| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056489 | A. Building<br>B. Wing | 03/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Hollywood Premier Healthcare Center | 5401 Fountain Ave.<br>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.

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|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43851<br><br>Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse (deliberate, aggressive, or violent behavior with the intention to cause harm) for one of three sampled residents (Resident 2), who was subjected to Resident 1's physical attack, who had diagnoses of schizophrenia (a serious mental disorder in which people interpret reality abnormally, may result in delusions and behavior that impairs daily functioning, may have grandiose delusions [strong beliefs of things that are untrue]). The facility failed to:<br><br>-Implement the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Prog, reviewed 1/31/2024, which indicated the facility shall uphold the resident's right to be free from physical abuse.<br><br>-Revise and update Resident 1's Behavior Problem Care Plan dated 1/16/2025, after a Change in Condition (COC) with three different panic attacks of yelling, hitting himself, and grabbed the nursing staff on 2/4/2025.<br><br>-Ensure an Interdisciplinary Team (IDT, healthcare professionals from various disciplines to collaborate and discuss a patient's case, share information, and develop a coordinated care plan) Meeting was conducted on 2/7/2025 upon Resident 1's re-admission to the facility after being transferred to General Acute Care Hospital (GACH) 1 for being a danger to himself and to others, per the facility's P&P titled, Behavioral Assessment, Intervention and Monitoring, reviewed 1/31/2024.<br><br>This deficient practice resulted in Resident 2 being subjected to physical abuse by Resident 1 while under the care of the facility. On 3/5/2025, one month after Resident 1 was transferred to a GACH for a psychiatric evaluation due to being a danger to self and others, Resident 1 punched Resident 2 in the face. Resident 2 complained of pain, had discoloration on the right side of her face and first aid was rendered. Resident 2 was transferred to GACH 2 and diagnosed with a left orbital fracture (a break in the bony structure that supports the eye).<br><br>Findings:<br><br>(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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of Resident 1's Admission Record indicated the facility initially admitted the resident on 10/1/2024 with diagnoses including schizophrenia, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily activities of living), panic disorder (a mental and behavioral disorder characterized by sudden periods of intense fear, discomfort, or a sense of losing control), and anxiety disorder (a mental health condition characterized by feelings of worry or fear that interferes with daily activities of living).<br><br>A review of the Minimum Data Set (MDS, a resident assessment tool) dated 12/13/2024, indicated Resident 1 was cognitively intact (had the ability to think, understand, and reason) and did not exhibit any physical or verbal behaviors directed towards others. The MDS indicated Resident 1 was taking an antipsychotic (medication used to treat symptoms of schizophrenia) and an antidepressant (used to treat depression) medication.<br><br>A review of Resident 1's Change of Condition (COC) documentation dated 1/16/2025 at 7:23 PM, indicated the resident was having behavioral symptoms and panic attacks without provocation (an action or statement that is intended to make someone angry). The COC indicated Resident 1 was yelling and striking the wall, door, and medical carts. The COC indicated Resident 1 verbalized having panic attacks, the physician was notified and recommended to monitor the resident for 72 hours.<br><br>A review of Resident 1's care plan initiated 1/16/2025, indicated the resident had a behavior problem of slamming doors, walls, and the medical cart related to the resident verbalizing he had a panic attack. The care plan indicated a goal for Resident 1 to have fewer episodes of behavior. The care plan interventions indicated to administer Resident 1's medication as ordered, monitor for side effects and effectiveness, anticipate and meet the resident's needs, assist the resident to develop more appropriate methods of coping and interacting, encourage the resident to express feelings appropriately, minimizing the potential for the resident's disruptive behaviors by offering tasks which divert attentions such as encouraging the resident to come to activities, discussing the resident's behavior if reasonable, explaining and reinforcing why the behavior was inappropriate or unacceptable to the resident, providing the resident opportunities for positive interaction, intervening as necessary to protect the rights and safety of others, approaching and speaking in a calm manner, removing the resident from the situation and taking him to an alternate location as needed, and listening to music with his phone and headset to help calm the resident.<br><br>According to a review of Resident 1's COC documentation dated 2/4/2025 (approximately three weeks later) at 2:31 AM, the resident was having behavioral symptoms and grabbed the nursing staff when he was having a panic attack. The COC indicated Resident 1 came out of the room yelling into the hallways. The COC indicated when Resident 1 approached the nursing station, the Charge Nurse (CN) asked Resident 1 what happened. Resident 1 stated he had a panic attack but felt okay and went back into his room. The COC indicated the Certified Nursing Assistant (CNA) informed the CN that as soon as Resident 1 came out of his room, he saw the CNA sitting in the hallway, grabbed the CNA, and then shook the CNA. The COC indicated Resident 1's physician was notified and ordered to inform the resident's psychiatrist (a medical doctor who specializes in the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders).<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of Resident 1's Nursing Progress Note dated 2/4/2025 at 2:34 PM (12 hours later), indicated the resident had another panic attack, suddenly started yelling, went to the lobby, started striking the wall, went to the social worker's office, came out, went to his room, and yelled again. The progress note indicated the facility ensured Resident 1's safety by removing objects in the resident's way and by watching the resident closely. The progress note indicated staff attempted to assess the cause of Resident 1's panic attack, but the resident did not want to discuss. The progress note further indicated Resident 1's psychiatric nurse practitioner was notified.<br><br>A review of Resident 1's Behavior Note (BN) dated 2/4/2025 at 3:18 PM, indicated Resident 1 suddenly stormed to his room yelling and screaming, hit himself and the wall with his hands, and attempted to hit the staff. The BN indicated Resident 1's psychiatric nurse practitioner was called and provided orders to transfer the resident on 5150 (a temporary, involuntary psychiatric hold, also known as a 72-hour hold, initiated by law enforcement or mental health professionals) and administer a one-time dose of Ativan (a medication used to treat anxiety) 1 milligram (mg) intramuscularly (IM, medication is injected directly into a muscle).<br><br>A review of Resident 1's Nursing Progress Note dated 2/4/2025 indicated at 5:30 PM Resident 1 had a third episode of anxiety, screaming, and yelling in the hallways. The progress note indicated at 7 PM an ambulance arrived to transfer Resident 1 to GACH 1 for a psychiatric evaluation due to being a danger to self and others.<br><br>A review of Resident 1's 'application for up to 72-hour assessment, evaluation, and crisis intervention or placement for evaluation and treatment' form dated 2/4/2025, indicated detainment of Resident 1 began at 6 PM. The form indicated Resident 1 was observed pacing, pulling his hair, that staff and residents were in fear for their safety and that Resident 1 was unpredictable. The form further indicated there was probable cause to believe that Resident 1 was a danger to themselves and a danger to others as a result of mental health disorders.<br><br>According to a review of Resident 1's care plan related to behavior problem of slamming doors, walls, and the medical cart, initiated 1/16/2025, the care plan failed to indicate an update or revision after Resident 1's COC on 2/4/2025.<br><br>A review of Resident 1's Nursing Progress Note dated 2/7/2025 at 4:10 PM, indicated the resident was readmitted to the facility with no aggressive behaviors noted.<br><br>A review of Resident 1's electronic health record (EHR) indicated the facility failed to conduct an Interdisciplinary Team Meeting to discuss and address Resident 1's behaviors from 2/4/2025, after the resident returned to the facility from GACH 1 on 2/7/2025.<br><br>A review of Resident 1's COC documentation dated 3/5/2025 at 5:24 PM (one month after being readmitted to the facility), indicated Resident 1 had a physical altercation with another resident (Resident 2). Resident 1's physician was notified and recommended to transfer Resident 1 to GACH 3 for a psychiatric evaluation.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A review of Resident 1's Nursing Progress Note dated 3/5/2025 indicated at approximately 5:15 PM, a physical altercation occurred between Resident 2 and Resident 1 in the facility lobby. The progress note indicated Resident 2 and Resident 1 were seated side by side, with Resident 2's wheelchair positioned between both residents. The progress note indicated that according to witness reports, Resident 1 moved Resident 2's wheelchair, which upset Resident 2 and lead to a verbal disagreement. The progress note indicated both Residents stood up, and Resident 1 suddenly threw a punch at Resident 2 striking the right side of Resident 2's face. The progress note indicated Resident 1 had no injuries, Resident 1's physician was notified and gave orders to transfer the resident to the GACH for further evaluation of his behavior. The progress note indicated at 5:35 PM the RN supervisor and CN interviewed Resident 1 about the incident and Resident 1 called Resident 2 a derogatory name.<br><br>A review of Resident 1's Nursing Progress Note dated 3/11/2025 indicated that at 2:30 PM, Resident 1 returned to the facility from the GACH.<br><br>A review of the IDT Note dated 3/11/2025 indicated Resident 1 wrote a letter indicating that Resident 1 would not bring physical harm to residents or to staff and Resident 1 signed the letter.<br><br>A review of Resident 2's Admission Record indicated the facility admitted the resident on 1/7/2025 with diagnoses including schizophrenia, bipolar disorder (a mental disorder that causes dramatic shifts in a person's mood or energy and may affect the person's ability to think clearly), depression, unsteadiness on their feet, muscle weakness, and anxiety disorder.<br><br>According to a review of Resident 2's MDS dated [DATE], the resident had moderately impaired cognition (problems with the ability to think, understand, and reason), did not exhibit physical or verbal behavioral symptoms towards others, and Resident 2 was taking antipsychotic medication.<br><br>A review of Resident 2's COC documentation dated 3/5/2025 at 5:28 PM, indicated the resident had a physical altercation with another resident (Resident 1). Resident 2's physician was notified and recommended to transfer the resident to the GACH for further evaluation and treatment.<br><br>A review of Resident 2's Nursing Progress Note dated 3/5/2025 indicated at approximately 5:15 PM, Resident 2 was noted to have discoloration on the right side of her face due to the altercation with Resident 1. The progress note indicated first aid was rendered, and a neuro check and vital sign assessment was completed for Resident 2. The progress note indicated Resident 2's attending physician was notified and provided orders to apply an ice pack to the affected area every 15 minutes for three applications and to transfer Resident 2 to the GACH for further evaluation of her injury. The progress note indicated at 5:40 PM the CN interviewed Resident 2 regarding the incident, and the resident stated she did not remember exactly what happened, all she could remember was a big man punched her in the face.<br><br>A review of the Physician's Order dated 3/5/2025, indicated to transfer Resident 2 to GACH 2 for further evaluation of facial trauma.<br><br>During a concurrent observation and interview on 3/18/2025 at 9:03 AM, in Resident 1's room, the resident was observed sitting on the side of the bed, calm, and watching television. Resident 1 stated he hit Resident 2 because she was irritating him. Resident 1 stated Resident 2 tried to throw her wheelchair at him, so he punched Resident 2 in her face. Resident 1 stated Resident 2 also punched him in his face.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 3/18/2025 at 9:12 AM, the Director of Social Services (DSS) stated Resident 1 had a history of mood swings and tantrums. The DSS stated Resident 1 verbalized and admitted that what he did to Resident 2 was wrong.<br><br>On 3/21/2025 at 9:21 AM, during an interview with Resident 3, who was cognitively intact, Resident 3 stated she witnessed the altercation between Resident 1 and Resident 2. Resident 3 stated Resident 2 used curse words and told Resident 1 to move, get out of the way. Resident 3 stated Resident 1 got up and punched Resident 2 in the face.<br><br>During a telephone interview on 3/18/2025 at 12:31 PM, RN 1 stated the altercation between Resident 1 and Resident 2 happened quickly. RN 1 stated Resident 2 complained of pain to the right side of her face 30 minutes after the incident, so the resident was given pain medication. RN 1 further stated Resident 1 previously had panic attacks, and when the resident would have these attacks he would scream, throw things on the floor, and bang the walls.<br><br>During a concurrent interview and record review on 3/18/2025 at 2:44 PM, Resident 1's care plan, COC's, and progress notes were reviewed with RN 2. RN 2 stated she was familiar with Resident 1. RN 2 stated Resident 1 had grabbed another staff member during one of his previous panic attacks. RN 2 stated Resident 1 had a care plan for his panic attacks that was initiated on 1/16/2025 which was not revised after his panic attack on 2/4/2025. RN 2 further stated an IDT meeting was not conducted for Resident 1's behaviors after the resident was transferred to the GACH for a psychiatric evaluation on 2/4/2025.<br><br>During a concurrent interview and record review on 3/18/2025 at 4:09 PM, Resident 1's care plan, COC's, and progress notes were reviewed with the DON. The DON stated Resident 2 could not remember much about the altercation and that Resident 1 admitted to punching Resident 2. The DON stated that on 2/4/2025 Resident 1 had a series of panic attacks during which he shook a CNA. The DON stated the resident's care plan for panic attacks was initiated on 1/16/2025 and had not been updated or revised after his panic attacks on 2/4/2025. The DON stated Resident 1's care plan for panic attacks should have been revised after having a change of condition on 2/4/2025. The DON confirmed and stated there was no IDT meeting conducted after Resident 1's change of condition on 2/4/2025 and she also looked in Resident 1's EHR and did not see that an IDT meeting was held to discuss Resident 1's behaviors after the 5150 hold. The DON stated an IDT meeting should have been held within 72 hours of Resident 1's return to the facility. The DON stated Resident 1's panic attacks were an ongoing area of concern for the resident which was why it was important to ensure the resident's behaviors were discussed during an IDT meeting. The DON stated punching another resident was not acceptable behavior and abuse was not acceptable in the facility.<br><br>A review of the facility's P&P titled, Behavioral Assessment, Intervention and Monitoring, reviewed 1/31/2024, indicated under Interventions and Management, the IDT evaluated behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident, and developed a plan of care accordingly. Atypical behavior was differentiated from behavior that was dangerous or problematic for the resident (s) or staff, or behavior that signals underlying distress. If a behavior was atypical but not problematic or dangerous and the resident did not appear to be in distress, then the IDT monitors for changes but did not necessarily intervene to normalize the behavior. Safety strategies were implemented immediately, if necessary, to protect the resident and others form harm.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The P&P indicated the care plan included as a minimum: a description of the behavioral symptoms, including frequency, intensity, duration, outcomes, location, environment; and precipitating factors or situations; targeted and individualized interventions for the behavioral and/or psychosocial symptoms; the rationale for the interventions and approaches; specific and measurable goals for targeted behaviors; and how the staff would monitor the effectiveness of the interventions. Interventions were individualized and part of an overall care environment that supports physical, functional, and psychosocial needs, and strives to understand, prevent, or relieve the resident's distress or loss of abilities.<br><br>A review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, reviewed 1/31/2024, indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The IDT, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan or each resident .Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident's condition, when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment.<br><br>A review of the facility's P&P titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Prog, reviewed 1/31/2024, indicated Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The resident abuse, neglect, and exploitation prevention program consists of a facility wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone include but not necessarily limited to: facility staff, other residents, consultants, volunteer, staff from other agencies, family members, legal representatives, friends, visitors, and/or any other individual .Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive, or emotional problems. |