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	09/15/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the physician when the resident had a change of condition for one of three sampled residents (Resident 1). For Resident 1, the facility failed to notify the primary physician on 8/23/25 when Resident 1 had a seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), irregular heart rate and desaturation (when blood oxygen level drops below the normal range). This deficient practice had the potential for Resident 1 to have worsening conditions without appropriate intervention. During a review of the admission Record indicated the facility admitted Resident 1 on 6/3/19 and re-admitted on [DATE] with diagnoses including failure to thrive (presence of one or more medical condition that put them at risk of further decline), dementia (a progressive state of decline in mental abilities) and seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 8/18/25 indicated Resident 1 had severe cognitive impairment. Resident 1 was dependent on eating, oral hygiene, toileting, shower, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a review of the Change of Condition (COC) dated 8/23/25 at 6:35 p.m., indicated on 8/23/25 at 5:30 p. m., Resident 1 had a heart rate of 147 to 152 beats per minute (bpm, normal resting heart rate ranges from 60 to 100 bpm), temperature of 99.8 degrees Fahrenheit (normal range is 97 degrees F to 99 degrees F), oxygen saturation (amount of oxygen that's circulating in the blood) of 85% (normal range is 95% to 100%) and had a seizure like activity. The COC indicated Resident 1 was given oxygen at five liters by nasal cannula (NC, nasal prongs) and seizure precautions were implemented. The COC indicated Resident 1's primary physician was notified, and a message was left with the answering service. The same COC indicated .new orders awaited. During a concurrent interview and record review on 9/12/25 at 9:33 a.m., Resident 1's COC dated 8/23/25 was reviewed with licensed vocational nurse (LVN 1). LVN 1 stated on 8/23/25 Resident 1 had a COC that included seizure-like activity lasting about 10 seconds, heart rate of 147 bpm and oxygen saturation was 85%. LVN 1 stated Resident 1 was given oxygen five liters and Resident 1's oxygen saturation improved to 90%. LVN 1 stated Resident 1's physician was notified by leaving a message with the primary physician's answering service. LVN 1 stated she was unable to find documentation that Resident 1's physician called back, or new orders were given. LVN 1 further stated the physician needs to be notified when Resident 1 had a COC because the physician would give orders or may want to give order to transfer Resident 1 to the general acute hospital for evaluation. During a telephone interview on 9/12/25 at 11:35 a.m. , Resident 1's nurse practitioner (NP) stated when Resident 1 had a COC on 8/23/25 he would have sent Resident 1 to the general acute hospital by paramedics for evaluation. During an interview on 9/19/25 at 12:38 p.m., the director of nursing (DON) stated if Resident 1's physician did not call back, we are supposed to call the medical director for orders. During a review of the facility's policy and procedures (P&P) titled Acute Condition Changes - Clinical Protocol reviewed on 1/16/25, the P&P indicated the nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less). The same policy indicated the attending physician (or practitioner providing back-up coverage) will respond in a timely manner to notification of problems or changes in condition and status. The nursing staff will contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review the facility failed to obtain blood sugar level by fingerstick according to accepted professional standards of practice for one of two sampled residents (Resident 2). For Resident 2, who had diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), the facility failed to obtain blood sugar level when Resident 2 had nothing to eat from 3 p.m. to 9:30 p.m. on 8/30/25.This deficient practice had the potential for Resident 2 to suffer from either hypoglycemia (blood sugar level drop below normal) or hyperglycemia (abnormally high blood sugar) and for the facility not giving Resident 2 proper intervention. During a review of the admission Record indicated the facility admitted Resident 2 on 8/25/25 with diagnoses including DM and dysphagia (difficulty swallowing).During a review of the Minimum Data Set (MDS, a resident screening tool) dated 8/26/25 indicated Resident 2 had severe cognitive impairment. Resident 2 was dependent on oral hygiene, toileting hygiene, shower, upper/lower body dressing and putting on/taking off footwear. During a review of Resident 2's care plan initiated on 8/26/25 indicated Resident 2 had diagnosis of DM and was at risk for hyperglycemia and hypoglycemia. The care plan goal indicated Resident 2 will have blood sugar level within normal limits of 65 millimoles per liter (mmol/L, unit of measurement) to 115 mmol/L. The care plan interventions included to monitor blood sugar as ordered. During a review of the Change of Condition (COC) dated 8/30/25 at 3:21 p.m., indicated Resident 2 pulled out his nasogastric tube (NGT, a thin, soft tube that goes through the nose, down the throat and into the stomach) on 8/30/25 at 3 p.m. The COC indicated the facility attempted to re-insert the NGT but was unsuccessful. Resident 2's primary physician was notified, and the physician gave order to transfer Resident 2 to the general acute hospital (GACH) for NGT replacement. During a concurrent interview and record review with licensed vocational nurse (LVN 1) on 9/12/25 at 8:45 a.m., Resident 2's COC dated 8/30/25 was reviewed. LVN 1 stated Resident 2 pulled out his NGT on 8/30/25 at around 3 p.m. Resident 2's primary physician gave order to transfer Resident 2 to GACH for NGT placement. LVN 1 stated the ambulance came at 9:30 p.m. and transferred Resident 2 to GACH. LVN 1 stated Resident 2 had nothing to eat for six and half hours from 3 p.m. to 9:30 p.m. LVN 1 stated Resident 2's blood sugar level was not obtained. LVN 1 stated it is important to test Resident 2's blood sugar level to ensure Resident 2's blood sugar level .was not low or high. During a telephone interview on 9/12/25 at 9:14 a.m., LVN 2 stated Resident 2 pulled out his NGT on 8/30/25 and the primary physician gave an order to transfer Resident 2 to GACH. LVN 2 stated she did not obtain Resident 2's blood sugar level. LVN 2 stated Resident 2 had the potential to have hyperglycemia or hypoglycemia. During a review of the facility's policy and procedures (P&P) titled Nursing Care of the Older Adult with Diabetes Mellitus reviewed on 1/16/25, the P&P indicated to monitor the blood glucose as indicated if the individual is fasting before a medical procedure, has returned to the facility after a significant absence or has an acute infection or illness.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide laboratory services for one of three sampled residents (Resident 1). For Resident 1, the facility failed to follow the physician order to obtain blood sample for comprehensive metabolic panel (CMP, series of 14 blood tests that provide information about a person's current metabolism) on 8/15/25. This deficient practice resulted in Resident 1 not provided laboratory services that would help determine the medical and diagnostic needs of Resident 1. During a review of the admission Record indicated the facility admitted Resident 1 on 6/3/19 and re-admitted on [DATE] with diagnoses including failure to thrive (presence of one or more medical condition that put them at risk of further decline), dementia (a progressive state of decline in mental abilities) and seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 8/18/25 indicated Resident 1 had severe cognitive impairment. Resident 1 was dependent on eating, oral hygiene, toileting, shower, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a review of the Physician Order dated 8/13/25 at 9:53 a.m., indicated an order to obtain blood sample from Resident 1 for CMP to be done on 8/15/25. During a concurrent interview and record review, on 9/12/25 at 10:25 a.m., the Physician Order dated 8/13/25 was reviewed with LVN 3. LVN 3 stated the physician gave an order on 8/13/25 to get blood sample from Resident 1 for CMP. The order indicated the blood sample was to be done on 8/15/25. LVN 3 stated she was unable to find the CMP result and stated she was unable to find documentation why the CMP was not done. During an interview, on 9/12/25 at 10:35 a.m., the medical record director (MRD) stated she was unable to find the result of Resident 1's CMP because the CMP was not done on 8/15/25. During an interview on 9/12/25 at 10:50 a.m., the director of staff development (DSD) stated if Resident 1's CMP was not done, we will not be able to identify what is wrong. with the resident. During a review of the facility's policy and procedures (P&P) titled Laboratory and Diagnostic Test Results - Clinical reviewed on 1/16/25, the P&P indicated the physician will identify and order diagnostic and laboratory testing based on the resident's diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. The same Policy indicated a nurse will try to determine whether the test was done that included:a. as a routine screen or follow-up.b. To assess a condition change or recent onset of signs and symptomsc. to monitor the drug level.