STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056489	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hollywood Premier Healthcare Center	5401 Fountain Ave. Los Angeles, CA 90029

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on interview and record review, the facility failed to ensure the consultant pharmacist (CP) completed a thorough review of one of three sampled residents (Resident 1) medical records from 12/29/2022 to 5/22/2024. By failing to identify and report to physician when laboratory (labs) tests ordered for medication management, were not done. This deficient practice increased the risk that medication therapy for Resident 1 not being optimized for the best possible health outcomes and could have led to a negative impact on the resident ' s overall physical, mental, and psychosocial well-being. Findings: During a review of Resident 1's Admission Record (a document containing demographic and diagnostic information), dated 5/22/2024, the admission record indicated that the resident was admitted on [DATE] and readmitted on [DATE], diagnoses included, Dementia (progressive loss of memory), bipolar disorder (a condition of major mood swings), and seizures (a sudden rush of abnormal electrical activity in your brain). A review of Resident 1 ' s Order Summary Report with active orders as of 4/30/2024, included orders for two seizure medications Depakote (Divalproex Sodium, also used for bipolar disorder [a condition of major mood swings]) and Keppra (Levetiracetam) as follow: 1. Depakote Oral Tablet Delayed Release 125 milligrams (mg), with instructions to give one tablet by mouth two times a day for bipolar disorder manifested by mood swings, order date 10/23/2023. 2. Keppra Tablet 500 mg, with instructions to give one tablet by mouth two times a day for seizures, order date 9/7/2021. During a review of Resident 1's Physician Orders for lab tests, indicated the prescriber included lab orders for Resident 1 as follow: On 2/28/2022 lab orders were placed to check Resident 1 ' s Complete Blood Count (CBC), Basic Metabolic Panel (BMP), Lipids, Renal Panel, thyroid stimulating hormone (TSH), Vitamin D, Valproic Acid every third Tuesday of February, May, August, and November. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/2023 lab orders were placed to check Resident 1 ' s Depakote level, one time for 1 day until 3/28/2023. On 5/11/2023 lab orders were placed to check Resident 1 ' s Keppra level, CBC, CMP, Lipids Panel, TSH, Vitamin D, and Valproic Acid, one time only until 5/12/2023. On 9/21/2023 lab orders were placed to check Resident 1 ' s Keppra level, CBC, CMP, Lipids, Renal Panel, TSH, Vitamin D, and Valproic Acid, one time only until 9/22/2023. On 1/3/2024 lab orders were placed to check Resident 1 ' s Keppra level, CBC, CMP, Lipids Panel, TSH, Vitamin D, and Valproic Acid, one time only until 1/5/2024. During a review of the Consultant Pharmacist's Medication Regimen Review (MRR - a monthly report summarizing he consultant pharmacist's individualized suggestions to the attending physician to optimize a resident's medication therapy), indicated on CP ' s form titled, Consultant Pharmacist ' s Medication Regimen Review: Listing of Residents Reviewed with No Recommendations, listed Resident 1 as a resident with no recommendations from CP on the following dates, 1/1/2024, 1/5/2024, 2/1/2024, 2/18/2024, 4/1/2024, and 4/24/2024. During a concurrent interview and review of Resident 1 ' s clinical records on 5/22/2024 at 4:56 PM with the Director of Nursing (DON), Resident 1 ' s MRR between 1/1/2024 through 4/24/2024 was reviewed. The DON stated that she did not see pharmacist recommendations regarding labs for Resident 1 in the resident ' s physical chart. The DON reviewed CP ' s MRR for the months of 1/2024, 2/2024, 3/2024, and 4/2024 and stated there was no pharmacist recommendation for Resident 1 regarding Resident 1 not having lab work done every three months as ordered on 2/28/2022 or for Resident 1 not having lab work done as ordered on 3/27/2023, 5/11/2023, 9/21/2023, and 1/3/2024. During an interview on 5/22/2024 at 5:14 PM with the facility ' s Consultant Pharmacist (CP) in the presence of the DON, the CP stated, labs ordered by the prescriber should have been done as ordered. The CP stated valproic levels could reach toxic levels and should be monitored. The CP stated that he must have overlooked the orders for Resident 1 ' s labs. The CP stated that he randomly checked lab orders for residents and confirmed by stating he (CP) did not make any recommendations to the facility or prescriber when Resident 1 ' s orders for labs were not done. A review of the facility ' s Policy and Procedures titled, Medication Regimen Review, revised 1/2024, indicated, The Consultant Pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication .The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication .The MRR involves a thorough review of the resident ' s medical record to prevent, identify, and report and resolve medication related problems, medication errors and order irregularities, for example .inadequate monitoring for adverse consequences . other medication errors, including those related to documentation .Within 24 hours of the MRR, the Consultant Pharmacist provides a written report to the attending physician for each resident identified as having a non-life threatening medication irregularity. The report contains: a. The resident's name; b. The name of the medication; (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. The identified irregularity; and d. The pharmacist's recommendation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on interviews and record reviews the facility failed to follow physician orders for laboratory (labs) services for one out of three residents (Resident 1) receiving two anticonvulsant medications Keppra (levetiracetam) and Depakote (is made by combining valproic acid and sodium valproate). This deficient practice of failing to monitor Resident 1 ' s labs placed Resident 1 at risk for medication related adverse reactions. Findings: During a review of Resident 1's Admission Record (a document containing demographic and diagnostic information), dated 5/22/2024, the admission record indicated that the resident was admitted on [DATE] and readmitted on [DATE], diagnoses included, Dementia (progressive loss of memory), Bipolar Disorder (a condition of major mood swings), and seizures (a sudden rush of abnormal electrical activity in your brain). A review of Resident 1's History and Physical (H&P), dated 3/12/2024, Resident 1 ' s H&P indicated the resident has fluctuating capacity to understand and make decisions. A review of Resident 1 ' s Minimum Data Summary (MDS), dated [DATE], indicated Resident 1 had intact cognition (mental action or process of acquiring knowledge and understanding), required supervision or touch assistance with eating and oral hygiene, and required substantial or maximal assistance with upper body dressing, personal hygiene, and dependent upon facility ' s staff for lower body dressing. A review of Resident 1 ' s Order Summary Report with active orders as of 4/30/2024, included orders for two seizure (is a sudden rush of abnormal electrical activity in your brain) medications Depakote (Divalproex Sodium, also used for bipolar disorder [a condition of major mood swings]) and Keppra (Levetiracetam) as follow: 1. Depakote Oral Tablet Delayed Release 125 mg, with instructions to give one tablet by mouth two times a day for bipolar disorder manifested by mood swings, order date 10/23/2023 2. Keppra Tablet 500 mg, with instructions to give one tablet by mouth two times a day for seizures, order date 9/7/2021. During a review of Resident 1's Physician Orders for laboratory (lab) tests, indicated the prescriber included lab orders for Resident 1 as follow: On 2/28/2022 lab orders were placed to check Resident 1 ' s Complete Blood Count (CBC), Basic Metabolic Panel (BMP), Lipids, Renal Panel, thyroid stimulating hormone (TSH), Vitamin D, Valproic Acid every third Tuesday of February, May, August, and November. On 3/27/2023 lab orders were placed to check Resident 1 ' s Depakote level, one time for 1 day until 3/28/2023. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/11/2023 lab orders were placed to check Resident 1 ' s Keppra level, CBC, CMP, Lipids Panel, TSH, Vitamin D, and Valproic Acid, one time only until 5/12/2023. On 9/21/2023 lab orders were placed to check Resident 1 ' s Keppra level, CBC, CMP, Lipids, Renal Panel, TSH, Vitamin D, and Valproic Acid, one time only until 9/22/2023. On 1/3/2024 lab orders were placed to check Resident 1 ' s Keppra level, CBC, CMP, Lipids Panel, TSH, Vitamin D, and Valproic Acid, one time only until 1/5/2024. A review of Resident 1 ' s Care Plans indicated for: Refusal of laboratory test initial date 10/17/2023 and revised 5/21/2024, indicated goal, Will be able to work with resident to resolve the reason for non-compliance Interventions/Tasks included, Notify MD at refusal of medication. Involve family with care .Determine residents ' reason for being non-compliance. A review of Nursing Progress Notes dated 5/20/2024 indicated, Transfer to (General Acute Care Hospital [GACH]) d/t (do to) refusal of lab. Test for further evaluation. During an interview with Resident 1 on 5/22/2024 at 12:01 PM inside of resident ' s room, Resident 1 stated, I got my labs done at the hospital because a doctor did it. Here no doctor comes around. Resident 1 stated he wanted to be transferred back to a facility closer to his family and where he had a doctor, he was familiar with. Resident 1 stated he did not want the facility to do lab test until he saw a doctor. Resident 1 stated, I saw a doctor at the hospital, but not at the facility. I don ' t know if I have seen a nurse practitioner. Resident 1 stated, I think I see a psychiatrist once a month. During a concurrent interview and record review on 5/22/2024 at 3:07 PM with a Licensed Vocational Nurse (LVN) 2, Resident 1 ' s current physician orders, labs, and labs from the GACH on 5/21/2024 were reviewed. LVN 2 stated, Resident 1 refused lab tests on 1/22/2024, 1/5/2024, 10/24/2023, and 9/26/2023, was transferred out to the hospital 5/21/2024 and returned to the facility the same night (5/21/2024). LVN 2 reviewed the lab test results from the GACH, dated 5/21/2024 and stated there was no record the GACH checked Resident 1 ' s serum (amount of drug (medication) in the blood) levels for Keppra (levetiracetam) or Depakote (valproic acid). During a concurrent interview and record review on 5/22/2024 at 3:31 PM with two Registered Nurses (RN 1 and RN 2), Resident 1 ' s labs result between 2/2022 through 5/2024 were reviewed. RN 1 stated Resident 1 ' s clinical records indicated Resident 1 ' s last lab results for Depakote (valproic acid level) and Keppra (levetiracetam levels) was last documented as taken on 12/29/2022 for Keppra and Depakote was last documented as taken on 5/18/2022. RN 1 stated without labs the facility would not know if the resident was in therapeutic range for adequate seizure control or if the medication was too low or too high which could result in toxicity (when too much medication is in the bloodstream which could lead to adverse, unwanted, or harmful effects to the resident). RN 2 stated the concern for not obtaining labs for Depakote or Keppra would be not knowing if the medications were effective or at the right dose for Resident 1. During a concurrent interview and review of nursing and physician progress notes for Resident 1, on 5/22/2024 at 4:02 PM, with RN 1 and RN 2, RN 2 stated she did not see a note to indicate the physician was notified that resident 1 did not have lab test done as ordered since 12/29/2022. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/22/2024 at 4:23 PM with the Director of Nursing (DON), Resident 1 ' s orders, lab orders, lab results, and GACH transfer records for 5/21/2024, were reviewed. The DON stated Resident 1 agreed to be transferred to the GACH on 5/21/2024 and was transferred back to the facility the same day (5/21/2024). The DON stated there was no baseline labs done at the GACH for Resident 1 ' s Keppra or Depakote, which was the plan when Resident 1 was transferred to the GACH. The DON reviewed the GACH transfer order dated 5/21/2024 and stated Resident 1 ' s transfer order to the GACH was broad and did not specify what labs should be included and there was no lab request indicated to check Resident 1 ' s Depakote or Keppra levels at the GACH during the visit on 5/21/2024. The DON stated the physician ordered labs for Resident 1 to be done every three months, but they were not being done. The DON stated when Resident 1 was sent out to the GACH on 5/21/2024 the facility missed the opportunity to obtain all the needed labs for Resident 1. The DON stated a nurse practitioner (NP) went once a month to see residents, including Resident 1. During an interview on 5/22/2024 at 5:14 PM with the facility ' s Consultant Pharmacist (CP) in the presence of the DON, the CP stated, labs ordered by the prescriber should have been done as ordered. The CP stated valproic levels could reach toxic levels and had to be monitored. The CP stated that he must have overlooked the orders for Resident 1 ' s labs. The CP stated that he randomly checked lab orders for residents and did not make any recommendations to the facility or prescriber when Resident 1 ' s orders for labs were not done. During an interview on 5/22/20224 at 5:30 PM, with NP, in the presence of DON, the NP stated that he was not aware that Resident 1 was not having labs done. The NP stated Resident 1 had lab orders to monitor the seizure medication levels to prevent the level from being too low which could cause a seizure, or the level could be too high or become toxic which would not be safe for the resident. The NP stated if the resident was refusing labs the facility should have consulted with Resident 1 ' s psychiatrist for possible transfer to the GACH. A review of the facility ' s Policy and Procedures (P&P) titled, Lab and Diagnostic Test Results - Clinical, revised 1/2024, indicated, The physician will identify, and order diagnostic and lab testing based on the resident ' s diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests . A review of the facility ' s P&P titled, Seizures and Epilepsy - Clinical Protocol, revised 1/2024, indicated, The physician and staff will help identify individuals who have a history of seizure or epilepsy, and individuals who are receiving antiepileptic medications for any reason; for example, seizure prophylaxis after a recent stroke or treatment for behavioral symptoms related to dementia .In addition, the nurse shall assess and document/report the following .Last blood level of any anticonvulsants being given .The physician will monitor antiepileptic medication blood levels periodically, where applicable. A review of the facility ' s P&P titled, Requesting, Refusing and/or Discontinuing Care or Treatment, revised 1/2024, indicated, .If a resident requests, discontinues or refuses care or treatment, the Unit Manager, Charge Nurse, or Director of Nursing Services will meet with the resident to: a. determines why the resident is requesting, refusing, or discontinuing care or treatment; b. try to address the resident's concerns and discuss alternative options; and (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. discuss the potential outcomes or consequences (positive and negative) of the resident's decision . Detailed information relating to the request, refusal or discontinuation of care or treatment will be documented in the resident's medical record. Documentation pertaining to a resident's request, discontinuation or refusal of treatment shall include at least the following: a. The date and time the care or treatment was attempted; b. The type of care or treatment; c. The resident's response and stated reason(s) for request, discontinuation, or refusal; d. The name of the person attempting to administer the care or treatment; e. That the resident was informed (to the extent of their ability to understand) of the purpose of the treatment and the potential outcome of not receiving the medication/or treatment; f. The resident's condition and any adverse effects due to the request; g. The date and time the practitioner was notified as well as the practitioner's response; h. All other pertinent observations; and i. The signature and title of the person recording the data. The healthcare practitioner must be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious consequences of the request.