:20 a.m. Abdomen-LUQ -Insulin Glargine Subcutaneous Solution 100 unit/ml 4/16/2024 at 5:20 p.m. Arm-left 4/17/2024 at 5:50 a.m. Arm-left 4/28/2024 at 5:47 a.m. Arm-left 4/28/2024 at 4:31 p.m. Arm-left 6/13/2024 at 8:47 p.m. Abdomen-LUQ 6/14/2024 at 8:39 p.m. Abdomen-LUQ During a concurrent interview and record review on 6/26/2024, at 1:24 p.m., with RN 2, reviewed Resident 109's Order Summary Report and the Location of Administration of Insulin from 4/2024 to 6/2024. RN 2 stated there were multiple instances that the sites of insulin administration of insulin were not rotated. RN 2 stated insulin administration sites should be rotated to prevent lipodystrophy and bruising and hardening of the tissues. During an interview on 6/28/2024, at 4:35 p.m., with the DON, the DON stated it is important to rotate insulin administration sites to prevent phlebitis (inflammation of a vein) and lipodystrophy. A review of the facility provided Highlights of Prescribing Information titled, Humalog (insulin lispro) injection, for subcutaneous or intravenous use, with initial U.S. Approval in 1996, indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 44376 Based on interview and record review, the facility failed to ensure the facility communicated necessary information to the resident, to the continuing care provider and other authorized persons at the time of an anticipated discharge to one out of three sampled residents (Resident 123) selected for closed record review by failing to complete the following in the Discharge Planning Review: 1. Medication Reconciliation 2. Equipment and Supplies 3. Learning Needs Related to Conditions The deficient practice had the potential to result in provision of inappropriate and untimely care to residents. Findings: A review of Resident 123's Admission Record indicated the facility admitted the resident on 1/19/2024, with diagnoses including atherosclerotic heart disease (thickening or hardening of the arteries) and cognitive communication deficit (difficulty with any aspect of communication). A review of Resident 123's History and Physical (H&P), dated 1/28/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 123's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/29/2024, indicated the facility discharged the resident on 3/29/20224 to home/community and coded the type of discharge as unplanned. A review of Resident 123's Order Summary Report, dated 3/28/2024, indicated the following orders: - May discharge 3/29/2024, to Independent Living 1 (IL 1) with (w/) home health (HH, a wide range of health care services that can be given in the home), physical therapy (PT)/occupational therapy (OT)/ registered nurse (RN), durable medical equipment (DME, equipment and supplies ordered by a health care provider for everyday or extended use)- front wheel walker (FWW, a mobility aid that helps provide stability and balance while walking). A review of Resident 123's Notice of Proposed Transfer and Discharge, dated 3/29/2024, indicated the resident was discharged to IL 1. The discharge reason indicated the discharge was appropriate because the resident's health has improved sufficiently so that the resident no longer required services provided by the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 123's Discharge Planning Review (DPR), initiated on 1/19/2024, indicated the resident initiated the discharge to home/community. The DPR's medication reconciliation, equipment, and supplies, learning needs related to conditions, and contacts were not signed by the discharging nurse. During a concurrent interview and record review on 6/27/2024, with Case Manager 1 (CM 1), reviewed Resident 123's Discharge Planning Review. CM 1 stated the discharging nurse did not complete the medication reconciliation, equipment, and supplies, learning needs related to conditions, and contacts of the Discharge Planning Review. CM 1 added the discharging nurse did not make a copy of the discharge medication list provided to the resident on discharge to be kept on file. CM 1 stated it was important to ensure the Discharge Planning Review of the resident was completed, dated, and signed by the discharging nurse to ensure the resident's safe discharge to home/community. During an interview on 6/28/2024, at 4:35 p.m., with the Director of Nursing (DON), the DON stated it was important to provide the resident the medication list so that the resident's primary care physician (PCP) will be aware of what medications were continued or stopped. The DON stated completing the Discharge Planning Review will prepare the resident to be discharged in the community safely and prevents readmission. A review of the facility's recent policy and procedure titled, Discharge and Transfer of Residents, last reviewed on 5/23/2024, indicated to ensure that discharge planning is complete and appropriate, and that necessary information is communicated to the continuing care provider. When a resident is near a planned discharge, the interdisciplinary Team (IDT) will complete a Discharge Summary/Post Discharge Plan of Care. Nursing Staff will complete a Discharge Summary/Post Discharge Plan of Care for each resident, which will include a recapitulation of the resident's stay and a final summary of the resident's status. A copy of the Discharge Summary/Post Discharge Plan of Care will be provided to the resident, resident representative, or the receiving facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to ensure one (Resident 26) of one sampled resident investigated during a random observation was provided care and services to maintain good grooming and personal hygiene by: 1. Failing to ensure the resident was groomed and provided showers and proper skin care as scheduled. 2. Failing to document accurately shower/bath provided and or refusals. These deficient practices resulted in Resident 26 having poor grooming and personal hygiene that could negatively impact the resident`s quality of life and self-esteem. Cross reference to F684. Findings: A review of Resident 26's Admission Record indicated the facility admitted the resident on 5/9/2018 and readmitted on [DATE] with diagnoses including major depressive disorder (a condition that describes a constant feeling of sadness and loss of interest, which stops a person from doing normal activities), muscle wasting and atrophy, and difficulty in walking. A review of Resident 26's History and Physical dated 3/30/2024, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 26's Minimum Data Set (MDS - an assessment and care screening tool) dated 5/3/2024, indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and required supervision with eating; substantial /maximal assistance with bathing and dressing; partial/moderate assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). A review of Resident 26's care plan on risk for skin break/ulcer formation related to impaired mobility, incontinence, decreased sensation of skin, thin fragile skin related risk factors initiated 11/5/2021 with target date 8/11/2024 indicated weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissues and exudate and any other notable changes or observations as one of the interventions. A review of Resident 26's ADL Flowsheet for 5/2024 and 6/2024 indicated bathing or shower on Monday and Thursday. The flowsheet indicated the following: - Resident 26 refused bathing/shower on 5/6/2024, 5/9/2024, and 6/6/2024. - Resident 26 was provided bed/towel bath on 5/20/2024, 5/23/2024, 6/3/2024, and 6/6/17/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- There was no documented evidence if Resident 26 was provided or refused bath/shower or bed/towel bath on 6/20/2024 and 6/24/2024. - From 5/10/2024 - 5/19/2024 and 6/7/202 - 6/16/2024, the flowsheet was marked with an X on shower days 5/13/2024, 5/15/2024, 6/10/2024, and 6/13/2024. During an observation on 6/27/2024 at 8:15 a.m. inside Resident 26's room, observed resident lying in bed asleep and partially covered with a sheet with both lower legs exposed. Observed resident's both lower legs with dry, scaly skin and redness on the right shin. During an interview on 6/27/2024 at 8:43 a.m., with Treatment Nurse 2 (TN 2), TN 2 stated Resident 26 had dry skin and peeling of skin on both lower legs and redness on the right shin. TN 2 stated the CNAs are supposed to apply lotion after providing ADL care to residents to help moisten the skin and prevent skin breakdown from very dry skin. During an interview on 6/27/2024 at 9:01 a.m., with Licensed Vocational Nurse 11 (LVN 11), LVN 11 stated Resident 26's skin was flaky and dry, and with redness on the right shin. LVN 11 stated she did not know when Resident 26's skin dryness started. LVN 11 stated CNAs are supposed to apply lotion after shower to help moisten the skin and prevent skin breakdown. During an interview on 6/27/2024 at 9:30 a.m., with Registered Nurse 1 (RN 1), RN 1 stated skin check on residents are done every shift and documented by the charge nurse. RN 1 described Resident 26's skin as slightly dry with redness on the right shin. RN 1 stated CNAs are supposed to apply lotion after providing care to the residents to moisten the skin and prevent skin breakdown. During a concurrent observation on 6/27/2024 at 12:08 p.m. inside Resident 26's room, Certified Nursing Assistant 9 (CNA 9) stated Resident 26's both lower legs had dry scaly skin with redness on the right shin. CNA 9 stated if a resident refuse shower, she offers at least three times and if the resident still refuse, she will offer bed/towel bath instead. CNA 9 stated residents have lotion on their nightstands and is applied everyday with during ADL care. During a concurrent interview and record review on 6/27/2024 at 12:21 p.m., with the Director of Staff Development (DSD), reviewed Resident 26's ADL Flowsheet and shower schedule. The DSD stated Resident 26 's shower schedule is on Mondays and Thursdays. The DSD there was no documented evidence if Resident 26 was provided or refused bath/shower or bed/towel bath on 6/20/2024 and 6/24/2024; from 5/10/2024 - 5/19/2024 and 6/7/202 - 6/16/2024, the flowsheet was marked with and X on shower days 5/13/2024, 5/15/2024, 6/10/2024, and 6/13/2024. The DSD stated the X mark means bathing/shower was not triggered in the CNA task to be provided to Resident 26 and could mean that the resident was not provided or offered bathing/shower or bed/towel bath. The DSD stated CNAs are supposed to apply lotion to residents after providing appropriate ADL care as they are a high risk for dry, scaly skin due to the level of assistance required to help moisten the skin and prevent skin breakdown. The DSD stated if residents refused, ADL care should be offered multiple times and documented in the flowsheet. The DSD stated not providing the appropriate ADL care Resident 26 needs could potentially affect his quality of life and self-esteem. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/28/2024 at 4:50 p.m., with the Director of Nursing (DON), the DON stated appropriate ADL care should be provided by the CNAs to residents including applying lotion to moisten the skin and prevent skin breakdown as their skin is very fragile and gets easily dry and scaly. The DON stated if ADL was provided or the resident refused, it should be documented in the flowsheet. The DON stated not receiving the appropriate ADL care could potentially affect Resident 26's quality of life and self-esteem. A review of the facility's policy and procedure titled Resident Rights - Quality of Life, last reviewed 5/23/2024, indicated that each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being. A review of the facility's policy and procedure titled, Resident Rights, last reviewed 5/23/2024, indicated the facility makes every effort to assist residents to participate in exercising his/her rights by encouraging the residents to participate in planning their daily care routines including ADLs. A review of the facility's policy and procedure tilted, ADL Documentation, last reviewed 5/23/2024, indicated a purpose to provide consistency in documentation of resident status and care given by nursing staff. The policy indicated the facility will ensure documentation of the care provided to the resident for completion of ADLS manually or electronic. A review of the facility's policy and procedure titled, Showering and bathing, last reviewed 5/23/2024, indicated a tub or shower bath is provided to residents for cleanliness, comfort, and prevent body odors. The policy indicated to observe the skin during bath, and report any broken skin, bruises, rashes, cut, skin discoloration or reddened areas to the charge nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview and record review the facility failed to implement their policy and procedure on cardiopulmonary resuscitation (CPR, an emergency procedure used to restart a person's heartbeat and breathing after one or both have stopped) by failing to maintain CPR certification training that included hands-on practice and in-person skills assessment to one of six sampled licensed staff (Licensed Vocational Nurse 3 [LVN 3]) investigated during review of sufficient and competent nurse staffing task. The deficient practice had the potential for staff to perform substandard life-saving measures to residents that can lead to debility and death. Findings: A review of LVN 3's Basic Life Support (BLS, a set of essential emergency procedures designed to sustain life in victims experiencing cardiac arrest) Provider Card certification from National CPR Foundation, dated [DATE], indicated, the mentioned individual is now certified in the mentioned course by demonstrating proficiency by successfully passing the examination in accordance with the Terms and Conditions of National CPR Foundation (NCPRF). Valid for 2 Years. During a concurrent interview and record review on [DATE], at 9:19 a.m., with the Director of Staff Development (DSD), reviewed LVN 3's Employee File. The DSD stated LVN 3 took the National CPR Foundation online course to renew LVN 3's BLS certification. The DSD stated the renewal course did not have a hands-on training. During a telephone interview on [DATE], at 10:31 a.m., with LVN 3, LVN 3 stated he took the CPR renewal course online and did not have an in-person and hands-on training validation for performing CPR. During an interview on [DATE], at 4:35 p.m., with the Director of Nursing (DON), the DON stated LVN 3 should have CPR certification with in-person and with hands on training to ensure LVN 3 can competently provide CPR to residents. The DON stated the failure of the staff to be validated for hands on training for CPR can lead to inability of the staff to perform CPR appropriately and had the potential to result in resident death. A review of the facility's Job Description for LVN Staff Nurse, indicated a licensed professional nurse under the supervision of a Registered Nurse who provides nursing care and services to residents in a long-term care setting. Qualifications: - Valid CPR certification. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's recent policy and procedure titled, Cardiopulmonary Resuscitation, last reviewed on [DATE], indicated Licensed Nursing Staff shall maintain current CPR certification for Healthcare Providers through a CPR provider whose training includes hands-on practice and in-person skills assessment; online-only certification is not acceptable. Licensed Nursing Staff are required to be certified in basic CPR and must be recertified every two years.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 26) investigated during a random observation received treatment and care in accordance with professional standards of practice to meet the resident's physical, mental, and psychosocial needs by failing to assess and identify new skin issues when the resident was observed with discoloration around the ankle area. This deficient practice placed the resident at risk for not receiving the necessary treatment and services related to discoloration in the resident's ankle area. Cross reference to F677. Findings: A review of Resident 26's Admission Record indicated the facility admitted the resident on 5/9/2018 and readmitted on [DATE] with diagnoses including major depressive disorder (a condition that describes a constant feeling of sadness and loss of interest, which stops a person from doing normal activities), muscle wasting and atrophy, and difficulty in walking. A review of Resident 26's History and Physical dated 3/30/2024, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 26's Minimum Data Set (MDS - an assessment and care screening tool) dated 5/3/2024, indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and required supervision with eating; substantial /maximal assistance with bathing and dressing; partial/moderate assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). A review of resident 26's Order Summary Report indicated the following: -5/17/2024 Monitor for signs and symptoms of bleeding such as: 0 - none, 1 = discolored urine, 2 = black tarry stools, 3 = sudden severe headaches, 4 = nausea/vomiting, 5 = diarrhea, 6 = muscle/joint pain, 7 = lethargy, 8 = bruising, 9 = sudden changes in mental status, 10 = anxiety, 11 = drowsiness every shift. -Aspirin (ASA) oral tablet chewable 81 milligrams (mg - a unit of measurement) give 1 tablet by mouth 1 time a day for cerebrovascular accident (CVA = also known as stroke, a condition that occurs when blood flow cannot reach a part of the brain or there is sudden bleeding in the brain) prophylaxis (a term that refers to preventive measure) give with lunch. A review of Resident 26's care plan indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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	1. Potential for bleeding or bruising due to use of ASA initiated on 11/5/2021 with target date 8/11/2024 indicated skin discoloration as one of the adverse reactions. The care plan indicated a goal that the resident will be free from discomfort or adverse reactions related to anticoagulant (AC - (a type of medication that prevents the blood from, clotting too easily) use. The care plan indicated the following interventions: - Daily skin inspection and report abnormalities to the nurse. - Monitor/document/report as needed adverse reactions of AC therapy such as blood tinged or red blood in urine, black, tarry stools, dark or bright red blood in stool, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. 2. Resident at risk for skin break/ulcer formation related to impaired mobility, incontinence, decreased sensation of skin, thin fragile skin related risk factors initiated 11/5/2021 with target date 8/11/2024 indicated weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissues and exudate and any other notable changes or observations as one of the interventions. -A review of Resident 26's Medication Administration Record (MAR) from 6/1/2024 to 6/26/2024 for monitoring of signs and symptoms of bleeding every shift indicated the resident did not have any signs and symptoms of bleeding , documented as 0 in the number of episodes (such as: 0 - none, 1 = discolored urine, 2 = black tarry stools, 3 = sudden severe headaches, 4 = nausea/vomiting, 5 = diarrhea, 6 = muscle/joint pain, 7 = lethargy, 8 = bruising, 9 = sudden changes in mental status, 10 = anxiety, 11 = drowsiness every shift. During an observation on 6/27/2024 at 8:15 a.m. inside Resident 26's room, observed resident lying in bed asleep and partially covered with a sheet with both lower legs exposed. Observed both lower legs with discoloration in a straight line above the ankles. During a concurrent observation on 6/27/2024 at 8:24 a.m. inside Resident 26's room, Certified Nursing Assistant 9 (CNA 9) verified the discoloration around the resident's ankles. CNA 9 stated she was not aware of the resident having skin issues or skin discoloration and if she had seen the discoloration, she would have reported it to the charge nurse immediately. CNA 9 stated she did not know when did the discoloration developed on the resident. During a concurrent interview and record review on 6/27/2024 at 8:43 a.m., with Treatment Nurse 2 (TN 2), reviewed Resident 26's Weekly Skin/Wound Assessment. TN 2 stated the last documented weekly skin check for Resident 26 was on 5/28/2024. TN 2 skin checks are done every Thursday. TN 2 stated she was made aware today (6/27/2024) Resident 26 had discoloration on both lower legs. TN 2 stated the discoloration did not happen overnight and stated she thinks the discoloration was cause by the resident wearing socks. TN 2 stated it was important to perform skin checks on the residents to identify any skin changes or wounds and to provide proper interventions timely. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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	During an interview on 6/27/2024 at 9:01 a.m., with Licensed Vocational Nurse 11 (LVN 11), LVN 11 stated she observed the discoloration on Resident 26's both lower legs above the ankles on 6/27/2024 at 8:30 a.m. and stated the discoloration appeared to be marks from wearing socks and appeared to be resolving. LVN 11 stated she reported the change in skin condition to the Director of Nursing (DON) and TN 2. LVN 11 skin checks are done every shift by the charge nurses and CNAs assigned to the resident. LVN 11 stated she did not receive any report regarding the resident's skin discoloration from the previous shift. During an interview on 6/27/2024 at 9:30 a.m., with Registered Nurse 1 (RN 1), RN 1 stated skin check on residents are done every shift and documented by the charge nurse. RN 1 stated Resident 26's discoloration on both lower legs was reported to her by TN 2. RN 1 stated she observed linear discoloration around Resident 26's ankle area. RN 1 stated she was not sure how and when it happened and stated the discoloration did not happen overnight. RN 1 stated weekly skin checks are done by TN 1 and TN 2 for residents with wounds. RN 1 stated the discoloration around Resident 26's ankles should have been reported immediately so proper treatment and interventions can be provided timely and to prevent worsening of the skin discoloration. During a concurrent interview and record review on 6/28/2024 at 4:50 p.m., with the DON, reviewed Resident 26's care plans, MAR for 6/2024, and Order Summary Report for 6/2024. The DON verified Resident 26 had a physician's order to monitor for signs and symptoms of bleeding such as bruising due to AC use. The DON stated the charge nurses documented in the MAR from 6/1/2024 to 6/26/2024 that there were no episodes of signs and symptoms of bleeding. The DON stated 0 in the MAR indicated there were no episodes observed. The DON verified the care plan indicated to monitor for signs and symptoms of any adverse reactions for the use of AC such as bruising. The DON stated she was made aware of the discoloration around the resident both ankles 6/27/2024 and there were no prior reports of skin discoloration. The charge nurses are supposed to monitor Resident 26 for signs and symptoms of any adverse reaction from the AC use such as bruising or discoloration and document in the MAR every shift and notify the physician if present. The DON stated the nurses should have monitored the resident for signs and symptoms of bleeding, document, and notify the physician every shift so appropriate treatment and interventions can be provided timely to prevent further skin issues. A review of the facility's policy and procedure titled, Resident Rights - Quality of Life, last reviewed 5/23/2024, indicated that each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being. A review of the facility's policy and procedure titled, Skin and Wound Management, last reviewed 5/23/2024, indicated the following: - The facility staff will take appropriate measures to prevent and reduce that residents will develop pressure ulcers and other skin conditions. - All nursing staff is responsible for the prompt reporting of any skin related conditions to the Licensed Nurse (LN). The LN will notify the attending physician promptly at the first occurrence of a pressure ulcer or other skin related problems. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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	- A LN will complete the Weekly Skin Evaluation for each resident. If the resident has a non-pressure ulcer, wound or other skin problems (tear, bruise, laceration), the LN will also complete the Skin Ulcer Site Sheet. - CNAs will complete body checks on resident's shower days and report unusual findings to the LN. - New non-pressure ulcers, skin tears, bruises and lacerations will be documented on the 24-Hour Log and an incident report will be completed by the LN to determine casual factors contributing to the development of the skin condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review the facility failed to provide an environment free from accidents and hazards, ensure residents received adequate supervision, and implement and modify interventions to prevent accidents three of five residents (Resident 326, 6, and 8) reviewed under the accidents care area by failing to: 1. Ensure Resident 326, a resident that used tobacco, did not store cigarettes at bedside. 2. Ensure Resident 326 was appropriately assessed by the interdisciplinary team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of the resident) to identify the resident as an independent or at-risk smoker. These deficient practices had the potential to result in a facility fire from improper disposal of smoking materials and resident injuries from burns. 3. Ensure Resident 6's bed was not left in the high position while unattended by staff. This deficient practice had the potential to result in Resident 6 sustaining fractures (broken bones) from falls. 4. Accurately assess Resident 8's risk for elopement (when a resident who is incapable of adequately protecting himself, and who departs the health care facility unsupervised and undetected) in the Elopement Evaluation, dated 5/19/2024. This deficient practice has the potential to place residents at risk for injury from elopement. Findings: a. A review of Resident 326's Admission Record indicated the facility admitted the resident 6/6/2024 with diagnoses that included encephalopathy (a disturbance in brain function that may cause confusion and memory loss), sequelae of cerebral infarction (commonly known as stroke, caused by a blockage in a blood vessel in the brain, leading to brain damage), and chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow). A review of Resident 326's Minimum Data Set (MDS - an assessment and care screening tool) dated 6/13/2024, indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident required maximal assistance with toileting, bathing, transferring from chair/bed, dressing, oral hygiene, toileting, and personal hygiene. The MDS indicated the resident currently used tobacco. A review of Resident 326's Care Plan (CP) titled, Tobacco Use, initiated 6/7/2024, indicated the resident would adhere to the tobacco/smoking policies of the facility. The CP indicated to conduct Smoking Safety Evaluation on admission and as needed, educate resident on the facility's tobacco/smoking policy, orient the resident on the smoking times and procedures, and ensure eyeglasses are on. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 326's Smoking and Safety assessment form, dated 6/7/2024, indicated the resident used tobacco and had balance problems while sitting or standing. A review of Resident 326's Letter of Agreement dated 6/7/2024, indicated to ensure that smoking practices are conducted in a safe manner, the facility will require smokers to follow specific smoking guidelines, which include the following: residents that desire to smoke will be evaluated by the facility Interdisciplinary Team to determine if they are independent or an at risk smoker, all smokers understand that all smoking accessories (cigarettes) must be returned to and kept under the control of the smoking attendant. All at risk smokers are required to wear protective smoking aprons while smoking. The form indicated Resident 326 declined to sign the form. A review of Resident 326's Multidisciplinary Care Conference form, dated 6/7/2024, indicated the resident was a smoker. The form did not indicate if the resident was an independent or at risk smoker. During a concurrent observation and interview on 6/25/2024 at 11:20 a.m., Resident 326 lay in bed. Observed two cigarettes on the resident's nightstand. Resident 326 stated he was a smoker, and the cigarettes belonged to him. During a concurrent observation and interview on 6/25/2024 at 11:25 a.m., with Activities Assistant 1 (AA 1), AA 1 stated Resident 326 was a smoker. AA 1 stated the facility had a smoking patio for residents that was supervised by facility staff. AA 1 stated Resident 326 sometimes got cigarettes from staff and sometimes he had his own cigarettes. AA 1 stated some residents can keep their cigarettes and other residents cannot keep their cigarettes. AA 1 entered Resident 326's room and confirmed there were two cigarettes on Resident 326's nightstand. AA 1 exited Resident 326's room and walked down the hallway. Observed AA 1 did not remove Resident 326's cigarettes from the room. During a concurrent interview, and record review on 6/26/2024 at 1:02 p.m., Minimum Data Set Coordinator 1 (MDSC 1) reviewed Resident 326's Smoking and Safety assessment form dated 6/7/2024, Letter of Agreement dated 6/7/2024, and Multidisciplinary Care Conference form, dated 6/7/2024. MDSC 1 stated residents that smoke have a smoking assessment at admission. MDSC 1 stated residents that smoke are given a Letter Agreement that indicates cigarettes must be returned to and kept under the control of the smoking attendant and that the IDT will determine if the resident is an independent smoker or an at risk smoker. MDSC 1 stated there was no documentation to indicate if Resident 326 was an independent or at-risk smoker. MDSC 1 stated at risk smokers are required to wear smoking aprons, but the IDT did not indicate if the resident was independent or at risk. MDSC 1 stated she was not aware Resident 326 had cigarettes in his room. MDSC 1 stated if a resident has cigarettes in their room and decides to smoke it could result in a fire or burns to the resident from falling ashes. During an observation and interview on 6/26/2024 at 1:38 p.m., MDSC 1 walked to the smoking patio where Resident 326 sat at a table smoking. Observed MDSC 1 speak with Resident 326. Observed Resident 326 stated to MDSC 1, Did you take my two cigarettes?. Observed MDSC 1 stated to Resident 326 that she did not take his cigarettes and he could not keep cigarettes in his room. Resident 326 stated, Thank you for telling me. MDSC 1 exited the smoking patio and stated she did not know who took Resident 326's cigarettes, but if it was a staff member they should have notified the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/27/2024 at 11 a.m., with the Director of Nursing (DON) reviewed Resident 326's Smoking and Safety assessment form dated 6/7/2024, Letter of Agreement dated 6/7/2024, Multidisciplinary Care Conference form, dated 6/7/2024, and the facility policy regarding smoking. The DON stated Resident 326 was assessed as a smoker and an admission IDT conference was completed. The DON stated the Letter of Agreement is part of the facility process and the IDT should have determined if the resident was an independent smoker or an at-risk smoker. The DON stated she did not know if Resident 326 was an independent or at-risk smoker because the IDT did not determine it. The DON stated at risk smokers require interventions like wearing a smoking apron. The DON stated she was notified on 6/26/2024 that Resident 326 had cigarettes in his room. The DON stated the resident was not admitted with cigarettes and must have obtained them from the facility and taken them to his room. The DON stated AA 1 should have asked Resident 326 why he had cigarettes and removed them from his room. The DON stated the facility policy was not followed because the IDT did not determine if the resident was an independent or an at-risk smoker with safety interventions, and the resident had cigarettes in his room. The DON stated she was not sure who took Resident 326's cigarettes from his room. The DON stated when residents have cigarettes it could lead to residents smoking whenever and wherever they wanted possibly leading to accidents like burning themselves or dropping cigarettes and not being able to pick them up resulting in a fire. A review of the facility provided policy and procedure titled, Smoking Residents, last reviewed 5/23/2024, indicated residents are informed of this policy prior to or during the admission process and care conferences. Using the resident smoking assessment, the licensed nurse will assess residents who express a desire to smoke and present it to the interdisciplinary team for review. The IDT will develop an individualized plan of care for safe storage, use of smoking materials, assistance and/or required supervision, for residents who smoke. The resident will be educated regarding the risks of smoking and the smoking safety measures recommended by the IDT. This will be documented in the resident's clinical record. A review of the facility provided policy and procedure titled, Resident Safety, last reviewed 5/23/2024, indicated the purpose of the policy was to provide a safe and hazard free environment. Any facility staff member who identifies an unsafe situation, practice or environment risk factors should immediately notify their supervisor or charge nurse. b. A review of Resident 6's Admission Record indicated the facility admitted the resident 4/21/2023 and readmitted the resident on 4/18/2024 with diagnoses that included vascular dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), difficulty walking, metabolic encephalopathy, and cognitive communication deficit. A review of Resident 6's MDS, dated [DATE], indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated the resident required substantial/maximal assistance from staff for bathing, dressing, toileting, moving from sitting on side of bed to lying flat, and transferring from bed to chair. A review of Resident 6's Care Plan titled, Fall Prevention and Management, initiated 4/22/2023, indicated the resident was a high fall risk with a history of falls, poor safety judgement, and predisposing disease or injury. The CP indicated a goal to minimize risk for falls and provide a safe environment that minimizes complications associated with falls. The CP indicated to place the bed in the low position. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/25/2024 at 11:30 a.m., observed Resident 6 lying in bed with the bed in the elevated, high position. During a concurrent observation and interview and record review on 6/25/2024 at 11:45 a.m., observed Resident 6 lying in bed with the bed in the elevated, high position. Observed the resident's adjustable bed side rolling table in the high position at the same height as the bed. Resident 6 stated she did not know how to move her bed height up or down. During a concurrent observation and interview on 6/25/2024 at 11:55 a.m., the Director of Staff Development entered Resident 6's room and stated the resident's bed was in the high position. Resident 6 stated she really did not know how to lower the bed. The DSD used the bed control to lower Resident 6's bed to the lowest position. During a follow up interview on 6/25/2024 at 12 p.m., the DSD stated Resident 6 had periods of confusion and the resident should not be left with the bed in the high position to prevent incidents from falls. The DSD stated the bed left in the high position could potentially result in a big impact from the resident falling from high up. The DSD stated falling from the bed in the high position could result in injuries to the resident like a concussion or fractures. During an interview on 2/26/2024 at 3:03 p.m., with MDSC 1, MDSC 1 stated Resident 6 was a risk for falls because the resident had limited mobility and required assistance. MDSC 1 stated Resident 6 may not have known the bed was in the high position and potentially it could have resulted in the resident falling. MDSC 1 stated if a resident fell from the bed in the high position, then there was a risk for injury including skin impairment and possibly fractures. During a concurrent interview and record review on 6/27/2024 at 11 a.m., with the Director of Nursing reviewed the facility policy and procedure regarding fall prevention. The DON stated all the facility staff are responsible for maintaining the residents' beds in the low position. The DON stated if the resident's bed was left in the high position, the resident could fall. The DON stated the facility policy indicated to provide a safe environment and it was the general practice to maintain the bed in the low position. The DON stated the facility policy was not followed. A review of the facility provided policy and procedure titled, Fall Management Program, last reviewed 5/23/2024, indicated the purpose of the policy was to provide residents with a safe environment that minimizes complications associated with falls. The facility will implement a Fall Management Program that supports providing an environment free from fall hazards. The Interdisciplinary team (IDT) and/or the licensed nurse will develop a care plan according to identified risk factors and root causes. 43418 c. A review of Resident 8's Admission Record indicated the facility originally admitted Resident 8 on 12/20/2011 and readmitted [DATE] with diagnoses including, but not limited to, difficulty walking, unsteadiness on feet, and cognitive communication deficit (trouble participating in conversations). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 8's MDS, dated [DATE], indicated Resident 8 has severely impaired vision, has severe impaired cognition (difficulty understanding and making decisions), required supervision to moderate assistance with activities of daily living including eating, hygiene, mobility, toileting, and surface-to-surface transfers, and used a wheelchair. Resident 8's MDS further indicated Resident 8 used a wander (random or repetitive locomotion that may be goal-directed [e.g., the person appears to be searching for something such as an exit] or may be non-goal-directed or aimless) or elopement alarm daily. A review of Resident 8's History and Physical (H&P), dated 1/23/2024, indicated Resident 8 does not have the capacity to understand and make decision. A review of Resident 8's Order Summary Report indicated Resident 8 was ordered the following: - On 2/29/2024, check the placement of the wander guard (medical device used to prevent elopements) on Resident 8's left ankle every shift. - On 2/29/2024, check the functioning of Resident 8's wander guard every shift. - On 6/11/2024, may apply a wander guard to the resident for episodes of wandering around the facility. A review of Resident 8's Change in Condition Evaluation, dated 1/24/2024, indicated Resident 8 attempted to elope out of the facility and was exhibiting hostile behavior towards staff by attempting to hit and curse at staff. A review of Resident 8's Care Plan, last revised 3/1/2024, indicated Resident 8 was at risk for wandering or elopement related to risk factors including, but not limited to, being legally blind. The care plan indicated interventions included to apply a wander guard for episodes of wandering around the facility every shift. A review of Resident 8's Elopement Evaluation, dated 5/19/2024, indicated Resident 8 does not have a history of elopement or attempted leaving the facility without informing staff and does not wander. The evaluation indicated the resident's wandering behavior is not likely to affect the privacy of others. The evaluation indicated the resident was not at risk for elopement. The elopement evaluation further indicated no clinical suggestions, including apply personal safety alarm devices or utilize exit alarms. During an observation on 6/26/2024, at 2:58 p.m., in the facility hallway, Resident 8 was in a wheelchair propelling himself forward towards a blood pressure machine. Resident 8 reached out with hand while propelling forward and touched the blood pressure machine. Resident 8 maneuvered his wheelchair around the blood pressure machine and continued to propel himself forward. Resident 8 wore a band with a small white square box on his left ankle. During an interview with Certified Nursing Assistant (CNA) 8, on 6/27/2024, at 3:47 p.m., CNA 8 stated he has been taking care of Resident 8 since 2016 and Resident 8 is able to move himself around the facility in his wheelchair. CNA 8 stated Resident 8 is blind and when moving around the facility he wanders around and sometimes goes room to room. CNA 8 further stated Resident 8 wears a wander guard on his ankle. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Licensed Vocational Nurse (LVN) 10, on 6/28/2024, at 8:43 a.m., LVN 10 stated Resident 8 is blind and wears a wander guard. LVN 10 stated Resident 8 is able to move himself around to either the patio, activities room, or his own room. LVN 10 further stated because of his impairments, Resident 8 has difficulty getting to where he wants to go to. During a concurrent interview and record review with MDSC 1, on 6/28/2024, at 9:05 a.m., Resident 8's medical record was reviewed. MDSC 1 confirmed Resident 8's Change in Condition Evaluation, dated 1/24/2024, indicated Resident 8 attempted to elope from the facility. MDSC 1 confirmed Resident 8's Elopement Evaluation, dated 5/19/2024, did not indicate Resident 8 had a history of attempted elopement from the facility and a score of one or higher indicates the resident being evaluated is at risk for elopement. MDSC 1 further confirmed Resident 8's Elopement Evaluation does not indicate clinical suggestions. MDSC 1 further stated the evaluation should have indicated the Resident 8 was at risk for elopement and it is important to accurately reflect the resident's condition to guide the facility staff to develop and implement a plan of care. During an interview with the DON, on 6/28/2024, at 4:36 p.m., the DON stated Resident 8 was at risk for elopement and he wanders and goes into other residents' rooms. The DON stated Resident 8 wears a wander guard and requires supervision or queuing. The DON further stated it is important to accurately assess a resident's safety to ensure interventions are developed and in place. A review of the facility's policy and procedure (P&P) titled, Wandering and Elopement, last reviewed 5/23/2024, indicated the facility will identify residents at risk for elopement upon admission, and when there is a change in the condition to minimize the risk of elopement to enhance the safety of residents of the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on observation, interview, and record review the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding (any method of feeding that uses the gastrointestinal tract to deliver nutrition and calories) to three out of three sampled residents (Resident 62, 379, and 17) by failing to: 1. Label the water flush bag (a plastic container bag with infusion tubing filled with water used to flush the feeding tube and as a source of hydration for residents on enteral feeding) with the correct rate of infusion per physician's order for Resident 62. 2. Label the irrigation syringe (a specialized medical instrument designed for the irrigation or cleansing of wounds, cavities, or body orifices) pouch with resident identifier and the date the irrigation syringe was last changed for Resident 379. 3. Indicate the rate and time the tube feeding formula was hung for Resident 17. The deficient practices had the potential for alternation in nutritional status and complications associated with enteral feeding such as peritonitis (a redness and swelling [inflammation] of the lining on the abdomen). Findings: 1. A review of Resident 62's Admission Record indicated the facility admitted the resident on 6/22/2022, with diagnoses including gastrostomy (a surgical procedure used to insert a tube, often referred to as g-tube, through the abdomen and into the stomach) malfunction, irritable bowel syndrome (a common disorder that affects the stomach and intestines, also called gastrointestinal tract), and dysphagia (difficulty swallowing). A review of Resident 62's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/5/2024, indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident had a feeding tube. A review of Resident 62's Order Summary Report, dated 12/7/2023, indicated an order for enteral feed order every shift g-tube feeding order: flush enteral tube with 45 cubic centimeters (cc, a unit of volume) of water every hour for (X) 18 hrs. via pump for total volume of 810 milliliters (ml, a unit of volume). A review of Resident 62's Care Plan titled, Tube feeding/nutrition and hydration: potential for nutritional risks such as weight changes and compromised hydration due to dysphagia, last revised on 6/23/2022, indicated an intervention to change tubings, water bag and syringe daily (labeled and dated). During an observation on 6/25/2024, at 9:35 a.m., inside Resident 62's room, observed Resident 62's water flush bag labeled with a rate of 60 milliliters per hour (ml/hr, running rate). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation, interview, and record review on 6/25/2024, at 12:34 p.m., with the Infection Preventionist (IP), inside Resident 62's room, observed the label on the water flush bag labeled with a rate of 60 ml/hr. During review of Resident 62's Order Summary Report, the IP stated the physician's order indicated to flush enteral tube with 45 cc of water every hour for 18 hrs. via pump. The IP stated it was important for the staff to ensure the enteral feeding bag and the water flush bag was labeled per physician's order to ensure proper nutrition and avoid under and over hydrating the resident. During an interview on 6/28/2024, at 4:35 p.m., with the Director of Nursing (DON), the DON stated licensed nurses should label the water flush bag with the correct rate per MD order to ensure the resident was getting the right hydration, not over nor under hydrating the resident. A review of the facility's recent policy and procedure titled, Enteral Feedings, last reviewed on 5/23/2024, indicated to administer enteral feeding formula per physician order. Label bag and tubing with date and time hung. Hang time is for no more than 24 hours. Change feeding bag and tubing every 24 hours or as required by manufacturer guidelines. A review of the facility provided manufacturer's guideline on the use of Feeding Pump Set 1 (FPS 1), last revised on 6/2022, indicated the set is intended for enteral feeding only. It is recommended that this device be replaced every 24 hours. 2. A review of Resident 379's Admission Record indicated the facility admitted the resident on 8/26/2021, and readmitted on [DATE], with diagnoses including gastro-esophageal reflux disease (GERD, a condition in which the stomach contents move up into the esophagus) and sepsis (a serious condition in which the body responds improperly to an infection). A review of Resident 379's History and Physical (H&P), dated 2/14/2024, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 379's MDS, dated [DATE], indicated the resident sometimes had the ability to make self-understood and understand others. The MDS indicated the resident had a feeding tube. A review of Resident 379's Order Summary Report, dated 6/18/2024, indicated an enteral feed order every night shift. Change tubing syringe daily. A review of Resident 379's Care Plan titled, Tube feeding/nutrition and hydration: potential for nutritional risks such as weight changes and compromised hydration due to cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life), last revised on 5/2/2024, indicated an intervention to change tubings, water bag and syringe daily (labelled & dated). During an observation on 6/25/2024, at 10:51 a.m., inside Resident 379's room, observed the irrigation syringe inside a plastic pouch not labeled with resident identifier and the date it was last changed. During a concurrent observation and interview on 6/25/2024, at 12:31 p.m., with the Business Office Staff (BOS), observed the irrigation syringe inside a plastic pouch not labeled with resident identifier and the date it was last changed. The BOS stated the irrigation syringe was not labeled. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/28/2024, at 4:35 p.m., with the DON, the DON stated staff should label the irrigation syringe with the name of the resident and date it was last changed in accordance with the facility policy. The DON stated it is important to label the syringe, so staff know who the syringe belongs to, to ensure the syringe is changed every 24 hours and for infection control. A review of the facility's recent policy and procedure titled, Enteral Feeding-Closed, last reviewed on 5/23/2024, indicated to label the formula container and tubing with date and time hung. Change syringe daily. A review of the facility's recent policy and procedure titled, Labeling and Supplying Immediate Environment of Residents, last reviewed on 5/23/2024, indicated the immediate environment (closet and door) of a resident is labeled with the name of the resident. A review of the facility provided manufacturer's guideline on the use of FPS 1, last revised on 6/2022, indicated the set is intended for enteral feeding only. It is recommended that this device be replaced every 24 hours. 43418 3. A review of Resident 17's Admission Record indicated the facility originally admitted Resident 17 on 1/6/2017 and readmitted the resident on 4/3/2024 with diagnoses including, but not limited to, generalized muscle weakness and encounter for attention to gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food). A review of Resident 17's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/23/2024, indicated Resident 17 had mild cognitive impairment (difficulty understanding and making decisions), required maximal assistance or was dependent on facility staff for activities of daily living, including hygiene, mobility, and surface-to-surface transfer, and had a feeding tube. A review of Resident 17's History and Physical (H&P), dated 4/5/2024, indicated the resident has the capacity to understand and make decisions and has a history of dysphagia (difficulty swallowing) and is on gastrostomy tube feeding. A review of Resident 17's Order Summary Report indicated Resident 17 was ordered the following: - On 6/22/2024, nothing by mouth. - On 6/22/2024, provide Nepro 1.8 (a type of tube feeding formula) at 45 milliliters (ml - a unit of measure for volume) per hour for 20 hours to provide 900 ml per 1620 calories (a unit of measure for energy) in 24 hours via gastrostomy tube, off at 8:00 a.m. and on at 12:00 p.m. or until the dose is consumed, and may hold feedings during activities of daily living care, showers, and transfers. A review of Resident 17's Care Plan, last revised 6/27/2024, indicated Resident 17 had the potential for nutritional risks such as weight changes and compromised hydration due to need for feeding tube. The care plan further indicated interventions included change tubing, water bag, and syringe daily, labeled and dated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation, on 6/25/2024, at 9:48 a.m., inside Resident 17's room, Resident 17 had a tube feeding pole to the right of the resident with a Nepro 1.8 (a type of tube feeding formula) bottle hanging on the pole. The Nepro 1.8 bottle was connected to tubing that went through the tube feeding pump (device that administers tube feeding and water at a specified rate) and was connected to Resident 17. The tube feeding pump was off. The Nepro 1.8 bottle's label indicated the date 6/25 and did not indicate the rate the tube feeding was set to and the time the tube feeding was hung. During an interview with Licensed Vocational Nurse (LVN) 6, on 6/26/2024, at 2:08 p.m., LVN 6 stated tube feeding should be labeled with the resident's name, date, the rate of administration, and time when the feeding was started. LVN 6 further stated if tube feeding is not labeled properly, the facility would not know if the tube feeding is still good to use since the formula is only good for one day after puncturing the bottle and the facility would not know if the resident is getting the right amount of feeding. During an interview with the Director of Nursing (DON), on 6/28/2024, at 4:36 p.m., the DON stated it is important to label the resident's tube feeding with the rate and time to ensure residents receive the appropriate nutrition to prevent weight loss or gain. A review of the facility's policy and procedure (P&P) titled, Enteral Feeding - Closed, last reviewed 5/23/2024, indicated to label the formula container and tubing with the date and time hung.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 43988 Based on observation, interview and record review, the facility failed to administer parenteral fluids (the intravenous administration of medication) consistent with professional standards of practice for one (1) out of 1 sampled resident (Resident 79) during a random observation of a resident with intravenous (IV) catheter (a thin, flexible tube that is inserted into a vein to draw blood and give treatments including IV fluids, drugs, or blood transfusions) by failing to indicate the date when the IV catheter dressing was last changed. This deficient practice placed the residents at risk for developing complications such as inflammation of the vein and infection. Findings: A review of Resident 79's Admission Record indicated the facility admitted the resident on 10/23/2023 with diagnoses including pressure ulcer (PU) stage four (a sore that extend below the subcutaneous fat into the deep tissues, including muscle, tendons, and ligaments) of the sacral region (refers to bottom of the spine), and congestive heart failure (a condition in which the heart has trouble pumping blood through the body). A review of Resident 79's History and Physical, dated 4/22/2024, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 79's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 5/1/2024, indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and required partial/moderate assistance from staff with most activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated the resident had stage four (4) PU. A review of Resident 79's Order Summary Report indicated the following physician's order: -For midline (a long, thin, flexible tube that is inserted into a large vein in the upper arm used to safely administer medication into the bloodstream) placement. -6/24/2024 vancomycin hydrochloride (a type of medication used in the treatment of serious bacterial infections) for two (2) weeks. Diagnosis: Osteomyelitis. Pharmacy to dose. -6/27/2024 vancomycin hydrochloride IV solution use 1 gram (gm - a unit of measurement) intravenously one time a day for right foot cellulitis until 7/10/2024 for 2 weeks. Pharmacy to dose. During a concurrent observation and interview on 6/25/2024 at 2:15 p.m. inside Resident 79's room with Registered Nurse 2 (RN 2), observed an IV catheter on the resident's left upper arm with transparent dressing. The dressing did not indicate the date the IV catheter was inserted. RN 2 stated the midline catheter was inserted on 6/24/2024. RN 2 stated the dressing should have indicated the date the IV catheter was inserted to inform the nurses when the next dressing change is due. RN 2 stated it is important to change the IV dressing timely to prevent risk of acquiring infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/28/2024 at 4:45 p.m., the Director of Nursing (DON), the DON stated all IV catheter dressings regardless of catheter type should indicate the date they were inserted so the nurses would know when the next dressing change is due. The DON stated it is important to change the IV dressing timely to prevent the resident from developing infection from the insertion site. A review of the facility's policy and procedure tiled, Central Access Guidelines and Procedures, last reviewed 5/23/2024, indicated the following: -An occlusive dressing shall be maintained over the central venous access site at all times to reduce the risk of infection to the insertion or exit site and surrounding area of a device such as midline catheters. -Central, peripherally inserted central catheter (PICC - a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart), and midline catheter dressings shall be changed every seven (7) days from date of insertion. -Transparent semi-permeable (TSM) dressings are the dressing of choice for all Central, PICC, and midline catheters.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44376 Based on observation, interview, and record review, the facility failed to ensure residents who need respiratory care are provided care consistent with professional standards of practice to one of four sampled residents (Resident 376) investigated during review of respiratory care area by failing to ensure administer oxygen at 2 liters per minute (LPM, the flow of oxygen via oxygen delivery device) via nasal cannula (a device that gives additional oxygen through the nose) per physician order. The deficient practice had a potential for Resident 376 to develop shortness of breath that could lead to hypoxemia (a low level of oxygen in the blood). Findings: A review of Resident 376's Admission Record indicated the facility admitted the resident on 11/29/2023, with diagnoses including pleural effusion (occurs when fluids build up in the space between the lung and the chest wall), cognitive communication deficit (difficulty with any aspect of communication), atherosclerotic heart disease (thickening or hardening of the arteries). A review of Resident 376's History & Physical (H&P), dated 4/22/2024, indicated the resident did not have the capacity to make decisions and make needs known. A review of Resident 376's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/19/2024, indicated the resident had the ability to make self-understood and understand others. A review of Resident 376's Order Summary Report, dated 3/19/2024, indicated an order for oxygen at 2 LPM via nasal cannula to keep oxygen saturation (O2 sat, a measure of the amount of hemoglobin [a protein inside red blood cells that carries oxygen from the lungs to tissues] that is bound to molecular oxygen at a given time point) at/above 93% for shortness of breath (SOB) and wheezing (a high-pitched whistling sound made while breathing). May titrate (slowly increasing the dose) up to 5 LPM to keep O2 sat above 93%. Every shift for supplemental oxygen. A review of Resident 376's Care Plan titled, The resident has oxygen therapy related to pleural effusion, not elsewhere classified, last revised on 3/20/2024, indicated an intervention of oxygen at 2 LPM via nasal cannula to keep O2 sat at/above 93% for shortness of breath (SOB) and. May titrate up to 5 LPM to keep O2 sat above 93%. During a concurrent observation and interview on 6/25/2024, at 9:59 a.m., with Certified Nursing Assistant 1 (CNA 1), inside Resident 376's room, observed the oxygen concentrator (device that provides oxygen needed for oxygen therapy) off. CNA 1 stated the resident was not getting oxygen via nasal cannula because the oxygen concentrator was off. CNA 1 stated the oxygen via nasal cannula should be on to provide the oxygen needed by the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/25/2024, at 10:13 a.m., with Licensed Vocational Nurse 4 (LVN 4), reviewed Resident 376's Order Summary Report. LVN 4 stated the order indicated the resident should be given oxygen at 2 LPM continuously via nasal cannula. LVN 4 stated not providing resident oxygen as ordered placed the resident at risk for respiratory distress. During an interview on 6/28/2024, at 4:35 p.m., with the Director of Nursing (DON), the DON stated licensed nurses should administer oxygen via nasal cannula to Resident 376 as prescribed by the physician to prevent SOB and respiratory distress. A review of the facility's recent policy and procedure titled, Oxygen Therapy, last reviewed on 5/23/2024, indicated oxygen is administered under safe and sanitary conditions to meet resident needs. Licensed Nursing staff will administer oxygen as prescribed. Administer oxygen per physician orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 44244 Based on interview and record review, the facility failed to ensure residents who received hemodialysis (HD, process of removing waste products and excess fluid from the body) received treatment in consistent with professional standards of practice and the comprehensive person-centered care plan for one of one sampled resident (Resident 52) investigated during review of dialysis care are by failing to: 1. Ensure licensed nurses performed and documented assessments after Resident 52 returned from hemodialysis sessions. 2. Ensure licensed nurses acquired and maintained Resident 52's written documentation from the hemodialysis center. These deficient practices placed the resident at risk for a delay in detecting complications resulting from HD. Findings: A review of Resident 52's Admission Record indicated the facility admitted the resident on 11/4/2023 with diagnoses that included end stage renal disease (the kidneys cease functioning on a permanent basis), cerebrovascular disease (damage to tissues in the brain due to a loss of oxygen to the area), aphasia (a language disorder that affects a person's ability to communicate), and muscle weakness. A review of Resident 52's Minimum Data Set (MDS - an assessment and care screening tool) dated 5/13/2024, indicated the resident usually was able to understand others and usually was able to make himself understood. The MDS further indicated the resident was dependent on staff for toileting, putting on and taking off footwear, and transfers from chair to bed. A review of Resident 52's physician orders indicated the following orders: -Dialysis every Tuesday, Thursday, and Saturday, dated 6/6/2024. - If bleeding occurs at permacath (a flexible tube inserted in the chest wall and used for dialysis treatment) site any time after dialysis, apply pressure with clean gauze for five to ten minutes. Repeat until bleeding stops. If this intervention does not control bleeding, notify physician, as needed, dated 4/29/2024. -Observe permacath site right upper chest for redness, vascular access, tenderness, bleeding and drainage, every shift, dated 4/29/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 52's Care Plan (CP) titled, Resident on dialysis related to disease process, initiated 11/30/2023, indicated goals that the resident will have immediate intervention should any signs or symptoms of complications from dialysis occurred, and the resident would have no sign or symptoms from dialysis. The CP indicated interventions to monitor dialysis access site for signs and symptoms of bleeding and infection and to monitor vital signs as needed and every shift. During a concurrent interview and record review on 6/26/2024 at 2:19 p.m., Minimum Data Set Coordinator 1 (MDSC 1) reviewed Resident 52's physician orders. MDSC 1 stated Resident 52 goes every Tuesday, Thursday, and Saturday to Hemodialysis Center 1 (HDC 1) for HD. MDSC 1 stated the licensed nurse assesses the resident and documents before HD and when the resident returns from HD. During an interview on 6/27/2024 at 8:56 a.m., MDSC 1 stated the HDC 1 provides written communication with the facility after Resident 52's HD that includes a resident assessment of vital signs, weight, any medications administered during HD, and any comments or special instructions for the facility. MDSC 1 stated upon return from HD, the licensed nurse will complete and document a post HD assessment that includes the date and time the resident returned from HD, the vital signs (measurements of the body's most basic functions such as body temperature, heart [pulse] rate, respiration rate [rate of breathing], blood pressure [pressure of circulating blood against the walls of blood vessels]), and HD access site. MDSC 1 stated HD residents are assessed because they are higher risk for changes in condition including bleeding at the HD access site, changes in their blood pressure, and changes in their cardiovascular (the heart and the blood vessels) status. During an interview on 6/27/2024 at 9:12 a.m., Licensed Vocational Nurse 8 (LVN 8) stated she cares for Resident 52. LVN 8 stated when Resident 52 returns from HD, she reviews the written communication from HDC 1 then shreds the form. During a concurrent interview and record review on 6/27/2024 at 9:32 a.m., MDSC 1 reviewed Resident 52's Pre-Dialysis Evaluation forms for May/June 2024, Pre and Post Dialysis Assessment forms for May/June for 2024, Post Dialysis Evaluation forms for May/June 2024, Progress Notes for May/June 2024, and Weighs and Vitals Summary for May/June 2024 and noted the following: -On 5/16/2024, a Pre and Post Dialysis form was completed indicating the resident went to HD, there was no documentation to indicate a post HD assessment was completed. -On 5/18/2024, a Pre and Post Dialysis form was completed indicating the resident went to HD, there was no documentation to indicate a post HD assessment was completed. -On 5/23/2024, a Pre and Post Dialysis form was completed indicating the resident went to HD, there was no documentation to indicate a post HD assessment was completed. -On 5/25/2024, a Pre-Dialysis Evaluation form was completed indicating the resident went to HD, there was no documentation to indicate the facility received and maintained HDC 1's written assessment of Resident 52 or that a post HD assessment was completed. -On 5/30/2024, Pre-Dialysis and Post-Dialysis Evaluation forms were completed indicating the resident went to HD, there was no documentation to indicate the facility received and maintained HDC 1's written assessment of Resident 52. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 6/6/2024, a Pre-Dialysis Evaluation form was completed indicating the resident went to HD, there was no documentation to indicate the facility received and maintained HDC 1's written assessment of Resident 52 or that a post HD assessment was completed. - On 6/8/2024, a Pre-Dialysis Evaluation form was completed indicating the resident went to HD, there was no documentation to indicate a post HD assessment was completed. - On 6/15/2024, a Pre-Dialysis Evaluation form was completed indicating the resident went to HD, there was no documentation to indicate the facility received and maintained HDC 1's written assessment of Resident 52 or that a post HD assessment for the resident's vital signs was completed. - On 6/22/2024, Pre-Dialysis and Post-Dialysis Evaluation forms were completed indicating the resident went to HD, there was no documentation to indicate the facility received and maintained HDC 1's written assessment of Resident 52. - On 6/25/2024, Pre-Dialysis and Post-Dialysis Evaluation forms were completed indicating the resident went to HD, there was no documentation to indicate the facility received and maintained HDC 1's written assessment of Resident 52. MDSC 1 further stated if the licensed nurse did not receive HDC 1's written assessment after Resident 52's HD session, it is the licensed nurse's responsibility to follow up to obtain the information. During an interview on 6/27/2024 at 10:51 a.m. the Director of Nursing (DON) stated she was made aware that LVN 8 stated she shredded HDC 1's written assessments of Resident 52 before it was scanned and saved in the resident's clinical record. The DON stated the written documentation from HDC 1 has information that belongs to the resident and should be kept in the resident's chart. The DON stated LVN 8 should not shred resident documents. The DON stated the facility process for HD residents is the licensed nurse completes and documents a pre-dialysis assessment of the resident. During HD, the dialysis center completes a written assessment that returns to the facility with the resident. Upon the resident's return from HD, the LN reviews the dialysis centers assessment and completes and documents a post dialysis assessment. The DON stated the dialysis center's written assessments are then scanned and saved in the resident's clinical record in the computer. The DON stated HD residents are assessed before, during, and after HD because they are at risk for fluid overload (a condition where the body has too much fluid), edema (swelling caused by too much fluid trapped in the body's tissues), weakness, and hypotension (low blood pressure). The DON stated it was important to ensure all assessments are done and documented because it is proof of what happened, and staff uses this information to monitor the resident. The DON stated without resident assessments staff may miss something and they may not be aware of any changes in the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility provided policy and procedure titled, Dialysis Care, last reviewed 5/23/2024, indicated the purpose of the policy was to provide dialysis care for residents in renal failure and those residents who require ongoing dialysis treatments. The facility maintains a contract with a dialysis service which addresses communication between the facility and provider. The facility will arrange a method of communication between the dialysis provider and facility. Catheter: monitor site for redness, vascular access, tenderness, bleeding, and drainage. The Dialysis provider will communicate in writing to the facility any problems encountered while the resident was at the dialysis provider and any ongoing monitoring required. All documentation concerning dialysis services and care of the dialysis resident will be maintained in the resident's medical record. Dialysis communication record: the nursing staff will send a dialysis communication form to the dialysis center every time a resident is scheduled for off-site dialysis, the provider's dialysis nurse will be responsible for documentation of dialysis treatment, documentation will be maintained in the resident's medical record. A review of the facility provided policy and procedure titled, Completion and Correction, last reviewed 5/23/2024, indicated the purpose of the policy was to ensure that medical records are complete and accurate. No portion of the record is to be obliterated, erased, or destroyed. A review of HDC 1's Contract, dated 9/19/2024, indicated to facilitate continuity of care and timely transfer of patients and records between the dialysis center and the skilled nursing facility the HDC 1 agrees to comply with all requests for timely documentation on services provided to residents pursuant to Federal and State laws and regulations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 44376 Based on observation, interview, and record review the facility failed to ensure the safe and appropriate use of bed rails (adjustable rigid plastic bars attached to the bed that may be positioned in various locations on the bed; upper or lower, either or both sides) to two of two sampled residents (Residents 118 and 378) investigated during review of physical restraints by failing to ensure Residents 118 and 378 were properly assessed for risk for entrapment (an event in which a resident is caught, trapped, or entangled in the spaces in or about the bed rail, mattress, or bed frame), ensure there was a physician order for Resident 118 and 378's use of bed rails, ensure Residents 118 and 378 or their representative were educated with the risks and benefits of bed rails, and ensure an informed consent was obtained from Residents 118 and 378 or their representative prior to installation of bed rails. These deficient practices had the potential to result in the restriction of residents' freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment, and death of residents. Cross reference to F604. Findings: 1. A review of Resident 118's Admission Record indicated the facility admitted the resident on 5/14/2024, with diagnoses including surgical amputation (the loss or removal of a body part) of the right foot 5th digit, muscle weakness, and unsteadiness of the feet. A review of Resident 118's History and Physical (H&P), dated 5/18/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 118's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/21/2024, indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident required supervision on mobility and activities of daily living (ADLs). A review of Resident 118's Bed Rail Assessment, dated 5/14/2024, indicated the following: -Side Rails/Assist Bar are indicated and serve as an enabler to promote independence. -Side Rails/Assist Bar are not indicated at this time. A review of Resident 118's Fall Risk Evaluation, dated 5/14/2024, indicated the resident was high risk for potential falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 118's Care Plan titled, The resident is at risk for falls related to right ankle/foot osteomyelitis (an inflammation or swelling of bone tissue that is usually the result of an infection), status post (s/p) surgical amputation right 5th digit, impaired mobility, unsteadiness on feet, last revised on 6/19/2024, indicated interventions including the resident needs a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, handrails on walls, personal items within reach. During a concurrent observation, interview, and record review on 6/25/2024, at 2:31 p.m., with Registered Nurse 2 (RN 2) and the Assistant Director of Nursing (ADON), inside Resident 118's room, observed Resident 118's both upper bed rails up. Resident 118's Order Summary Report, Bed Rail Assessment, and Consents were reviewed with RN 2. RN 2 stated there was no physician order for bed rail use and the assessment for bed rail use indicated contradictory recommendations (side rail use was indicated, and side rail use was not indicated). RN 2 stated there was no informed consent and documentation the resident or representative were educated on the risk and benefits of bed rail use prior to use. During an interview on 6/26/2024, at 1:09 p.m., with Registered Nurse 1 (RN 1), RN 1 stated prior to installing bed rails there should be a physician order, a risk for entrapment assessment, an informed consent from the resident or representative and documentation the resident or representative were educated on the risk and benefits of bed rail use to prevent injuries to the resident. During an interview on 6/28/2024, at 4:35 p.m., with the Director of Nursing (DON), the DON stated before installing bed rails there should be a risk for entrapment assessment, a physician order and an informed consent from the resident or their representative to ensure resident safety. A review of the facility's recent policy and procedure titled, Side Rails, last reviewed on 5/23/2024, the Interdisciplinary Team (IDT)- Restraint Reduction Committee will determine whether a resident should be provided with side rails on his/her bed, based on an individual assessment which includes the risk of entrapment. Physical Restraint is defined by the Centers for Medicare and Medicaid Services (CMS) as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. (Note: the definition of restraint is based on the functional status of the resident and not on the device, therefore any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could be considered a restraint). The Licensed Nurse will maintain the Side Rail Evaluation in the resident's medical record and develop a Care Plan reflecting that assessment. Prior to placing a side rail on the bed informed consent will be obtained when side rail meets the definition of a physical restraint even when it is also used as an enabler. The space between the mattress and side rails and other potential entrapment zones will be assessed to reduce the risk of entrapment (the amount of safe space may vary depending on the type of bed and mattress being used) upon admission when side rails are required or after admission if side rails are required, or when a mattress is replaced. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility provided Owner's Manual titled, Bed Frame 1 (BF 1), last revised on 4/1/2018, indicated mattress must fit bed frame and assist rail snugly to help prevent patient entrapment. Patient entrapment with assist rail may cause injury or death. Please follow the manufacturer's instructions and monitor patient frequently. Assist rails/bars are intended only to assist the resident during bed entry and exit. These devices are not side rails, nor are they intended to be used in a manner that makes user entry and exit more difficult. Accurate assessment of the resident and monitoring of correct maintenance and equipment use are required to prevent entrapment. On March 10, 2006, the U.S. Food and Drug Administration (FDA) released guidelines for reducing the risk of hospital bed entrapment entitled; Hospital bed System Dimensional and Assessment Guidance to reduce Entrapment. This guidance document identifies potential entrapment areas within the bed frame, rails and mattress and identifies those body parts most at risk for entrapment. Potential risks of bed rails may include: -Strangling, suffocating, body injury or death when patients or part of their body are caught between rails or between the bed rails and mattress. -More serious injuries from falls when patients climb over rails. -Skin bruising, cuts, and scrapes. -Inducing agitated behavior when bed rails are used as a restraint. -Feeling isolated or unnecessarily restricted. -Preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet. 2. A review of Resident 378's Admission Record indicated the facility admitted the resident on 6/18/2024, with diagnoses including hepatic encephalopathy (a decline in brain function that occurs as a result of severe liver disease), seizures, and muscle weakness. A review of Resident 378's H&P, dated 6/21/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 378's Fall Risk Evaluation, dated 6/18/2024, indicated the resident was high risk for potential falls. During a concurrent observation, interview, and record review on 6/25/2024, at 2:31 p.m., with Registered Nurse 2 (RN 2) and the Assistant Director of Nursing (ADON), inside Resident 378's room, observed Resident 378's both upper bed rails up. Resident 378's Order Summary Report, assessments, and consents were reviewed with RN 2. RN 2 stated there was no physician order for bed rail use, no bed rail assessment, no informed consent obtained from the resident or representative and no documentation the resident and their representative were educated on the risk and benefits of bed rail use prior to use. During an interview on 6/28/2024, at 4:35 p.m., with the Director of Nursing (DON), the DON stated before applying bed rails there should be a risk for entrapment assessment, a physician order and an informed consent from the resident or their representative to ensure resident safety. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's recent policy and procedure titled, Side Rails, last reviewed on 5/23/2024, the Interdisciplinary Team (IDT)- Restraint Reduction Committee will determine whether a resident should be provided with side rails on his/her bed, based on an individual assessment which includes the risk of entrapment. Physical Restraint is defined by the Centers for Medicare and Medicaid Services (CMS) as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. (Note: the definition of restraint is based on the functional status of the resident and not on the device, therefore any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could be considered a restraint). The Licensed Nurse will maintain the Side Rail Evaluation in the resident's medical record and develop a Care Plan reflecting that assessment. Prior to placing a side rail on the bed informed consent will be obtained when side rail meets the definition of a physical restraint even when it is also used as an enabler. The space between the mattress and side rails and other potential entrapment zones will be assessed to reduce the risk of entrapment (the amount of safe space may vary depending on the type of bed and mattress being used) upon admission when side rails are required or after admission if side rails are required, or when a mattress is replaced. A review of the facility provided Owner's Manual titled, BF 1, last revised on 4/1/2018, indicated mattress must fit bed frame and assist rail snugly to help prevent patient entrapment. Patient entrapment with assist rail may cause injury or death. Please follow the manufacturer's instructions and monitor patient frequently. Assist rails/bars are intended only to assist the resident during bed entry and exit. These devices are not side rails, nor are they intended to be used in a manner that makes user entry and exit more difficult. Accurate assessment of the resident and monitoring of correct maintenance and equipment use are required to prevent entrapment. On March 10, 2006, the U.S. Food and Drug Administration (FDA) released guidelines for reducing the risk of hospital bed entrapment entitled; Hospital bed System Dimensional and Assessment Guidance to reduce Entrapment. This guidance document identifies potential entrapment areas within the bed frame, rails and mattress and identifies those body parts most at risk for entrapment. Potential risks of bed rails may include: -Strangling, suffocating, body injury or death when patients or part of their body are caught between rails or between the bed rails and mattress. -More serious injuries from falls when patients climb over rails. -Skin bruising, cuts, and scrapes. -Inducing agitated behavior when bed rails are used as a restraint. -Feeling isolated or unnecessarily restricted. -Preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on interview, and record review the facility failed to: 1. Account for two doses of narcotics (also known as Controlled Medications or Controlled Substances [CM, CS]- medications which have a potential for abuse and may also lead to physical or psychological dependence) for Resident 63 and 226 in one of two inspected medication carts (Station 1 Cart 1.) 2. Account for one dose of narcotic for Resident 12 in one of two inspected medication carts (Station 3 Cart 3A.) 3. Document the disposition (destruction) of medications (drugs) on the Drug Disposition Record logs in three of three inspected Medication Rooms. These deficient practices increased the opportunity for non-controlled and CS diversion (the transfer of a controlled substance or other medication from a lawful to an unlawful channel of distribution or use) and increased the risk that Resident 12, 63 and 226 could have delayed medication treatment and continuity of care due to lack of availability of the CS, and accidental exposure to harmful medications, possibly leading to physical and psychosocial harm. Findings: During an observation on [DATE] at 12:08 PM, with Licensed Vocational Nurse (LVN) 1, in Medication Cart Station 1 Cart 1, there was a discrepancy in the count between the Individual Narcotic Record accountability log and the amount of medication remaining in the medication bubble pack (medication packaging system that contains individual doses of medication per bubble) for the following resident: 1. One dose of hydrocodone with acetaminophen (a combination CS used for pain) ,d+[DATE] milligram ([mg] - a unit of measure of mass) tablet was missing from the medication bubble pack compared to the count indicated on the Individual Narcotic Record accountability log for Resident 63. The Individual Narcotic Record accountability log for hydrocodone with acetaminophen indicated the medication bubble pack should have contained a total of 24 hydrocodone with acetaminophen ,d+[DATE] mg tablets, after the last administration of hydrocodone with acetaminophen ,d+[DATE] mg documented/signed-off on [DATE] at 10 AM, however the medication bubble pack contained 23 hydrocodone with acetaminophen ,d+[DATE] mg tablets and contained no other documentation of subsequent administrations. 2. One dose of pregabalin (a CS used for neuropathy [disease of nerves causing numbness and weakness]) 100 mg tablet was missing from the medication bubble pack compared to the count indicated on the Individual Narcotic Record accountability log for Resident 226. The Individual Narcotic Record accountability log for pregabalin indicated the medication bubble pack should have contained a total of 6 pregabalin 100 mg tablets, after the last administration of pregabalin 100 mg documented/signed-off on [DATE] at 5 PM, however, the medication bubble pack contained 5 pregabalin 100 mg tablets and contained no other documentation of subsequent administrations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, LVN 1 stated LVN 1 administered 1 hydrocodone with acetaminophen , d+[DATE] mg tablet to Resident 63 and 1 pregabalin 100 mg tablet to Resident 226 that morning at 9:00 AM and forgot to sign the Individual Narcotic Record accountability log. LVN 1 stated LVN 1 failed to follow the facility's policy of signing each CS dose on the Individual Narcotic Record accountability log after administering the dose for each resident. LVN 1 stated LVN 1 understands it is important to sign each dose once prepared to ensure accountability, prevention of CS diversion, and accidental exposures of harmful substances to residents. LVN 1 stated if documentation is not accurate then it can lead to medication error if overdosed (administering more than the prescribed dose) leading to overdose and possibly death stoppage of breathing for Residents 63 and 226. During an observation on [DATE] at 1:22 PM, with LVN 2, in Medication Cart Station 3 Cart 3A, there was a discrepancy in the count between the Individual Narcotic Record accountability log and the amount of medication remaining in the medication bubble pack (medication packaging system that contains individual doses of medication per bubble) for the following resident: 1. One dose of oxycodone with acetaminophen (a combination CS used for pain) ,d+[DATE] mg tablet was missing from the medication bubble pack compared to the count indicated on the Individual Narcotic Record accountability log for Resident 12. The Individual Narcotic Record accountability log for oxycodone with acetaminophen indicated the medication bubble pack should have contained a total of 38 oxycodone with acetaminophen ,d+[DATE] mg tablets, after the last administration of oxycodone with acetaminophen , d+[DATE] mg documented/signed-off on [DATE] at 9 AM, however the medication bubble pack contained 37 oxycodone with acetaminophen ,d+[DATE] mg tablets and contained no other documentation of subsequent administrations. During a concurrent interview, LVN 2 stated LVN 2 administered 1 oxycodone with acetaminophen , d+[DATE] mg tablet to Resident 12 that afternoon at 1 PM and forgot to sign the Individual Narcotic Record accountability log. LVN 2 stated LVN 2 failed to follow the facility's policy of signing each CS dose on the Individual Narcotic Record accountability log after administering the dose for each resident. LVN 2 stated LVN 2 understands it is important to sign each dose once prepared to ensure accountability, prevention of CS diversion, and accidental exposures of harmful substances to residents. LVN 2 stated CS are high risk medications and if documentation is not accurate then it can lead to medication error by overdosing (administering more than the prescribed dose) causing respiratory depression (stoppage of breathing) and death for Residents 12. During an observation on [DATE] at 9:08 AM, with Registered Nurse (RN) 1, in Medication Room Station 3, the Drug Disposition Record log was last documented on [DATE] for the disposition of non-controlled medications. During a concurrent interview, in the presence of LVN 2, RN 1 stated that the binder containing the Drug Disposition Record logs was last documented for the disposition of non-controlled medication for Medication Room Station on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:14 AM, with LVN 2, LVN 2 stated that when non-controlled medications that are discontinued, expired, changed or when residents are discharged needed to be disposed of and the disposition documented on the Drug Disposition Record log. LVN 2 stated this process happens quite frequently and several times a week, and it was unlikely that there would not be any medication dispositions since [DATE]. LVN 2 stated the Drug Disposition Record logs were not being consistently documented by several licensed nurses when disposing medications which can potentially create the opportunity for medication diversion. During an observation on [DATE] at 10:25 AM, with RN 1, in Medication Room Station 2, the Drug Disposition Record log contained no documentation for the disposition of non-controlled medications. During a concurrent interview, RN 1 stated that Medication Room Station 1 and 2 use the same binder containing the Drug Disposition Record logs as Medication Room Station 3 and there was no documentation for the disposition of medications documented in the binder for Medication Room Station 2. During an observation on [DATE] at 10:44 AM, with LVN 1, in Medication Room Station 1, the Drug Disposition Record log was last documented on [DATE] for the disposition of non-controlled medications for Station 1. LVN 1 stated all medication rooms share the same binder containing the Drug Disposition Record logs. LVN 1 stated medications were frequently disposed of several times a week and it was unlikely that there would not be medication dispositions since [DATE]. LVN 1 stated the Drug Disposition Record logs were not being consistently documented by several licensed nurses when disposing medications and without accountability for the disposal there was potential for medication diversion. During an interview on [DATE] at 12:48 PM, with the Director of Nursing (DON,) the DON stated that licensed nurses during the night shift are responsible for the disposition of non-controlled medications in all 3 medication rooms. The DON stated that all 3 medication rooms use the same binder that contains the Drug Disposition Record logs to be used for the disposition of non-controlled medications. The DON stated that the binder does not contain any documentation for the disposition of non-controlled substances for Medication room [ROOM NUMBER] and contains documentation for the disposition of non-controlled substances on [DATE] and [DATE] for Medication room [ROOM NUMBER] and 3, respectively. The DON stated perhaps due to lack of education facility licensed nurses failed to document the disposition of medications on the Drug Disposition Record logs. The DON stated without documentation and accountability there was the potential for medication diversion. The DON stated education will be provided immediately and separate binders created for each medication room for accessibility of the Drug Disposition Record logs during disposition. During an interview on [DATE] at 10:37 AM, with the DON, DON stated LVN 1 and 2 failed to follow policy of documenting the preparation of CS on the Individual Narcotic Record accountability log for Residents 12, 63 and 226. The DON stated not having accurate records can lead to diversion, as well as underdose (administering less than the prescribed dose) or overdose of Resident 12, 63 and 226 causing unnecessary adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) negatively impacting their health and wellbeing. During a review of Resident 12's Admission Record (a document containing demographic and diagnostic information,) dated [DATE], the Admission Record indicated Resident 12 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnose of Pressure Ulcer (Injury to skin and the tissue beneath resulting from prolonged pressure on the skin causing pain.) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 12's (Medication Administration Record ([MAR] - a record of mediations administered to residents), for [DATE], the MAR indicated Resident 12 was prescribed oxycodone with acetaminophen ,d+[DATE] mg tablet every 4 hours as needed for moderate to severe pain, starting [DATE], with a dose administered on [DATE] for a pain level of 9 by LVN 1. During a review of Resident 63's Admission Record, dated [DATE], the Admission Record indicated Resident 63 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnose of Pressure Ulcer (Injury to skin and the tissue beneath resulting from prolonged pressure on the skin causing pain.) During a review of Resident 63's MAR for [DATE], the MAR indicated Resident 63 was prescribed hydrocodone with acetaminophen ,d+[DATE] mg tablet every 4 hours as needed for moderate to severe pain, starting [DATE], with a dose administered on [DATE] for a pain level of 9 by LVN 1. During a review of Resident 226's Admission Record, dated [DATE], the Admission Record indicated Resident 226 was originally admitted to the facility on [DATE] with a diagnosis including muscle weakness. During a review of Resident 226's MAR for [DATE], the MAR indicated Resident 226 was prescribed pregabalin 100 mg tablet two times a day for neuropathy, starting [DATE], with a dose administered on [DATE] at 7:15 AM by LVN 1. Review of the policy and procedures (P&P), titled Controlled Substances, dated [DATE], the P&P indicated that Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. A. The Director of Nursing and the Consultant Pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. F. Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the Medication Administration Record (MAR): a. Date and time of administration (MAR, Accountability Record). b. Amount administered (Accountability Record). c. Remaining quantity (Accountability Record). d. Initials of the nurse administering the dose, completed after the medication is actually administered (MAR, Accountability Record) Review of the P&P, titled Medication Destruction for Non-Controlled Medications, dated [DATE], the P&P indicated that Discontinued medications and medications left in the facility after a resident's discharge .are destroyed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. The licensed healthcare professionals witnessing the destruction ensure the following information is entered on the medication disposition form: 1) Date of destruction. 2) Resident's name. 3) Name and strength of medication. 4) Prescription number, if applicable. 5) Amount of medication destroyed. 6) Signatures of witnesses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on interview and record review, the facility failed to ensure one (1) of three (3) sampled residents (Resident 67) drug regimen was free from unnecessary medications (any medication in excessive dose, excessive duration, without adequate monitoring) in accordance with the facility policy and procedure from 3/27/2024 to 5/6/2024 by failing to ensure: 1. Resident 67 had a specific, measurable target behavior related to the use of Risperdal (antipsychotic drug [a medication capable of affecting the mind, emotions, and behavior] used to treat mental illness) 2. Resident 67 was monitored for the number of specific occurrences of delusions with the use of Risperdal 3. Resident 67 was monitored for the side effects (also known as adverse effects - unwanted, uncomfortable, or dangerous effects that a drug may have) of Risperdal 4. Resident 67 was provided non-pharmacological (that do not involve medications or drugs) interventions (therapies) for delusions. These deficient practices had the potential to place Resident 67 at risk for significant adverse effects from the use of unnecessary antipsychotic drugs, which could result to impairment or decline in the residents' mental, physical condition, functional, and psychosocial status. Cross reference to F656 Findings: During a review of Resident 67's Admission Record (a document containing demographic and diagnostic information,) dated 06/26/2024, the Admission Record indicated Resident 67 was originally admitted to the facility on [DATE] with diagnosis including dementia (loss of memory and other mental abilities severe enough to interfere with daily life.) During a review of Resident 67's Minimum Data Set (MDS - a comprehensive resident assessment tool), dated 02/1/2024, indicated resident was moderately impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. MDS indicated Resident 67 had no mood and no behavioral symptoms, including no delusions. MDS indicated no psychiatric or mood disorder diagnosis. MDS indicated Resident 67 received antipsychotics on a routine basis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 67's Medication Administration Record ([MAR] - a record of mediations administered to residents) for March through May 2024, the MAR indicated Resident 67 was prescribed Risperdal 0.5 milligram ([mg] - a unit of measure of mass) to give one tablet by mouth twice a day for delusions, from 03/27/2024 to 05/06/2024. The MAR contained no documentation for monitoring the specific occurrence of delusions, adverse effects of Risperdal, or use of alternative therapies to Risperdal. During a review of the facility's pharmacy consultant (PC) Monthly Regimen Review (MRR), dated 04/25/2024, indicated Resident 67 had been on Risperdal for delusions. The review indicated, lacks an allowable diagnosis to support its use. In the column marked 'Follow-Through, documentation stated, Note written to physician. During an interview on 06/26/2024 at 2:32 PM, with Licensed Vocational Nurse (2), LVN 2 stated that Resident 67's Risperdal order for delusions is not a specific target behavior and the clinical record does not include monitoring for the specific occurrences of delusions by tally marks on the MAR, does not include monitoring for the side effects of Risperdal, and does not include alternate therapies to the use of Risperdal. LVN 2 stated without monitoring specific occurrences of delusions it will be unknown if Risperdal was effective in reducing the target behavior for Resident 67, without adequate side effect monitoring of Risperdal it may harm Resident 67 by causing dizziness and sedation, and without alternate therapies Risperdal maybe used unnecessarily further causing harm by negatively affecting the physical and psychosocial well-being of Resident 67. During a concurrent record review of Resident 67's clinical record, MAR and MRR and an interview on 06/28/2024 at 10:37 AM, with the Director of Nursing (DON,) the DON stated that Resident 67's order of Risperdal for delusions was not targeting a specific behavior. The DON stated the MRR indicated a note was written to the physician and the DON is unable to locate a response from the physician to the PC note. The DON stated that after a thorough search of Resident 67's clinical record the DON is unable to locate the care plan for the specific occurrences of delusions, the monitoring of side effects of Risperdal, and non-pharmacological interventions to the use of Risperdal. The DON also stated that the DON is unable to locate the monitoring of the specific occurrences of delusions and side effects on the MAR. The DON stated that monitoring for specific occurrences of delusions was important to measure effectiveness of Risperdal and when to make medication changes, such as lowering the dose or discontinuing. The DON stated that monitoring for side effects of Risperdal was important to ensure Resident 67 did not have unnecessary side effects such as tardive dyskinesia (uncontrolled face muscle movements,) akathisia (inability to hold still,) tremors, dizziness, sedation causing negative impact on their health and well-being. The DON stated the facility failed to include specific target behaviors for the use of Risperdal, monitor the specific occurrences of delusions, side effects of Risperdal, and use of alternate therapies for Resident 67. Review of the facility's Policy and Procedures (P&P,) titled Behavior/Psychoactive Drug Management, dated November 2018, the P&P indicated: It is the policy of the Facility to provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being. Definitions (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Antipsychotic medications - these are also called major tranquilizers or neuroleptics. These are the most powerful and dangerous of the psychotropic medication. Because of this they are the most highly regulated drugs used in the Skilled Nursing Facilities. Procedures I. Assessment A. Upon admission, quarterly, annually, and upon change of condition, the interdisciplinary Team (IDT) will collect and assess information about the resident including but not limited to past life experiences, description of behaviors, preferences .cognitive status and related abilities and medications. II. Interventions A. Non-pharmacological interventions i. Upon identification of factors that may contribute to a resident's mood or behavior symptoms, the Licensed Nurse shall initiate .Behavior Log with Non-pharmacological interventions. ii. The Licensed Nurse will notify and collaborate with the Attending Physician/Prescriber, family, resident, Responsible Party, and/or IDT members regarding the identified contributing factors to the resident's mood/behavior problems and the non-drug interventions taken to address the problems, as well as to evaluate the effectiveness of the non-drug interventions for further recommendations. iii. The Licensed Nurse will document the interventions taken and recommendations in the resident's Care Plan. F. Any order for psychoactive medications must include: v. Specific behavior manifested. H. Parameters for using Antipsychotics: ii. The resident's behavior symptoms should meet at least one of the following criteria in order to justify the use of antipsychotic medication: a. The symptoms are due to mania or psychosis (such as auditory, visual, or other hallucinations, delusions b. The behavior symptoms present a danger (documented) to the resident or others; or c. The symptoms are significant enough that the resident is experiencing one or more of the following: 1. Inconsolable or persistent distress 2. A significant decline in functions; or (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Substantial difficult receiving care I. Monitoring for Side Effects i. Depending on the specific classification of psychoactive mediation the resident should be observed and/or monitored for side effects and adverse consequences. ii. General/anticholinergic: constipation, blurred vision, dry mouth, urinary retention, sedation v. Neurologic: Akathisia, dystonia, extrapyramidal effects, akinesia; or tardive dyskinesia, stroke or TIA III. Evaluation A. Following admission, completion of MDS, quarterly, annually and upon significant change of condition, the IDT will review the following and make recommendations based on the resident's need: i. The effectiveness of non-drug interventions ii. Need for psychotropic medication; iii. Possible alternatives to use of psychotropic medications D. Documentation Requirements: ii. The Care Plan reflects the non-drug interventions prior to drug treatment, use of psychoactive medications, adverse reactions to psychoactive medications . iv. Occurrences of behaviors for which psychoactive medications are in use will be entered with hash marks (#) on the MAR every shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview and record review the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) to three out of three sampled residents (Residents 7, 118, and 109) investigated during review of insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin administration sites. The deficient practice had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross reference with F658. Findings: 1. A review of Resident 7's Admission Record indicated the facility admitted the resident on 1/19/2024, with diagnoses including type 2 diabetes mellitus (a disease in which the body does not control the amount of glucose [a type of sugar] in the blood) with diabetic chronic kidney disease (a decrease in kidney function that occurs in some residents who have diabetes) and diabetic peripheral neuropathy (a type of nerve damage that can occur with diabetes). A review of Resident 7's History and Physical (H&P), dated 4/26/2023, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 7's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/1/2024, indicated the resident had the ability to make self-understood and understand others. The MDS indicate the resident was receiving high-risk drug class hypoglycemic medication (a group of drugs used to help reduce the amount of sugar present in the body). A review of Resident 7's Order Summary Report indicated the following orders: -5/5/2024 Insulin Aspart Injection Solution 100 units per milliliters (unit/ml, a standardized way to quantify the effect of the medication) (Insulin Aspart). Inject as per sliding scale (varies the dose of insulin based on blood sugar level): if 70-149= 0 units; hypoglycemia (low blood sugar) protocol if blood glucose (BG) less than or equal to 70 mg/dl; 150-199= 2 units; 200-249= 3 units; 250-299= 5 units; 300-349= 7 units. Greater than 349 milligrams per deciliter (mg/dl, a milligram is one-thousandth of a gram), administer 10 units and inform MD immediately, subcutaneously before meals and at bedtime for diabetes mellitus (DM). Rotate injection sites. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-6/22/2024 Insulin Detemir Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Detemir). Inject 16 unit subcutaneously one time a day for DM. A review of Resident 7's Location of Administration of insulin for 4/2024 to 6/2024, indicated the insulin was administered on: -Insulin Detemir Subcutaneous Solution Pen-Injector 100 unit/ml 4/28/2024 at 9:18 a.m. Arm-left 4/29/2024 at 8:07 a.m. Arm-left -Insulin Glargine Solution 100 unit/ml 4/8/2024 at 6 p.m. Abdomen-Left Upper Quadrant (LUQ) 4/8/2024 at 8:55 p.m. Abdomen-LUQ 4/12/2024 at 9:42 a.m. Arm-left 4/13/2024 at 8:38 a.m. Arm-left Insulin Aspart Injection Solution 100 unit/ml 4/25/2024 at 7:23 a.m. Arm-left 4/25/2024 at 2:34 p.m. Arm-left 4/26/2024 at 6:47 a.m. Arm-right 4/26/2024 at 1:14 p.m. Arm-right 4/26/2024 at 3:31 p.m. Arm-left 4/26/2024 at 9:27 p.m. Arm-left 4/28/2024 at 6:37 p.m. Arm-right 4/28/2024 at 9:21 p.m. Arm-right 4/29/2024 at 4:41 p.m. Abdomen-Left Lower Quadrant (LLQ) 4/29/2024 at 10:40 p.m. Abdomen-LLQ 5/1/2024 at 6:27 p.m. Arm-right 5/1/2024 at 9:36 p.m. Arm-right (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/3/2024 at 4:41 p.m. Arm-right 5/3/2024 at 9:42 p.m. Arm-right 5/4/2024 at 4:55 p.m. Arm-right 5/4/2024 at 9:40 p.m. Arm-right 5/24/2024 at 5:50 p.m. Arm-right 5/24/2024 at 8:58 p.m. Arm-right 5/25/2024 at 6:44 a.m. Arm-right 5/25/2024 at 6:36 p.m. Abdomen-LLQ 5/25/2024 at 6:31 p.m. Abdomen-LLQ During a concurrent interview and record review on 6/26/2024, at 1:24 p.m., with Registered Nurse 2 (RN 2), reviewed Resident 7's Order Summary Report and the Location of Administration of insulin from 4/2024 to 6/2024. RN 2 stated there were multiple instances that the sites of insulin administration of insulin were not rotated. RN 2 stated insulin administration sites should be rotated to prevent lipodystrophy and bruising and hardening of the tissues. RN 2 stated not rotating insulin administration sites constitutes a medication error. During an interview on 6/28/2024, at 4:35 p.m., with the DON, the DON stated it is important to rotate insulin administration sites to prevent phlebitis (inflammation of a vein) and lipodystrophy. The DON stated not rotating insulin administration sites constitute medication error. The DON stated medication error results from not following the physician's order, professional nursing practice and manufacturer guidelines. A review of the facility's recent policy and procedure titled, Medication-Errors, last reviewed on 5/23/2024, indicated medication error means the administration of medication: D. Via the wrong route; or E. Which is not currently prescribed. A review of the facility provided Highlights of Prescribing Information titled, Insulin Aspart Injection, for subcutaneous or intravenous use, with initial U.S. Approval in 2000, indicated to rotate injection sites within the same region for one injection to the next to reduce risk of lipodystrophy and localized cutaneous amyloidosis. A review of the facility provided Highlights of Prescribing Information titled, Levemir (insulin detemir injection), for subcutaneous use, with initial U.S. Approval in 2005, indicated to rotate injection sites within an injection area (abdomen, thigh, or deltoid) to reduce the risk of lipodystrophy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 118's Admission Record indicated the facility admitted the resident on 5/14/2024, with diagnoses including type 2 diabetes mellitus and obesity (abnormal or excessive fat accumulation that presents a risk to health). A review of Resident 118's H&P, dated 5/18/2024, indicated the resident had the capacity to understand and make decisions. The MDS indicated the resident had the ability to make self-understood and understand others. The MDS indicate the resident was on a high-risk drug class hypoglycemic medication. A review of Resident 118's Order Summary Report indicated the following orders: -5/15/2024 Insulin Lispro Injection Solution 100 unit/ml (Insulin Lispro). Inject as per sliding scale: if 0-149= 0 units. If less than or equal to 70 mg/dl- hypoglycemia protocol; 150-199= 3 units; 200-249= 4 units; 250-299= 7 units; 300-349= 10 units; 350-399= 12 units. 399 or more- call doctor, subcutaneously before meals and at bedtime for type 2 DM. Rotate injection sites. -5/15/2024 Novolog Mix 70/30 FlexPen Subcutaneous Suspension Pen-injector (70-30) 100 unit/ml (Insulin Aspart Protamine & Aspart [Human]). Inject 8 unit subcutaneously two times a day for type 2 DM. Rotate injection sites. A review of Resident 118's Location of Administration of insulin for 5/2024 to 6/2024, indicated insulin was administered on: -Insulin Lispro Injection Solution 100 unit/ml 5/17/2024 at 5:19 p.m. Abdomen-LLQ 5/17/2024 at 9:04 p.m. Abdomen-LLQ 5/18/2024 at 5:21 p.m. Abdomen-LLQ 6/2/2024 at 6:09 a.m. Arm-left 6/2/2024 at 5:26 a.m. Arm-left 6/4/2024 at 9:22 p.m. Abdomen-Right Lower Quadrant (RLQ) 6/6/2024 at 6:11 p.m. Abdomen-RLQ 6/6/2024 at 4:53 p.m. Abdomen-RLQ 6/7/2024 at 6:54 p.m. Abdomen-RLQ 6/12/2024 at 10:11 p.m. Abdomen-RLQ 6/13/2024 at 5:28 p.m. Abdomen-RLQ 6/16/2024 at 5:57 a.m. Abdomen-LLQ (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/16/2024 at 7:32 a.m. Abdomen-LLQ 6/17/2024 at 5:39 a.m. Abdomen-LLQ 6/18/2024 at 5:47 p.m. Abdomen-RLQ 6/19/2024 at 6:22 a.m. Abdomen-RLQ 6/27/2024 at 8:14 p.m. Abdomen-RLQ 6/28/2024 at 10:30 a.m. Abdomen-RLQ -Novolog Mix 70/30 FlexPen Subcutaneous Suspension Pen-Injector (70/30) 100 unit/ml 6/2/2024 at 6:09 a.m. Arm-left 6/2/2024 at 5:26 p.m. Arm-left 6/6/2024 at 4:56 p.m. Abdomen-RLQ 6/7/2024 at 6:54 a.m. Abdomen-RLQ 6/16/2024 at 5:57 p.m. Abdomen-LLQ 6/16/2024 at 7:32 p.m. Abdomen-LLQ 6/17/2024 at 5:39 a.m. Abdomen-LLQ During a concurrent interview and record review on 6/26/2024, at 1:24 p.m., with RN 2, reviewed Resident 118's Order Summary Report and the Location of Administration of Insulin from 5/2024 to 6/2024. RN 2 stated there were multiple instances that the sites of insulin administration of insulin were not rotated. RN 2 stated insulin administration sites should be rotated to prevent lipodystrophy and bruising and hardening of the tissues. RN 2 stated not rotating insulin administration sites constitutes a medication error. During an interview on 6/28/2024, at 4:35 p.m., with the DON, the DON stated it is important to rotate insulin administration sites to prevent phlebitis (inflammation of a vein) and lipodystrophy. The DON stated not rotating insulin administration sites constitute medication error. The DON stated medication error results from not following the physician's order, professional nursing practice and manufacturer guidelines. A review of the facility's recent policy and procedure titled, Medication-Errors, last reviewed on 5/23/2024, indicated medication error means the administration of medication: D. Via the wrong route; or E. Which is not currently prescribed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility provided Highlights of Prescribing Information titled, Humalog (insulin lispro) injection, for subcutaneous or intravenous use, with initial U.S. Approval in 1996, indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. A review of the facility provided Highlights of Prescribing Information titled, Humulin 70/30 (70% human insulin isophane suspension and 30% human insulin injection [rDNA origin]) injectable suspension, for subcutaneous use, with initial U.S. Approval in 1989, indicated Humulin 70/30 should only be administered subcutaneously. Administer in the subcutaneous tissue of the abdominal wall, thigh, upper arm, or buttocks. To reduce the risk of lipodystrophy, rotate the injection site within the same region from one injection to the next. 3. A review of Resident 109's Admission Record indicated the facility admitted the resident on 4/13/2024, with diagnoses including type 2 diabetes mellitus, dysphagia (difficulty swallowing), and gastro-esophageal reflux disease (GERD, a common condition in which the stomach contents move up into the esophagus). A review of Resident 109's H&P, dated 4/15/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 109's MDS, dated [DATE], indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident was receiving high-risk drug class hypoglycemic medication. A review of Resident 109's Order Summary Report indicated the following orders: -6/11/2024 Insulin Glargine Subcutaneous Solution 100 unit/ml (Insulin Glargine). Inject 20 unit subcutaneously at bedtime for DM. -4/13/2024 Insulin Lispro Injection Solution 100 unit/ml (Insulin Lispro). Inject as per sliding scale: if 0-149= 0 units; 150-199= 1 unit; 200-249= 2 units; 250-299= 3 units; 300-349= 4 units; 350-399= 5 units; 400-999= 6 units, subcutaneously before meals and at bedtime for DM. A review of Resident 109's Location of Administration of insulin for 4/2024 to 6/2024, indicated the insulin was administered on: -Insulin Lispro Injection Solution 100 unit/ml 4/17/2024 at 11:39 a.m. Arm-right 4/17/2024 at 8:40 p.m. Arm-right 4/22/2024 at 9:04 a.m. Abdomen-LUQ 4/23/2024 at 6:12 p.m. Abdomen-LUQ 4/23/2024 at 10:05 a.m. Abdomen-LUQ 5/1/2024 at 9:13 p.m. Abdomen-Right Upper Quadrant (RUQ) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/2/2024 at 4:42 p.m. Abdomen-RUQ 5/3/2024 at 7:04 p.m. Arm-right 5/5/2024 at 5:34 a.m. Arm-right 5/10/2024 at 8:21 p.m. Abdomen-LUQ 5/12/2024 at 4:19 p.m. Abdomen-LUQ 5/24/2024 at 8:37 p.m. Abdomen-LUQ 5/25/2024 at 5:01 p.m. Abdomen-LUQ 6/13/204 at 11:39 a.m. Abdomen-RLQ 6/13/2024 at 8:47 p.m. Abdomen-RLQ 6/14/2024 at 8:52 p.m. Abdomen-LUQ 6/15/2024 at 4:53 p.m. Abdomen-LUQ 6/21/2024 at 6:33 p.m. Abdomen RLQ 6/21/2024 at 9:58 p.m. Abdomen-RLQ 6/23/2024 at 9:52 p.m. Abdomen-LUQ 6/24/2024 at 11:20 a.m. Abdomen-LUQ -Insulin Glargine Subcutaneous Solution 100 unit/ml 4/16/2024 at 5:20 p.m. Arm-left 4/17/2024 at 5:50 a.m. Arm-left 4/28/2024 at 5:47 a.m. Arm-left 4/28/2024 at 4:31 p.m. Arm-left 6/13/2024 at 8:47 p.m. Abdomen-LUQ 6/14/2024 at 8:39 p.m. Abdomen-LUQ (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/26/2024, at 1:24 p.m., with RN 2, reviewed Resident 109's Order Summary Report and the Location of Administration of Insulin from 4/2024 to 6/2024. RN 2 stated there were multiple instances that the sites of insulin administration of insulin were not rotated. RN 2 stated insulin administration sites should be rotated to prevent lipodystrophy and bruising and hardening of the tissues. RN 2 stated not rotating insulin administration sites constitutes a medication error. During an interview on 6/28/2024, at 4:35 p.m., with the DON, the DON stated it is important to rotate insulin administration sites to prevent phlebitis (inflammation of a vein) and lipodystrophy. The DON stated not rotating insulin administration sites constitute medication error. The DON stated medication error results from not following the physician's order, professional nursing practice and manufacturer guidelines. A review of the facility provided Highlights of Prescribing Information titled, Humalog (insulin lispro) injection, for subcutaneous or intravenous use, with initial U.S. Approval in 1996, indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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** 43455 Based on observation, interview, and record review the facility failed to record the medication refrigerator temperatures twice a day from June 1, 2024 to June 26, 2024 in two of three inspected medication rooms (Medication room [ROOM NUMBER] and 3.) These failures increased the potential for residents in the facility to receive medications that were ineffective or toxic due to the inadequate storage monitoring, and potentially experience medication adverse consequences resulting in the negative impact to residents' health and well-being. Findings: During an observation and concurrent interview on 06/26/2024 at 9:08 AM, with Registered Nurse (RN) 1, in the Medication Room Station 3, the refrigerator temperature monitoring log was observed containing documentation for the temperature once a day during the 11 PM to 7 AM shift from 06/01/2024 to 06/26/2024. RN 1 stated that the refrigerator temperature was monitored and documented once a day during the 11 PM to 7 AM shift. RN 1 stated monitoring the refrigerator temperature was important to ensure medications are maintained at an acceptable temperature range, and their potency (the strength of medication required to produce an effect) not affected. RN 1 stated if the refrigerator temperature was not monitored more than once a day it would not be known if the temperatures were maintained adequately and if the medications were negatively affected during that time. RN 1 stated using improperly maintained medications can harm the residents and not help treat their disease. During an observation and concurrent interview on 06/26/2024 at 10:44 AM, with Licensed Vocational Nurse (LVN) 1, in the Medication Room Station 1, the refrigerator temperature monitoring log was observed containing documentation for the temperature once a day during the 11 PM to 7 AM shift from 06/01/2024 to 06/26/2024. LVN 1 stated that the refrigerator temperature was monitored and documented once a day during the 11 PM to 7 AM shift and was unaware if the refrigerator temperature was within acceptable range the rest of the day. LVN 1 stated monitoring the refrigerator temperature was important to ensure medications are maintained at an acceptable temperature range, not negatively affected, or expired. LVN 1 stated potentially using expired medications can harm residents and not be effective in treating their disease. During an interview on 06/26/2024 at 12:48 PM, with the Director of Nursing (DON), the DON stated per facility policy the temperature of the refrigerator should be monitored and documented twice a day since vaccines are stored in the refrigerator. The DON stated not knowing the temperature of the refrigerator and if the appropriate temperature range was maintained, the vaccines may have lost efficacy and potency, be expired, and need to be disposed of and not used. The DON stated using expired vaccines will not be effective in treating the residents' conditions. The DON stated the facility was not in compliance for the refrigerator monitoring in June of 2024. Review of the facility's Policy & Procedures, titled Storage of Medications, dated May 2022, the P&P indicated that Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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	Temperature: F. The Facility should check the refrigerator or freezer in which vaccines are stored, at least two times a day, per CDC Guidelines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observation, interview, and record review the facility failed to follow and update the facility menu when: a. The menu posted in Resident 105's room was not updated. b. Staff served less than 3 ounces (oz, unit of measurement) of turkey each serving for lunch. This deficient practice had the potential to cause a decrease food intake resulting to unintentional (define) weight loss to 64 of 124 residents, frustrations, and psychosocial harm to the resident 1 (Resident 105). Findings: a. A review of Resident 105's Admission Record, indicated Resident 105 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of prostate (uncontrolled growth of malignant cells in the prostate gland), essential hypertension (HTN, high blood pressure), underweight (weight that is less than an acceptable weight) and severe protein-calorie malnutrition (a condition characterized by muscle and fat loss in the body). A review of Resident 105's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 9/18/2023, indicated Resident 105 was cognitively intact (able to understand and make decisions), able to eat with supervision or touching assistance (helper provides cues and/or touching assistance as the resident completes the activity) when eating. A review of Resident 105's diet order by Physician, dated 4/5/2024, indicated no added salt (NAS, no table salt added on the tray), regular texture with thin liquid consistency, fortified diet (adding foods such as butter, margarine, soup to the diet to increase calories and protein). A review of Resident 105's care plan, dated 5/1/2024 indicated resident has nutritional problem with a goal of maintaining adequate nutritional status by consuming at least 50% of meals daily. During concurrent interview with Resident 105 and observation of the posted menu in Resident 105 room on 6/25/2023 at 12:05 a.m., Resident 105 stated, the posted menu his wall was not updated, he was not aware of an alternate menu, and he was not asked about his food preferences since he got admitted for two (2) months. Resident 105 stated it was causing him frustrations. The menu posted on the wall indicated a date of 6/9/2024 to 6/16/2024. During an interview with Certified Nursing Assistant (CNA 2) on 6/25/2024, CNA 2 stated the menu was not updated with the current menu and the dietary staff was in-charge of updating the menus. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Dietary Supervisor (DS) on 6/26/2024 at 10:07 a.m., the DS stated the menus was posted in the activity room, nurses' station, kitchen and in the resident's room so that the residents would know what they would be getting everyday and compared to what we were serving. DS stated, sometimes she could not update the menus in the resident's room and if not updated, the residents would not know what food they were going to get. The DS stated the residents would be disappointed as they would not get what they expected to receive as a potential outcome. b. A review of the facility's menu spreadsheet (a list containing types and amount of foods of what each diet type would receive) titled Summer Menus dated 6/25/2024, Tuesday, indicated residents on regular (diet with no restrictions), low sodium diet (diet contained low salt foods), consistent carbohydrate diet (diet with same amount of carbohydrate per meal to control blood sugar), 80 grams protein, low salt and low potassium diet, and 80 grams protein, low potassium, low sodium, consistent carbohydrate diet, low fat, low cholesterol diet would get 3 oz of roast turkey. Residents would also receive half cup (1/2 c, unit of measurement) of broccoli or substitute vegetables. During an observation of the turkey portion sizes and interview with [NAME] 1 on 6/25/2024 at 12:18 p.m., [NAME] 1 stated she weighed all the turkey portions before the start of the trayline (area used to plate food of the residents) using a weighing scale. [NAME] 1 stated each turkey slice serving was 3 oz and it was important to follow proper portion sizes in the diets. [NAME] 1 weigh turkey meats using a weighing scale and the weight were as follows: First turkey meat: 2.7 oz Second turkey meat: 2.35 oz Third turkey meat: 2.65 oz Fourth turkey meat: 2.45 oz Fifth turkey meat: 2.8 oz Cook 1 stated they were giving less protein that could cause the residents to lose weight. During a concurrent observation of [NAME] 1 scooping the vegetables and interview with the DS on 6/25/2024 at 12:35 p.m., [NAME] 1 scooped the mixed vegetables and the scoop was not leveled and overflowing. The DS stated [NAME] 1 was supposed to follow a leveled scoop to ensure the diet and portion sizes were accurate. DS stated the potential outcome would be the residents could be getting excess nutrients compared to what they needed. During an interview with the DS on 6/25/2024 at 1:05 p.m., the DS stated she saw [NAME] 1 weigh the turkey before trayline however, the turkey portions were not an appropriate portion size. The DS stated the potential outcome to residents would be malnutrition because they were not getting enough protein. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facilities' Policies and Procedures (P&P) titled, Menus dated 5/23/2024 indicated Purpose. To ensure that the facility provides meals to the residents that meet the requirements of the Food and Nutrition Board of National Research Council of the National Academy of Sciences. (A) Menus will be posted in locations easily visible to residents. (II) Food served should adhere to the written menu. (IV) Resident meal of the month is posted on the weekly menu for the appropriate week after approval using the guidelines. A review of P&P titled Standardized Recipes dated 5/23/2024 indicated, the purpose was to provide the dietary department with guidelines for the use of standardized recipes. Policy: food products prepared and served by the dietary department will utilize standardize recipes. Procedure. (I) Standardized recipes are provided with the menu cycle. (II) Standardized recipes have adjustments for yields needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved flavor and appearance when: a. Broccoli was mushy, overcooked and did not have a garlic flavor. b. Glazed apple square was dry and served in a paper bowl. This deficient practice placed 120 of 124 facility residents at risk of unplanned weight loss, a consequence of poor food intake, getting food from the kitchen. Findings: a. A review of Resident 105's Admission Record, indicated Resident 105 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of prostate (uncontrolled growth of malignant cells in the prostate gland), essential hypertension (HTN, high blood pressure, underweight (weight that is less than acceptable weight) and severe protein-calorie malnutrition (a condition characterized by muscle and fat loss in the body caused by inadequate intake of food). A review of Resident 105's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 9/18/2023, indicated Resident 105 was cognitively intact (able to understand and make decisions), able to eat with supervision or touching assistance (helper provides cues and/or touching assistance as the resident completes the activity) when eating. A review of Resident 105's Order Summary Report, dated 4/5/2024, indicated no added salt (NAS, no table salt added on the tray), regular texture with thin liquid consistency, fortified diet (adding foods such as butter, margarine, soup to the diet to increase calories and protein). A review of Resident 105's care plan, dated 5/1/2024 indicated resident has nutritional problem with a goal of maintaining adequate nutritional status by consuming at least 50% of meals daily. During an interview with Resident 105 on 6/25/2024 at 12:05 p.m., Resident 105 stated the egg served for breakfast was fully looking square shaped with broccoli pieces and did not look good. 43418 b. A review of Resident 24's Admission Record indicated the facility originally admitted Resident 24 on 10/20/2022 and readmitted Resident 24 on 1/23/2024 with diagnoses including, but not limited to, protein-calorie malnutrition. A review of Resident 24's MDS, dated [DATE], indicated Resident 24 was able to understand and make decisions and required supervision to maximal assistance with activities of daily living, including eating, hygiene, mobility, toileting, and surface-to-surface transfers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 24's History and Physical (H&P), dated 9/21/2023, indicated the resident has the capacity to understand and make decisions. A review of Resident 24's Order Summary Report, dated 2/7/2024, indicated Resident 24 was ordered a NAS diet with regular texture and regular/thin liquid consistency. During an interview with Resident 24 and Family Member (FM) 2, on 6/25/2024, at 10:51 a.m., Resident 24 and FM 2 stated the food served does not look appetizing and was bland. A review of Resident 90's Admission Record indicated the facility originally admitted Resident 90 on 10/16/2023 and readmitted the resident on 12/12/2023 with diagnoses including, but not limited to, type two diabetes mellitus (long-term condition in which the body has trouble controlling blood sugar and using it for energy) and mild protein-calorie malnutrition. A review of Resident 90's MDS, dated [DATE], indicated Resident 90 had severe cognitive impairment (difficulty understanding and making decisions) and required supervision or was dependent on facility staff for activities of daily living, including eating, hygiene, mobility, toileting, and surface-to-surface transfers. A review of Resident 90's H&P, dated 12/14/2023, indicated Resident 90 has the capacity to understand and make decisions. c. A review of Resident 90's Order Summary Report, dated 6/24/2024, indicated Resident 90 was ordered a consistent carbohydrate diet standard portion with regular texture, regular/thin liquid consistency, and assistance with feeding due to attention. During an interview with Resident 90's Resident Representative (RP), RP 1, on 6/25/2024, at 3:35 p.m., RP 1 stated Resident 90 has concerns over the food, including bland taste and not receiving enough. RP 1 further stated she has to bring Resident 90 food when she visits. A review of the facility's summer menu spreadsheets (a list containing types and amount of foods of what each diet type would receive) dated 6/25/2024, indicated all the diets included the following food items on the tray: Broccoli with garlic 1/2 cup (c, household measurement) Bread stuffing 1/2 c Glazed apple square 1 pc, except for the following diets: consistent carbohydrate diet (CCHO, diet that had the same amount of carbohydrates per meal), During a test tray conducted with the Dietary Supervisor (DS) on 6/25/2024 at 12:49 p.m. for regular diet (diet with no restrictions), broccoli was mushy, overcooked and no garlic flavor. Stuffing looked dry and the glazed apple square was served in a Styrofoam bowl and looked dry. DS stated the broccoli did not have any flavor, needed a little spice, and had no garlic flavor. DS stated the stuffing also looked dry. DS stated the glazed apple square looked dry and presented in a disposable and did not look appetizing. DS stated residents could decrease their food intake causing weight loss, malnutrition, and non-healing wounds as a potential outcome. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON), on 6/28/2024m at 4:36 p.m., the DON stated it was important to provide residents with food that was palatable because it would encourage residents to eat and stimulate their appetite. A review of the facility's policies and procedures (P&P) titled Menus dated 5/23/2024, indicated Purpose. To ensure that the facility provides meals to residents that meet the requirements of the Food and Nutrition Board of the National Research Council of the National Academy Sciences. Policy. The Dietary Manager will develop menus in collaboration with the Dietitian. Menus are to be designated in consideration of resident preferences, dietary department resources, and seasonal availability of foods. (B) When a substitution is requested, the substitute item should be: (i) comparable with the rest of the meal taking into consideration color, texture, and flavor. A review of the facility's P&P titled Standardized Recipes dated 5/23/2024, indicated To provide the dietary department with guidelines for the use of standardized recipes. A review of the facility's P&P titled Vegetable Cookery dated 5/23/2024 indicated Policy. Dietary department employees ensure that the food prepared in a manner that preserves quality, maximizes nutrient retention, and obtains maximum yield of the product. (VII) Recipes will be used as a guideline. Additional seasoning may be added, to taste, for seasoning variation. (A) Therapeutic diets will be maintained with additional seasonings. A record review of the facility's recipe titled Broccoli with Garlic dated Week 4 Tuesday, indicated Ingredients: Broccoli fresh 30 lbs. or frozen 25 lbs., margarine, melted 15 oz, garlic powder 2 1/2 tbsp to 1/4 cup + 1 tbsp and salt 1 tbsp + 3/4 tsp. A record review of the facility's recipe titled Glazed Apple Square, dated Week 4, Tuesday, indicated Directions: (7) Just before serving, mix powdered sugar with hot water until sugar is dissolved. Drizzle syrup over top of squares.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observation, interview and record review, the facility failed to ensure resident receive and consume foods in the appropriate nutritive content as prescribed by a physician and or assessed by the interdisciplinary team to support the resident's treatment and plan of care when: One (1) of 1 resident on large portion diet (a diet which increases calorie and protein on the tray by doubling food portions) did not receive large portion of bread stuffing for lunch service. This deficient practice had the potential to cause weight loss for Resident 66. Findings: A review of Resident 66's Admission Record, indicated Resident 66 was admitted to the facility on [DATE] with diagnoses including type two (2) diabetes mellitus (DM2, long-term condition in which the body has trouble controlling blood sugar and using it for energy), dysphagia (difficulty swallowing) and muscle wasting and atrophy (thinning or loss of muscle tissue). A review of Resident 66's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 4/14/2024, indicated Resident 66 was cognitively intact (able to understand and make decisions) and able to eat with set-up and clean up assistance (helper sets up, cleans up and resident completes the activity). A review of Resident 66's Order Summary Report, dated 5/28/2024 indicated regular diet (diet with no restrictions), large portions, regular texture regular thin consistency. A review of Residents 66's Care Plan dated 7/6/2024 indicated resident had history of weight loss on 1/8/2024 and 6/12/2024 and on 5/24/2024 focus was to increase his energy; protein needs to meet estimated nutritional needs. Resident 66's interventions included regular diet; large portion initiated on 5/28/2024. During a concurrent trayline observation (an area where resident's foods were assembled) and interview with Dietary Supervisor (DS)on 6/25/2023 at 12:30 a.m., Resident 66's lunch meal received 2.5 ounces (oz, a unit of measurement) or number (#) 12, green scoop size of bread stuffing. The DS stated Resident 66 got #12 scoop portion size of bread stuffing however he should have gotten #8 scoop or four (4) oz. The DS stated Resident 66 got lesser portion that could cause weight loss to the resident. A review of the facility's menu spreadsheet (a list containing types and amount of foods of what each diet type would receive) titled Summer Menus dated 6/25/2024, Tuesday, indicated residents on large portion diet would get the following foods for lunch: Roast Turkey 3 oz Gravy 1 oz (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Bread stuffing #8 scoop (1/2 cup [c, unit of household measurement] or 4 oz) Broccoli with garlic 1/2 c Wheat rolls 1 piece. Margarine 1 tablespoon Glazed apple square 1 pc Milk 4 oz Large portions 2500-2800 kcal. A review of facility's policies and procedure (P&P) titled Menus dated 5/23/2024, indicated Purpose. To ensure that the facility provides meals to residents that meet the requirements of the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. Procedure: II. Food served should adhere to the written menu. A review of the P&P titled Therapeutic Diets dated 5/23/2024, indicated To ensure that the facility provides therapeutic diets to residents that meet nutritional guidelines and physician orders. Therapeutic diets are diets that deviate from the regular diet and require physician order. (b) Food portions served are equal to the written portion sizes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 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. 47441 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: A. Improper storage of food and food handling a. Raw chicken stored on top of bacon during thawing process. b. Four (4) dented cans were stored with the non-dented cans. c. Staff were not monitoring time and temperature when thawing poultry in the three-compartment sink (a type of sink used in dishwashing). d. Two (2) glasses of milk (42 and 50 degree Fahrenheit ([F, a scale of measuring temperatures] respectively) were above 41 F e. Resident's food from the outside were not labeled nor dated. B. Kitchen cleanliness and sanitation a. Reach-in refrigerator's gasket had black dirt residue and build up. b. Canned good had flour residue. c. Ice machine vents had dust. d. Pots and pans were stacked wet during storage. e. Staff were unable to verbalize dishmachine temperatures and failed to use the correct test strips when checking chlorine (a chemical used to disinfect dishes and utensils) concentration. f. Staff were not following chlorine test strips manufacturer's guidelines. C. Kitchen equipment and cross-contamination a. Dry storage racks had chips, not smooth and paint was coming off. b. Broken floor tile in the dry storage area. D. Dry storage area temperature was more than 80 F. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	These failures 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 (transfer of bacteria from one object to another) in 120 of 124 medically compromised residents who received food and ice from the kitchen. Findings: A. a. During an initial kitchen tour observation and interview with the Dietary Supervisor (DS) on 6/25/2024 at 8:47 a.m., raw chicken was stored above the bacon during the thawing process in the walk-in refrigerator. DS stated raw chicken must be stored at the bottom of the shelves to avoid juice spillage to other food to prevent salmonella that could get the resident's sick. A review of the facility's Policies and Procedures (P&P) titled Food Storage dated 5/23/2024, indicated To establish guidelines for storing, thawing, and preparing of food. Food items will be stored, thawed, and prepared in accordance with good sanitary practice. All items will be correctly labeled and dated. (B) Raw meat, poultry, and seafood should be stored in refrigerators/freezers in the following: i. [Top] ready to eat food. ii. Seafood iii. Whole cuts of beef and pork iv. [Bottom] Whole and ground poultry. A review of Food Code 2017, indicated 3-302.11 Packaged and Unpackaged Food-Separation, Packaging, and Segregation. (A) Food shall be protected from cross-contamination. (2) Except when combined as ingredients, separating types of raw animals from each other such as beef, fish, lamb, pork, and poultry during storage, preparation, holding, and display by: (b) Arranging each type of food in equipment so that cross-contamination of one type with another is prevented and (c) Preparing each type of food at different times or in separate areas. b. During an observation of the dry storage room at 6/25/2024 at 9:11 a.m., three (3) cans of sliced apple and one (1) can of peach filling had dents. During an interview with DS on 6/25/2024 at 9:29 a.m., DS stated there were four (4) dented cans that were stored with non-dented cans. DS stated the area for dented cans was by the disposables and dented cans had to be separated from regular storage because they could not use dented cans. DS stated the cans were damaged and it could be consumed by the residents. DS stated residents could get sick but did not remember the symptoms if food from dented cans were served to them. A review of the facility's P&P titled Food Storage dated 5/23/2024, indicated XI. Canned Vegetables Storage Guidelines (D) Dented or bulging cans should be placed in a separate area and return for credit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Food Code 2017 indicated 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. c. During concurrent observation of food preparation and interview with [NAME] 1, [NAME] 1 was thawing raw chicken in the sanitize sink. [NAME] 1 stated she started thawing an hour ago, but she did not monitor the water temperature. [NAME] 1 stated she will use the chicken for alternate menu. During an interview with DS on 6/25/2024 at 11:02 a.m., DS stated the process of thawing was in the refrigerator for three (3) days however there were times they used the sink method by using running water if the food item was still frozen. DS stated they did not monitor time and temperature when thawing in the sink. DS stated it was important to monitor time and temperature to avoid bacterial growth in food. A review of the facility's P&P titled Meat Cookery and Storage dated 5/23/2024, indicated II. Meat to be defrosted will be pulled three days prior to service and defrosted in a dry, cool area 41 F or lower. (B) If meat is frozen and needs a quick defrost, it may be defrosted in a pan or sink with constant running cold water until adequately defrosted for preparation. A review of Food Code 2017 indicated 3-501.13 Thawing. (B)Completely submerged under running water: (1) At a water temperature of 21 F (70 F) or below, (4) For a period of time that does not allow thawed portions of a raw animal food requiring cooking as specified under 3-4011.11 (A) or (B) to be above 5 C (41 F), for more than 4 hours including: (a) The time food is exposed to the running water and the time needed for preparation for cooking. d. During a concurrent observation of trayline (an area where resident's food was assembled), and interview with DS on 6/25/2024 at 12:00 p.m., a cup of milk was at 42 and another glass was at 50 F. DS stated they served milk before the cart came out. During an interview with DS on 6/26/2024 at 10:36 a.m., the DS stated it was important to maintain milk temperatures to 40 F and below so that the resident would not get sick of diarrhea, vomiting and stomach infection. A review of the facility's P&P titled Food Storage dated 5/23/2024, indicated III. Eggs, Milk, and Cheese Storage Guidelines. B. Dairy items should be kept under refrigeration until use. Store at temperatures below 41 F. A review of the facility's P&P titled Food Temperatures dated 5/23/2024, indicated Purpose. To provide the dietary department with guidelines for food preparation and service temperatures. (II) Acceptable Serving Temperatures: Milk, juice less than 41 F. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Food Code 2017, indicated 3-501.16 Time/Temperature for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as a public health control as specified under 3-501.19, and except as specified under (B) and in (C) of this section, Time/Temperature Control for safety food shall be maintained: (2) At 5 C (41 F) or less. e. During concurrent observation of the refrigerator in the activity room and interview with Licensed Vocational Nurse 1 (LVN 1) on 6/26/2024 at 10:48 a.m., a bag of sour cream, a bag of butter, three (3) bags of prepared foods were not labeled and dated. LVN 1 stated they labeled the residents food from the outside with resident's name, and they had three days to keep it. LVN 1 stated they threw foods after 3 days when it was not consumed. LVN 1 stated it was important to label the food with the resident's name to ensure the right resident would get the right food to prevent allergies and allergic reactions. LVN 1 stated it was also important to date the food to ensure it was not spoiled that could get residents sick, could be toxic to them and not safe for human consumption. A review of the facility's P&P titled Food Brought in by Visitors dated 5/23/2024, indicated B. Ensuring safe food handling once the food is brought to the facility, including safe reheating and hot/cold holding and handling of leftovers. II. Perishable food requiring refrigerator will be discarded after two (2) hours at bedside, and if refrigerated it will then be labeled, dated, and discarded after 48 hours. A review of Food Code 2017 indicated 3-501.17 Commercially processed food, open and hold cold, (B) except specified in (E) - (G) of this section, refrigerated, ready-to-eat time/temperature control for food safety food prepared and packed by a food processing 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 on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacture's use-by- date if the manufacturer determined the use-by date based on food safety. B. a. During an initial kitchen tour observation and interview with the DS on 6/25/2024 at 8:59 a.m., the reach-in refrigerator's gasket had black dirt buildup. The DS sated both left and right refrigerator gaskets had dirt, cleaning was done daily, and deep cleaning was every Wednesday. The DS stated it was important to maintain the cleanliness of the refrigerator's gaskets due to infection control and to avoid molds. The DS stated the potential outcome to the residents would be diarrhea and vomiting. A review of the facility's P&P titled P-DS49 Sanitation of Reach in Refrigerator dated 5/23/2024, indicated Daily task: (b) Wash the inside and outside of the door frame, the front of the door and the gaskets using detergent solution and clean cloth. (c) Rinse the inside and outside of the door frame, the front of the door, and the gaskets with clean water and sanitize with sanitizing solution and clean cloth. (d) Allow the inside and outside of the door frame, the front of the door, and the gasket to air dry. A review of Food Code 2017 indicated 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be clean to sight and touch. 4-701.10 Food Contact Surfaces and Utensils shall be sanitized. 4-702.11 Before use After cleaning. Utensils and Food-Contact Surfaces of Equipment shall be sanitized before use after cleaning. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During concurrent observation of the dry canned goods and interview with the DS on 6/25/2024 at 9:29 a. m., DS stated the canned goods had flour debris and residue and it should be cleaned because of cross-contamination that would make the resident's sick. A review of the facility's P&P titled Cleaning Schedule dated 5/23/2024, indicated Policy. The dietary staff will maintain sanitary environment in the dietary department by complying with the routine cleaning schedule developed by the dietary manager. II. The dietary manager monitors the cleaning schedule to ensure compliance. A review of Food Code 2017 indicated 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be clean to sight and touch. (B) NonFood-Contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. c. During a concurrent observation of the ice machine in the rehabilitation area and interview with DS on 6/26/2024 at 10:24 a.m., DS stated the ice machine vents had dust and the last time it was cleaned today according to the cleaning log. During an interview with the MD on 6/26/2024 at 12:32 p.m., the MD stated the janitor would clean the outside and the vents daily. The MD stated the vent had dust and the janitor told him. MD stated it was important to maintain the cleanliness of the ice machine to prevent germs and for infection control. A review of the facility's P& P titled Ice Machine-Operation and Cleaning dated 5/23/2024, indicated Purpose. To establish guidelines for the use and cleaning of the ice machine. II. Sanitation of equipment (A) Wash the exterior of the machine using detergent solution and clean cloth. (B) Rinse exterior of the machine with clean water and clean cloth. d. During an observation of the dishwashing process on 6/26/2024 at 1:03 p.m., pans were stacked wet by the stove. During an interview with Food Service Worker 2 (FSW 2) and the DS on 6/26/2024 at 1:25 p.m., FSW 2 stated after washing the dishes she had to wait for the dishes to air dry. The DS stated it was important to air dry dishes so that it would be dry when resident used it and to avoid bacteria from growing when its stacked or stored wet. A review of Food Code 2017 indicated 4-901.11 Equipment and Utensils, air-drying required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate draining. (B) May not be cloth dried. e. During concurrent observation, demonstration of the dishwashing process by Food Service Worker 1 (FSW 1) on 6/26/2024 at 1:07 p.m., FSW 1 used QT10 test strips when testing chlorine concentration. FSW 1 stated she checked the dishmachine temperature by reading the chlorine test strips and comparing to the color chart to 120 F. During an interview with DS on 6/26/2024 at 1:45 p.m., the DS stated she was not sure if FSW 1 was trained in using the dishmachine because she was new and was prioritizing other tasks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled Dishmachine Temperature Recording dated 5/23/2024 indicated Purpose. To establish guidelines for temperature monitoring and recording during the use of dishmachine. (III) Read temperature gauges on the machine while racks are in the machine. (IV) Record A temperature daily on DS-33-Form A- Dishmachine Temperature Log. Wash temperature 120-150 F. Rinse Temperature 120-150 F. A review of the facility's P&P titled Dishmachine Operation and Cleaning dated 5/3/2024 indicated (I) Check water temperature according to manufacturer's guidelines. (A) Check water temperature gauges. A review of Food Code 2017, indicated 5-501.110 Mechanical Warewashing Equipment Wash Solution Temperature (B) The temperature of the wash solution in spray-type warewashers that use chemicals to sanitize may not be less than 120 F. f. During a concurrent observation, demonstration of the dishmachine chlorine testing by FSW 2, interview with FSW 2 and record review on 6/26/2024 at 1:25 p.m., FSW 2 pulled chlorine test strip and rubbed it in a dishpan for four (4) seconds. A review of the facility's test chlorine test strips manufacturer's guidelines indicated: (1) Dip and remove quickly. (2) Blot immediately with paper towel. (3) Compare to color chart at once. The DS stated it was important to follow manufacturer's guidelines of the chlorine test strips to ensure that chlorine was in the right concentration to kill bacteria in the dishes during dishwashing. DS stated staff did not follow manufacturer's guidelines because of they way they were trained. A review of the facility's P&P titled Dishmachine Temperature Recording dated 5/23/2024 indicated (IV) The concentration of the sanitary solution during the rinse cycle is 50ppm for chlorine sanitizer. This is used for low temperature dishmachines. (VII) A pH test kit is used daily and may be obtained form the chemical supplier or low temperature dishmachines. A review of Food Code 2017 indicated 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. A review of Food Code 2017 indicated 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitation- Temperature, pH, Concentration, and Hardness. Verifying the adequacy of chlorine-based solutions can be accomplished on an on-going basis by confirming that the concentration, temperature, and pH of the sanitizing solutions comply with paragraphs 4-501.114 (A) using acceptable test methods and equipment. The manufacturer should provide methods (e.g. test strips, kits, etc.) to verify that the equipment consistently generates solution on-site at the necessary concentration to achieve sanitation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. a. During an observation of the dry storage area racks on 6/25/2024 at 9:06 a.m., the storage racks had chips, not smooth and paint was coming off. During an interview with the DS on 6/25/2024 at 9:29 a.m., the DS stated the dry storage racks had chips and the paint was coming off. The DS stated paint could go to the food for cross-contamination and the racks surfaces were not smooth so bacteria could go in the cracks. A review of the facility's P&P titled Food Storage dated 5/23/2024, indicated XII Dry Storage Guidelines (D) Shelving should be sturdy and provided with a surface which is smooth and easily cleaned. A review of Food Code 2017 indicated 4-202.11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be (1) Smooth (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. b. During an observation of the dry storage area floors on 6/25/2024 at 9:16 a.m., the tile by the middle storage area floor was broken. During an interview with DS on 6/25/2024 at 9:29 a.m., the DS stated the floor in the dry storage area was broken. DS stated it was important to maintain the tiles to prevent bacterial growth, mold, and infection control. A review of the facility's P&P titled Floor Safety dated 5/23/2024, indicated Floors shall be maintained in safe manner. D. During an observation of the dry storage area on 6/25/2024 at 9:16 a.m., there was no thermometer in the area and the dry storage log indicated a temperature was at 60 F. During an interview with the DS on 6/25/2024 at 9:27 a.m., the DS stated it felt hot in the storage area and heat would make food not safe for consumption. The DS stated they opened the electric fan but did not know how to use the air condition. During an interview with DS on 6/25/2024 at 10:12 a.m., the DS stated she placed a thermometer in the storage area today and it read more than 80 F. A review of the facility's log titled Dry Storage Temperature Log, dated June 2024, indicated Dry food storage area should be ventilated with a temperature of 50-70 F. If the temperature is not within this range, report to supervisor-on-duty immediately or contact maintenance for correction. Document corrective actions taken in appropriate column as necessary. A review of the facility's P&P titled Food Storage dated 5/23/2024, indicated XII Dry Storage Guidelines (C) The area should be well lit and ventilated with a temperature of 50-70 F.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 47441 Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly by: a. Not completely covering 1 (one) of 1 black dumpsters (large trash container designed to be emptied into a truck) and 3 of 6 blue recycle bins from unknown period of time. b. Three blue boxes were on the floor. c. Flies and a dead rat were found around the trash area. This deficient practice had a potential to attract birds, flies, insects, pest and possibly spread infection to 120 of 124 facility residents. Findings: During a concurrent observation of the dumpster area outside of the facility and interview with Dietary Supervisor (DS) on 6/26/2024 at 10:34 a.m., 1 black trash bin was not completely closed and 3 blue recycle bins were overflowing with boxes. There were giant flies on the ground and dead rat around the trash area. The DS stated the trash bins were not completely closed and the boxes were on the floor. The DS stated there were flies and insects around the trash area. DS stated it was important for to maintain trash bins close and ensure cleanliness of the trash area for infection and pest control. The DS stated the insects could contaminate food and would cause residents with wounds to worsen due to infection. During an interview with the Maintenance Director (MD) on 6/26/2024 at 12:32 p.m., the MD stated the trash black bin was not completely close because it was overflowing with trash, the blue recycle bins were also overflowing boxes and the trash area was overcrowded with boxes on the floor. The MD stated the bins should be completely closed and the boxes should not be on the floor to prevent infection and pest control. The MD stated the trash surroundings should be clean and clear to prevent flies and contamination. The MD stated the dead rat in the area was not thrown away right away as they placed baking soda on it first to completely kill it and to remove the odor. MS stated the potential outcome of this was the residents could get sick, but he was not sure what kind of sickness they could get. A record review of the facility's policies and procedures (P&P) titled Waste Management dated 5/23/2024, indicated Purpose. To reduce risk of contamination from regulated waste and maintain appropriate handling and disposable of all waste. IV. Food waste will be placed in covered garbage and trash cans. A review of Food Code 2017, indicated, 5-501.15 Outside receptacles. (A) Receptacles and waste handling units for REFUSE, recyclables, and returnable used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Food Code 2017, indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review, the facility failed to maintain and infection prevention and control program to help prevent the development and transmission of communicable diseases and infections by failing to: 1. Ensure the nasal cannula (NC - tubing connected to a device that gives additional oxygen [O2] through the nose) was not touching the floor for three of four sampled residents (Residents 20, 376, and 57) reviewed under the Respiratory care area. 2. Label the urinal bottle (a container used to collect urine) with resident identifier for three of nine sampled residents (Resident 30, 120, and 278) reviewed under the Infection Control task and one of one sampled resident (Resident 106) reviewed under the Urinary Tract Infection (a condition in which bacteria invade and grow in the urinary tract) care area. 3. Ensure the urine collection bag (a bag designed to collect urine drained from the bladder via a catheter) was not touching the floor for one of nine sampled residents (Resident 63) reviewed under the Infection Control task. 4. Ensure Certified Nursing Assistant 1 (CNA 1) and Certified Nursing Assistant 2 (CNA 2) put on a gown prior to repositioning residents on enhanced barrier precautions (EBP - a type of precaution that involves utilizing gown and gloves during high contact activities for residents with known infection or at risk for acquiring infections) for one of nine sampled residents (Resident 79) reviewed under the Infection Control task. 5. Ensure linens in the linen cart were enclosed with a nonpermeable (any material that will allow water to penetrate) cover. These deficient practices had the potential for cross-contamination (the physical movement or transfer of harmful bacteria from one person, object, or place to another) and placed the residents at risk for acquiring infections. Findings: a. A review of Resident 20's Admission Record indicated the facility admitted the resident on 11/16/2022 and readmitted the resident on 12/22/2023 with diagnoses that included Parkinson's disease (a progressive disorder that affects the nervous system that causes unintended or uncontrollable movements), acute respiratory failure (a serious condition that occurs suddenly when the lungs cannot get enough oxygen) with hypoxia (low levels of oxygen in the body tissues), and pneumonia (inflamed or swollen lung tissue caused by an infection from a germ). A review of Resident 20's Minimum Data Set (MDS - an assessment and care screening tool) dated 5/20/2024, indicated the resident was sometimes able to understand others and was sometimes able to make herself understood. The MDS further indicated the resident was dependent on staff for eating, bathing, dressing, personal hygiene, toileting, and mobility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 20's Physician Orders indicated an order for O2 at two liters per minute (LMP, a unit of measurement) via NC to keep O2 saturation (sat, a measurement of oxygen in the blood) at/above 93 percent (%, a unit of oxygen saturation measurement) for shortness of breath (SOB) and wheezing. May titrate (adjust) up to five LPM to keep O2 sat above 93%, as needed (PRN) for SOB and wheezing, dated 5/9/2024. A review of Resident 20's Care Plan (CP) titled, Oxygen: the resident has PRN oxygen therapy for SOB or wheezing, initiated 11/17/2022, indicated to give medications as ordered by physician and monitor and document side effects. A review of Resident 20's CP titled, At Risk for ineffective breathing pattern/impaired respiratory function related to refusal of Prevnar 13 (a medication to prevent pneumonia) and flu vaccine (medication used to prevent a highly contagious respiratory illness, which spreads easily through the air or when people touch contaminated surfaces), initiated 11/17/2022, indicated to use routine cleaning and disinfecting strategies per policy. During an observation on 6/25/2024 at 12:15 p.m., observed Resident 20 lying in bed, O2 was administered to Resident 20 via NC. Observed the NC tubing wrapped behind the O2 concentrator (a device that provides supplemental O2) cord and the NC tubing was touching the floor. During an observation and interview on 6/25/2024 at 12:20 p.m., Licensed Vocational Nurse 7 (LVN 7) entered Resident 20's room and stated the NC was touching the floor. LVN 7 stated oxygen tubing should not be on the floor because bacteria could go up through the tubing to the resident's nose and infect the resident. During an interview and record review on 6/27/2024 at 11 a.m., the Director of Nursing (DON) reviewed the facility policy regarding infection control and oxygen tubing. The DON stated oxygen tubing should always be off the floor for infection control. The DON stated when the oxygen tubing is on the floor it could lead to infections in the lungs and could cause complications resulting in pneumonia and other health problems. The DON stated the facility policies were not followed. A review of the facility provided policy and procedure titled, Oxygen Therapy, last reviewed 5/23/2024, indicated oxygen is administered under safe and sanitary conditions to meet resident needs. A review of the facility provided policy and procedure titled, Infection Prevention, last reviewed 5/23/2024, indicated the facility's infection control policies and procedures are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. 43988 b . A review of Resident 30's Admission Record indicated the facility admitted the resident on 5/13/2024 with diagnoses including osteomyelitis of lumbar region (a bone infection that develops from bacteria as a result of an injury to the spine or after surgery), and unsteadiness on feet. A review of Resident 30's History and Physical, dated 5/18/2024, indicated the resident had the capacity to understand and make decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 30's MDS dated [DATE], indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance with toileting. The MDS indicated the resident was always incontinent of bladder. During a concurrent observation and interview on 6/25/2024 at 11:52 a.m. inside Resident 30's room, with Restorative Nursing Assistant 1 (RNA 1), observed a urinal bottle hanging on the resident's left bed rail. RNA 1 stated the urinal bottle was not labeled with the resident's name and/or room number. RNA 1 stated the urinal bottle should have been labeled with at least the room number to prevent switching of urinals in between residents in the same room. RNA 1 stated Resident 30's roommate uses a urinal bottle as well. During an interview on 6/28/2024 at 4:42 p.m., the DON stated the urinal bottles should be labeled with the resident room number or the resident's last name to ensure the other residents do not use the urinal bottle and to prevent cross contamination. A review of the facility's policy and procedure titled, Infection Control - Policies and Procedures, last reviewed 5/23/2024, indicated the facility maintains a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. c. A review of Resident 120's Admission Record indicated the facility admitted the resident on 5/13/2024 with diagnoses including local infection of the skin and subcutaneous tissue (means beneath, or under, all the layers of the skin made up mostly of fat cells), other abnormalities of gait and mobility, and generalized weakness. A review of Resident 120's History and Physical, dated 5/29/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 120's MDS dated [DATE], indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance with toileting. The MDS indicated was always incontinent of bladder. During a concurrent observation and interview on 6/25/2024 at 10:16 a.m. inside Resident 120's room, with Licensed Vocational Nurse 5 (LVN 5), observed a urinal bottle hanging on the resident's left bed rail. LVN 5 stated the urinal bottle did not have a resident identifier. LVN 5 stated the urinal bottle should have been labeled with the room number and resident name to prevent switching of urinals in between residents in the same room and prevent cross contamination. During an interview on 6/28/2024 at 4:42 p.m., DON stated the urinal bottles should be labeled with the resident room number or the resident's last name to ensure the other residents do not use the urinal bottle and to prevent cross contamination. A review of the facility's policy and procedure titled, Infection Control - Policies and Procedures, last reviewed 5/23/2024, indicated the facility maintains a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. d. A review of Resident 278's Admission Record indicated the facility admitted the resident on 6/14/2024 with diagnoses including unsteadiness on feet, urinary tract infection (UTI - an infection in any part of the urinary system., and generalized muscle weakness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 278's History and Physical, dated 6/25/2024, indicated the resident was oriented with occasional confusion. A review of Resident 278's MDS dated [DATE], indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and required total or dependent assistance from staff with toileting. The MDS indicated was frequently incontinent of bladder. During a concurrent observation and interview on 6/25/2024 at 11:00 a.m. inside Resident 278's room, with Assistant Director of Nursing (ADON), observed a urinal bottle hanging on the resident's left bed rail. The ADON stated the urinal bottle did not have a resident identifier. The ADON stated the urinal bottle should have been labeled with the room number and resident name so the staff would know who the urinal bottle belongs to and to prevent switching of urinals and cross contamination. During an interview on 6/28/2024 at 4:42 p.m., the DON stated the urinal bottles should be labeled with the resident room number or the resident's last name to ensure the other residents do not use the urinal bottle and to prevent cross contamination. A review of the facility's policy and procedure titled, Infection Control - Policies and Procedures, last reviewed 5/23/2024, indicated the facility maintains a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. e. A review of Resident 57's Admission Record indicated the facility admitted the resident on 1/11/2023 and readmitted the resident on 7/12/2023 with diagnoses including pneumonia, and chronic obstructive pulmonary disease (COPD - a condition that happens when the lungs and airways become damaged and inflamed usually associated with long term exposure to harmful substances such as cigarette smoke. A review of Resident 57's History and Physical, dated 3/31/2024, indicated the resident had difficulty speaking, able communicate, and oriented only to person. A review of Resident 57's MDS dated [DATE], indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated the resident received oxygen therapy. A review of Resident 57's Order Summary Report indicated: -Oxygen at two (2) liters per minute (L/min - a unit of measurement via NC to keep O2 saturation at/above 93. May titrate up to five (5) L/min every shift for COPD management. During a concurrent observation and interview on 6/25/2024 at 10:20 a.m. with Licensed Vocational Nurse 9 (LVN 9) inside Resident 57's room, observed Resident 57 lying in bed with O2 at 2 L/min via NC. Observed the oxygen tubing touching the floor. LVN 9 stated the tubing should not be touching the floor as the tubing can get contaminated and placed the resident at risk for acquiring infection. During an interview on 6/28/2024 at 4:42 p.m., the Director of Nursing (DON), the DON stated Resident 57's O2 tubing should not be touching the floor as the resident can get infection from the contaminated tubing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Infection Control - Policies and Procedures, last reviewed 5/23/2024, indicated the facility maintains a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. f. A review of Resident 63's Admission Record indicated the facility admitted the resident on 5/9/2022 and readmitted the resident on 6/28/2022 with diagnoses including muscle wasting and atrophy (refers to a decrease in size and wasting of muscle tissue) multiple sites, and adult failure to thrive (a condition that happens when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal). A review of Resident 63's History and Physical, dated 11/21/2023, indicated the resident had the capacity to understand and make decisions. A review of Resident 63's MDS dated [DATE], indicated the resident had severely impaired cognition and required total/dependent assistance from staff with all activities of daily living. The MDS indicated the resident had an indwelling catheter (a flexible tube inserted into the bladder to empty it of urine into a bag). A review of Resident 63's Order Summary Report indicated: -Indwelling foley catheter 16French (Fr - a unit of measurement for catheter size) with ten (10) milliliters (ml - a unit of measurement) balloon via gravity drainage. During a concurrent observation and interview on 6/25/2024 at 10:20 a.m., with the Director of Staff Development (DSD), inside Resident 63's room, observed Resident 63 lying in bed at its lowest position. Observed the urinary collection bag touching the floor. The DSD stated the urine collection bag should not be touching the floor as the tubing can get contaminated and placed the resident at risk for acquiring infection. During an interview on 6/28/2024 at 4:42 p.m., with the DON, the DON stated Resident 63's urine collection bag should not be touching the floor as the resident can get infection from the contaminated bag. A review of the facility's policy and procedure titled, Infection Control - Policies and Procedures, last reviewed 5/23/2024, indicated the facility maintains a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. g. A review of Resident 79's Admission Record indicated the facility admitted the resident on 10/23/2023 with diagnoses including pressure ulcer (PU) stage four (a sore that extend below the subcutaneous fat into the deep tissues, including muscle, tendons, and ligaments) of the sacral region (refers to bottom of the spine), and congestive heart failure (a condition in which the heart has trouble pumping blood through the body). A review of Resident 79's History and Physical, dated 4/22/2024, indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 79's MDS dated [DATE], indicated the resident had an intact cognition and required partial/moderate assistance from staff with most activities of daily living. The MDS indicated the resident had stage four pressure ulcer. During an 6/25/2024 at 9:00 a.m. inside Resident 79's room, observed Resident 79 lying in bed with the head of elevated. Observed a sign on the wall that indicated EBP please wear gown and glove during high contact. Resident 79 stated she needed to be repositioned. During a concurrent observation and interview on 6/25/2024 at 9:10 a.m., with Certified Nursing Assistant 2 (CNA 2) and Certified Nursing Assistant 3 (CNA 3) inside Resident 79's room, observed CNA 2 and CNA 3 don gloves and repositioned the resident. CNA 2 and CNA 3 did not wear a gown when they repositioned the resident. CNA 2 and CNA 3 stated Resident 79 was placed on EBP and the sign on the wall indicated to wear gown and gloves during high contact. CNA 2 and CNA 3 stated repositioning Resident 79 was a high contact care activity, and they should have donned (put on) a gown prior to repositioning the resident. CNA 2 and CNA 3 stated donning the gown and gloves will prevent spread of infection to other residents. During an interview on 6/28/2024 at 4:42 p.m., with the DON, the DON stated staff should wear gown and gloves during high contact care activity for residents on EBP to prevent the spread of infection to other residents. A review of the facility's policy and procedure titled, Infection Control - Policies and Procedures, last reviewed 5/23/2024, indicated the facility maintains a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. A review of the Center for Disease Control and Prevention (CDC - the nation's health protection agency that works with state health departments and other organizations throughout the country to help prevent and control disease) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug Resistant Organisms (MDROs) last updated 7/12/2022, indicated the following: -EBPs are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. -EBP may be indicated for residents with wounds or indwelling medical devices, regardless of MDRO colonization status and infection or colonization with and MDRO. 44376 h. A review of Resident 106's Admission Record the facility admitted the resident on 3/26/2024, with diagnoses including sepsis (a serious condition in which the body responds improperly to an infection) and type 2 diabetes mellitus (a disease in which the body does not control the amount of glucose [a type of sugar] in the blood) with diabetic chronic kidney disease (a decrease in kidney function that occurs in some residents who have diabetes). A review of Resident 106's History and Physical (H&P), dated 3/27/2024, indicated the resident had the capacity to understand and make decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 106's MDS, dated [DATE], indicated the resident had the ability to make self-understood and understand others. During a concurrent observation and interview on 6/25/2024, at 2:31 p.m., with Payroll 1 (P 1), inside Resident 106's room, observed two urinal bottles on the resident's bedside table, without a resident identifier. P 1 stated the urinal bottles should be labeled with the name and room number of the resident to prevent switching of urinals between residents and for infection control. During an interview on 6/28/2024 at 4:25 p.m., the DON stated the urinal bottles should be labeled with the resident room number or the resident's last name to ensure the other residents do not use the urinal bottle and to prevent cross contamination. A review of the facility's recent policy and procedure titled, Labeling and Supplying Immediate Environment of Residents, last reviewed on 5/23/2024, indicated the immediate environment (closet and door) of a resident is labeled with the name of the resident. In bottom drawer, place basin, covered urinal and bedpan as needed. A review of the facility's recent policy and procedure titled, Infection Control- Policies & Procedures, last reviewed on 5/23/2024, indicated the facility's infection control policies and procedures are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. i.A review of Resident 376's Admission Record indicated the facility admitted the resident on 11/29/2023, with diagnoses including pleural effusion (occurs when fluids build up in the space between the lung and the chest wall), cognitive communication deficit (difficulty with any aspect of communication), atherosclerotic heart disease (thickening or hardening of the arteries). A review of Resident 376's H&P, dated 4/22/2024, indicated the resident did not have the capacity to make decisions and make needs known. A review of Resident 376's MDS, dated [DATE], indicated the resident had the ability to make self-understood and understand others. A review of Resident 376's Order Summary Report, dated 3/19/2024, indicated an order for oxygen at liters per minute (LPM, the flow of oxygen via oxygen delivery device) via nasal cannula (a device that gives additional oxygen through the nose) to keep oxygen saturation (O2 sat, a measure of the amount of hemoglobin [a protein inside red blood cells that carries oxygen from the lungs to tissues] that is bound to molecular oxygen at a given time point) at/above 93% for shortness of breath (SOB) and wheezing (a high-pitched whistling sound made while breathing). May titrate (slowly increasing the dose) up to 5 LPM to keep O2 sat above 93%. Every shift for supplemental oxygen. During a concurrent observation and interview on 6/25/2024, at 9:59 a.m., with Certified Nursing Assistant 1 (CNA 1), inside Resident 376's room, observed the resident's oxygen tubing touching the floor. CNA 1 stated the oxygen tubing should be off the floor for infection control. During an interview on 6/28/2024, at 4:35 p.m., with the DON, the DON stated Resident 376's oxygen tubing should be kept off the floor to prevent infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's recent policy and procedure titled, Oxygen Therapy, last reviewed on 5/23/2024, indicated oxygen is administered under safe and sanitary conditions to meet resident needs. Licensed Nursing staff will administer oxygen as prescribed. Administer oxygen per physician orders. A review of the facility's recent policy and procedure titled, Infection Control- Policies & Procedures, last reviewed on 5/23/2024, indicated the facility's infection control policies and procedures are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. 43418 j. During a concurrent observation and interview with the Infection Preventionist (IP), on 6/28/2024, at 3:01 p. m., outside resident room [ROOM NUMBER], a linen cart contained gowns, towels, and sheets. The linen cart was enclosed with a green-colored mesh-like cover. The IP confirmed the contents in the linen cart were visible through the see-through covering. The IP stated linen carts should be closed when not in use to prevent cross-contamination. The IP further stated if cross-contamination occurs there is a potential spread for infection. During a concurrent observation and interview with the Maintenance Director (MD), on 6/28/2024, at 3:23 p. m., outside the laundry room, multiple linen carts in the hallway contained gowns, sheets, and towels. Two linen carts were enclosed with a green-colored mesh-like cover. The MD confirmed the contents of the linen carts were visible and stated there is a potential for cross-contamination since the mesh-like cover could expose the linens in the cart to debris or liquid. During an interview with the DON, on 6/28/2024, at 4:36 p.m., the DON stated it is important to ensure linens in the linen cart are enclosed with a nonpermeable cover to protect the clean linens from dirt and liquid. The DON further stated if exposed, there is a potential for cross-contamination. A review of the facility's policy and procedure (P&P) titled, Infection Control - Policies & Procedures, last reviewed 5/23/2024, indicated the facility's infection control policies and procedures are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. A review of a document provided by the facility titled, Linen Carts - Open Shelf - 20 inches (a unit of measure for length) depth and 50 inches width, undated, indicated cart cover advantages are as follows: -Breathable standard mesh is flame resistant, mildew resistant, and high tear and tensile (capable of being drawn out or stretched) strength. The cart cover advantage does not indicate the breathable standard mesh is antimicrobial (designed to fight the growth of bacteria, mold, fungus, and other microbes). -All solid vinyl fabrics are antimicrobial, flame resistant, high tear and tensile strength, and excellent cleanability.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 43988 Based on observation, interview, and record review, the facility failed to maintain mechanical, electrical, and resident care equipment in safe operating condition for one (Resident 57) of nine sampled residents investigated under Environment task when Resident 57s bed controller (device used to change the height and angle of the bed) cable was covered with black plastic tape with exposed wires. This deficient practice had the potential to place residents at risk for injury from accidents. Findings: A review of Resident 57's Admission Record indicated the facility admitted the resident on 1/11/2023 and readmitted the resident on 7/12/2023 with diagnoses including pneumonia (a common lung infection caused by germs, such as bacteria, viruses, and fungi), and chronic obstructive pulmonary disease (COPD - a condition that happens when the lungs and airways become damaged and inflamed usually associated with long term exposure to harmful substances such as cigarette smoke. A review of Resident 57's History and Physical, dated 3/31/2024, indicated the resident had difficulty speaking, able communicate, and oriented only to person. A review of Resident 57's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 4/16/2024, indicated the resident had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated the resident received oxygen therapy. During an observation on 6/25/2024, at 10:20 a.m., inside Resident 57's room, Resident 57 was observed lying in bed with the bed controller on the left side of the resident. The base of the bed controller cable was wrapped with black plastic tape and there were white, red, blue, and yellow wires that were exposed and not covered with the black tape. During a concurrent observation and interview, with Licensed Vocational Nurse 5 (LVN) 5, on 6/25/2024, at 10:25 a.m., inside Resident 57's room, LVN 5 stated Resident 57's bed controller cable had exposed wires and it is not safe for the resident to have exposed wires next to them. LVN 5 further stated the exposed wires had the potential for accidents such as fire and could also possibly cause an electrical shock. During an interview on 6/28/2024 at 10:00 a.m., the Maintenance Director (MD), the MD stated it was important to ensure all resident care equipment are in good working condition for resident safety. The MD stated the exposed wires could potentially result in accidents such as an electrical shock resulting in injuries. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Maintenance Service, last reviewed 5/23/2024, indicated a purpose to protect the health and safety of residents, visitors, and facility staff. The policy indicated the Maintenance Department maintains all areas of the building, grounds, and equipment. 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 43418 Based on observation, interview, and record review, the facility failed to provide a safe environment for residents for one of nine sampled residents reviewed under the Environment task (Resident 17) when Resident 17's cell phone charger was plugged into an extension cord (length of electric cord that permits the use of an appliance at some distance from a fixed socket) that was plugged into a power strip (an electrical device consisting of a cord with a plug on one end and several outlets on the other) that was plugged into an electrical wall outlet (a socket that connects an electrical device to an electricity supply). This deficient practice had the potential to place residents at risk for injury from accidents. Findings: A review of Resident 17's Admission Record indicated the facility originally admitted Resident 17 on 1/6/2017 and readmitted the resident on 4/3/2024 with diagnoses including, but not limited to, generalized muscle weakness and encounter for attention to gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food). A review of Resident 17's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/23/2024, indicated Resident 17 had mild cognitive impairment (difficulty understanding and making decisions), required maximal assistance or was dependent on facility staff for activities of daily living, including hygiene, mobility, and surface-to-surface transfer, and had a feeding tube. A review of Resident 17's History and Physical (H&P), dated 4/5/2024, indicated the resident has the capacity to understand and make decisions and has a history of dysphagia (difficulty swallowing) and is on gastrostomy tube feeding. During an observation on 6/25/2024, at 9:48 a.m., inside Resident 17's room, Resident 17's cell phone was on top of a cell phone charger dock placed on Resident 17's bed side table, located to the right of the resident. The cell phone charger dock was plugged into an extension cord. The extension cord was plugged into a power strip. The power strip was plugged into an electrical wall outlet between Resident 17's bed and tube feeding pole. During a concurrent observation and interview with Licensed Vocational Nurse (LVN) 6, on 6/26/2024, at 2:08 p.m., inside Resident 17's room, LVN 6 confirmed Resident 17's cell phone was on a cell phone charger dock, that was plugged into to an extension cord, that was plugged into a power strip, that was plugged into an electrical wall outlet. LVN 6 further stated that was not a safe practice due to the potential for fires. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with the Maintenance Director (MD), on 6/26/2024, at 2:34 p. m., inside Resident 17's room, the MD confirmed Resident 17's cell phone was on a cell phone charger dock, that was plugged into to an extension cord, that was plugged into a power strip, that was plugged into an electrical wall outlet. The MD stated the practice was not safe because the wires can be source for fire from the heat from the wiring. During an interview with the Director of Nursing (DON), on 6/28/2024, at 4:36 p.m., the DON stated it is important to not use an extension cord and power strip concurrently for resident safety and prevent injury from accidents. A review of the facility's policy and procedure (P&P) titled, Maintenance Service, last reviewed 5/23/2024, indicated the maintenance department maintains all areas of the building, grounds, and equipment. The P&P indicated functions of the maintenance department may include, but are not limited to, maintaining the building in good repair and free from hazards.