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	07/08/2024

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 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** 48661 Based on observation, interview, and record review, the facility failed to provide direct supervision of residents when smoking in the facility's smoking patio as indicated in the facility's policy and procedure (P&P) titled, Smoking Policy - Residents dated August 2022, for three of three sampled residents (Residents 1, 2 and 3). As a result, on 6/20/2024 Resident 1 hit Resident 2 on the chin and also hit Resident 3 on the forehead while unsupervised in the smoking patio. Findings: A review of Resident 1's Admission Record indicated the facility admitted the resident on 6/12/2024, with diagnoses including schizophrenia (a serious mental illness that affects how a person would think, feel, and behave), depression (constant feeling of sadness and loss of interest, which stops you doing your normal activities), and epilepsy (disorder of the brain characterized by repeated seizures). A review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment and care screening tool) dated 6/19/2024, indicated Resident 1 had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 1's active diagnoses included depression and schizophrenia and the resident was receiving antipsychotic medication (type of psychiatric medication which were available on prescription to treat psychosis) and antidepressant medication (increase the activity of chemicals call neurotransmitters in the brain). A review of Resident 1's History and Physical (H&P) dated 6/20/2024, indicated the resident did not have the capacity to understand and make medical decisions. A review of Resident 1's Change in Condition (COC) dated 6/20/2024 at 9:30 PM, indicated the resident was physically aggressive and hit another resident around 8:05 PM. The COC indicated the resident representative and physician were notified. The COC indicated the facility was to transfer the resident to the hospital for psychiatric evaluation (assess a person's mental health status) due to the physical aggression. (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 1's care plan for Physically Aggressive Behavior dated 6/20/2024, indicated a goal to minimize the risk of evidence of behavior problems. The Care Plan interventions included approaching the resident in a warm and positive manner, encourage to express feelings appropriately, and monitor behavior episodes. A review of Resident 1's Psychological Service Note dated 6/21/2024, indicated the resident was encouraged to seek out staff for concerns or issues especially with any increase in mood disturbances or agitation. A review of Resident 2's Admission Record indicated the facility admitted the resident on 4/30/2024, with diagnoses including schizophrenia, anxiety disorder (feelings of fear, dread, and uneasiness that may occur as a reaction to stress), and acute kidney failure (occurs when the kidneys suddenly become unable to filter waste products from your blood). A review of Resident 2's H&P dated 5/1/2024, indicated the resident had capacity to understand and make decisions. A review of Resident 2's MDS dated [DATE], indicated the resident's cognition was intact. The MDS indicated Resident 2's active diagnoses included anxiety disorder and schizophrenia and the resident was receiving antipsychotic medication. The MDS indicated the resident was a tobacco (a plant that leave high levels of addictive chemical nicotine) user. A review of Resident 2's COC dated 6/20/2024 at 9:43 p.m., indicated to monitor for psychological impact related to recent incident (the COC did not indicate what the incident was). The COC indicated the resident's conservator (a court proceeding in which a probate judge appoints a responsible adult or organization) and physician were notified. The COC indicated the resident was to be monitored for psychological impact and 72 hours neuro checks (evaluation of a person's nervous system). A review of Resident 2's care plan for Risk for Negative Psychological impact due to Incident dated 6/20/2024, indicated a goal for the resident was to have no negative psychological problems. The Care Plan interventions included allowing the resident time to answer questions and verbalize feelings, monitor / document resident's feelings, and offer diversional activities of interest. A review of Resident 2's Psychological Service Note dated 6/21/2024, indicated the resident was a recent victim of aggression by a make peer. The note indicated the resident felt safe and was praised for not retaliating against Resident 1 after the incident. A review of Resident 3's Admission Record indicated the facility admitted the resident on 12/7/2023 and readmitted the resident on 5/23/2024, with diagnoses including schizophrenia, bipolar disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme highs [mania or manic episodes] to lows [depression or depressive episode]), and anxiety disorder. A review of Resident 3's MDS dated [DATE], indicated the resident's cognition was intact. The MDS indicated Resident 3's active diagnoses included anxiety disorder, bipolar disorder, and schizophrenia and the resident was receiving antipsychotic and antianxiety medication (help reduce the symptoms of anxiety). The MDS indicated the resident was a tobacco user. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 3's H&P dated 5/24/2024, indicated the resident had the capacity to understand and make decisions. A review of Resident 3's COC dated 6/20/2024 at 9:42 PM, indicated to monitor for psychological impact related to recent incident. The COC indicated the physician was notified. The COC indicated to monitor for neuro check and negative psychological impact. A review of Resident 3's care plan for Risk for Negative Psychological impact due to Incident dated 6/20/2024, indicated a goal for the resident to have no negative psychological problem. The Care Plan interventions included allowing the resident time to answer questions and verbalize feelings, monitor / document resident's feelings, and offer diversional activities of interest. A review of Resident 3's Psychological Service Note dated 6/21/2024, indicated the resident felt safe and explored the experience and the emotions during the incident related. The physician validated the resident's emotional experience. A review of the undated Smoking Hours indicated smoking hours were from 9 AM to 12 PM, 1 PM to 5 PM, and 6 PM to 8 PM. The Smoking Hours indicated the smoking patio was closed from 12 PM to 1 PM and 5 PM to 6 PM. During an observation in the smoking patio on 7/8/2024 at 10:37 AM, the facility receptionist (the facility staff in charge of the smoking patio) was observed with approximately 8 residents and 1 staff member (receptionist) during the designated smoke break and asked if the residents wanted an apron. Only one resident was noted with an apron and the other residents refused. The Receptionist was observed providing the residents with a cigarette and lighting the cigarette. Three large metal ash receptacles noted within the smoking patio. During an interview on 7/8/2024 at 10:22 AM, Resident 3 stated the Receptionist that watched over the smoke breaks and would leave at 5 PM. Resident 3 stated after the Receptionist would leave no staff members were in the smoking patio watching the residents. Resident 3 stated the staff checked on the residents to make sure the residents were okay, but the staff did not stay in the smoking patio during the smoke break. Resident 3 stated on the day of the incident there were no staff members in the smoking patio. During an interview on 7/8/2024 at 10:50 AM, Resident 2 stated on the day of the incident (6/20/2024) with Resident 1 there were no staff in the smoking patio with the residents. Resident 2 stated when staff saw what was happening, they (staff) went to the patio. Resident 2 stated staff did not go to the patio after the receptionist left at 5 PM. During an interview on 7/8/2024 at 10:55 PM, the Receptionist stated there should have always been a staff member with the patient's during a smoke break, or else the residents could burn their body or be injured. The Receptionist stated she asked every resident if the wanted an apron, gave them a cigarette and lit it for them, as she was outside to monitor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/8/2024 at 1:41 PM, the Director of Nursing (DON) stated a staff member had to be outside during a smoke break. The DON stated if residents were in the smoking patio, staff had to stay with the residents. The DON stated if staff was not there, there was potential for injury like a burn or an altercation between residents. The DON stated the incident could have been prevented on 6/20/2024 if a staff member was in the smoking patio to intervene right away. A review of the facility's policy and procedure (P&P) titled, Smoking Policy - Residents, dated August 2022, indicated Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor, or volunteer worker at all times while smoking.