

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056489	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/10/2024
NAME OF PROVIDER OR SUPPLIER Hollywood Premier Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661</p> <p>Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse (intentional bodily injury) for one sampled resident (Resident 1) by failing to ensure Resident 2's whereabouts every hour per the Physician's Order.</p> <p>This deficient practice resulted in Resident 1 being subjected to physical abuse after Resident 2 poked Resident 1 with a grabbing stick, resulting in Resident 1 having pain to the right knee.</p> <p>Findings:</p> <p>a. A review of the Admission Record indicated the facility initially admitted Resident 1 on 9/5/2023 and readmitted the resident on 3/16/2024 with diagnoses including cardiomyopathy (disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body), heart failure and functional quadriplegia (complete immobility due to severe disability or frailty from another medical condition without injury to the brain or spinal cord).</p> <p>A review of the History and Physical (H&P) dated 5/13/2024, indicated Resident 1 had the capacity to understand and make decisions.</p> <p>A review of the Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 3/12/2024, indicated Resident 1's cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated the resident required substantial / maximal assistance from facility staff with showering, toileting hygiene, transfers, and required set-up / clean-up assistance from facility staff with eating and oral hygiene.</p> <p>A review of the Interdisciplinary Team (IDT) Progress Note dated 5/28/2024, indicated the IDT met with Resident 1 to discuss concerns regarding another resident (Resident 2) carrying a grabbing stick because the grabbing stick could be used as a weapon. The IDT Progress Note indicated Resident 1 also believed Resident 2 was upset because the crayons had to be shared during activities.</p> <p>A review of the Change of Condition (COC) dated 6/1/2024, indicated another resident (Resident 2) hit Resident 1's right knee with a grabbing stick, a skin assessment was completed and no changes were observed. The COC indicated the family and physician were notified and orders to monitor for pain, psych evaluation and an x-ray (form of electromagnetic radiation, similar to visible light) of the right knee was to be obtained.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Risk for Negative Psychological Impact care plan developed on 6/1/2024 due to Resident 1's altercation, had a goal for the resident to effectively cope with feelings, have no indications of negative psychological problems, and for the resident to verbalize feelings related to emotional state. The care plan interventions indicated allowing the resident time to answer questions and to verbalize feelings, perceptions, and fears, encourage resident to vent / share feelings, and frequent visual monitoring.</p> <p>A review of the Pain Evaluation dated 6/1/2024, indicated Resident 1 had pain to the right and left thigh. The Pain Evaluation indicated the resident had a numeric rating scale of seven from a zero to 10 (10 as the worst pain you could imagine) range. The Pain Evaluation indicated the resident's PRN (as needed) medications include acetaminophen 325 milligrams (mg - unit of measurement), two tabs every 6 hours, Hydrocodone-Acetaminophen 5-325 mg, by mouth every 6H PRN for moderate pain; Hydrocodone-Acetaminophen 10-325 mg, q4H PRN for severe pain.</p> <p>A review of Resident 1's Nursing Progress Note dated 6/2/2024, indicated a post incident skin assessment was performed and there was no redness, inflammation, bruising, or pain on the right knee.</p> <p>A review of Resident 1's Psychological Service Note dated 6/7/2024, indicated the resident did not have concerns or issues and felt safe in the facility. The Psychological Service Note indicated the resident was in a positive mood and denied depression and anxiety.</p> <p>b. A review of Resident 2's Admission Record indicated the facility admitted the resident on 8/3/2020 with diagnoses that included dementia (difficulty thinking, remembering, and reasoning), depression (constant feeling of sadness and loss of interest, which stops you doing your normal activities), and lack of coordination (not able to move different parts of the body together well or easily).</p> <p>A review of the History and Physical (H&P) dated 3/4/2024, indicated Resident 2 did not have the capacity to understand and make decisions.</p> <p>A review of the MDS dated [DATE], indicated Resident 2 had severe cognitive impairment (problems with ability to think, learn, remember, use judgement, and make decisions) and did not have mood or behavior issues.</p> <p>A review of Resident 2's COC dated 6/1/2024, indicated Resident 2 hit Resident 1 on the knee with a grabbing stick. The COC indicated a mental status evaluation was done and no changes were observed. The COC indicated a behavioral status evaluation was done and no changes were observed. The COC indicated the family and physician were notified and orders for a psych consult was obtained.</p> <p>A review of Resident 2's Behavior of Physical Contact without Apparent Cause care plan developed 6/1/2024, had a goal to eliminate and / or resolve without negative results, minimize harm to others, minimize harm to self, and use socially acceptable behavior to resolve conflict. The care plan interventions indicated to provide counseling to vent feelings, explore alternate coping mechanisms, and monitor the resident's whereabouts every hour, and separate the residents and re-direct.</p> <p>A review of the Physician's Order dated 6/1/2024, indicated to monitor Resident 2's whereabouts every hour.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Social Services Progress Note dated 6/3/2024, indicated Resident 2 was alert and oriented times one with confusion. The Social Services Progress Note indicated Resident 2 did not hit Resident 1 but pointed the grabber and poked Resident 1 a little bit. Resident 2 did not have a reason as to why the incident happened. The Social Services Progress Note indicated Resident 2 could not recall the day or time the incident happened and started talking about irrelevant matters not related to the incident.</p> <p>A review of Resident 2's Psychological Service Note dated 6/7/2024, indicated the resident's presenting and ongoing symptoms include depression / mood swings. The Psychological Service Note indicated the resident appeared to be in a positive mood and did not have concerns or issues. The Psychological Service Note indicated the staff reported Resident 2 was allegedly an aggressor towards another peer, but the accounts were inconsistent and to monitor the patient for safety and well-being.</p> <p>During an observation on 6/10/2024 at 9:50 AM, in the activities room, Resident 1 was sitting in the wheelchair nearest to the patio entrance with a staff member. Resident 2 was sitting in a wheelchair in the back of the room nearest to the front lobby entrance. Resident 1 and Resident 2 were not near each other.</p> <p>During an interview on 6/10/2024 at 9:59 AM, Resident 1 stated Resident 2 poked her right leg in the lobby near the front door. Resident 1 stated after Resident 2 poked her leg, the leg hurt because of the arthritis. Resident 1 stated one month prior, Resident 2 hit and grabbed her hair. Resident 1 stated the Director of Social Services (DSS) was notified and the facility started to separate the residents.</p> <p>During an interview on 6/10/2024 at 11:20 AM, Resident 2 stated there was nothing to say and did not want to discuss the incident with Resident 1 any further.</p> <p>During an interview on 6/10/2024 at 11:37 AM, Resident 3 stated Resident 2 pulled Resident 1's hair in the activity room about a month and a half ago. Resident 3 stated Resident 1 was nervous, scared and had trauma from the incidents. Resident 3 stated the DSS was informed of the incident with the grabbing stick and the swooping of Resident 1's hair. Resident 3 stated the DSS took Resident 2 to the office and discussed the situation.</p> <p>During an interview on 6/10/2024 at 11:50 AM, Licensed Vocational Nurse (LVN) 1 stated Resident 1 was very alert and oriented, liked to socialize, and go to activities. LVN 1 had been the nurse for Resident 1 on various occasions including today. LVN 1 stated Resident 1's behavior had not changed since the incident and Resident 1 had not expressed being fearful from the experience.</p> <p>During an interview on 6/10/2024 at 12:15 PM, Certified Nursing Assistant (CNA) 1 stated Resident 2 liked to go to activities and color. CNA 1 stated Resident 2's behavior / demeanor had not changed since the incident and had not complained about anything.</p> <p>During an interview on 6/10/2024 at 1:44 PM, the Director of Activities (DA) stated if an incident occurs in the activities room, the first step was to separate the residents. The DA was on vacation during the time of the incident but stated the DA and assistants were always observing and monitoring the residents. The DA stated Resident 1 never expressed being fearful.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/10/2024 at 1:56 PM, the DSS stated the incident with Resident 2 poking Resident 1's right leg could have been prevented if the facility initiated and documented separating the residents from the start of the first incident. The DSS stated Resident 1 had never expressed she was fearful or demonstrated changes in behavior since the incident. The DSS stated the facility took away the grabber from Resident 2 and was stationed closer to the nurses station for the nurses to monitor the resident closely.</p> <p>A review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention, dated April 2021, indicated to protect residents from abuse, neglect, exploitation by anyone including, but not necessarily limited to other residents. The P&P indicated to develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents.</p> <p>A review of the facility's P&P titled, Resident-to-Resident Altercations, dated September 2022, indicated Behaviors that may provoke a reaction by residents or others include physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing / shoving, biting, spitting, threatening gestures, and throwing objects. The P&P indicated if two residents were involved in an altercation, staff must document in the resident's clinical record all interventions and their effectiveness.</p>		