

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 02/09/2026
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure to provide adequate supervision for one of four sampled residents (Resident 1) to prevent a resident-to-resident altercation (negative and aggressive physical or verbal interactions). On 2/1/2026 at approximately 7:55 AM, Resident 1, who required a one-on-one supervision (assignment of a dedicated staff member), stepped inside Resident 2's room and Resident 2 pushed Resident 1 out of her (Resident 2's) room. This failure caused Resident 2 to push Resident 1 and had the potential for Resident 1 and Resident 2 to sustain physical injuries. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 9/25/2025, and readmitted the resident on 11/25/2025, with diagnoses including but not limited to unspecified affective mood disorder (a mental health condition characterized by significant, long-term disruptions in a person's emotional state, including extreme sadness (depression) or extreme highs (mania/hypomania), and psychosis (a mental health symptom characterized by a loss of contact with reality, where an individual has trouble distinguishing between what is real and what is imaginary). During a review of Resident 1's Care Plan Report dated 9/29/2025, the Care Plan Report indicated Resident 1 was at risk for attempting elopement (resident makes an intentional, unauthorized departure) as evidenced by two attempts to leave the facility. The Care Plan Report indicated for the nursing staff to conduct frequent visual checks. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 10/2/2025, the MDS indicated the resident sometimes made himself-understood and understood others. The MDS indicated Resident 1 had severely impaired cognition (means a person has a very serious difficulty with thinking, remembering, concentrating, and making decisions). The MDS indicated Resident 1 was dependent on needing maximal assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's History and Physical (H&P), dated 11/7/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 1's Progress Notes Psychiatric Narrative Note dated 1/17/2026, the Progress Notes Psychiatric Narrative Note indicated Resident 1 was seen for a psychiatric (is the branch of medicine that focuses on the prevention, diagnosis, and treatment of mental, behavioral, and emotional disorders) evaluations following nursing reports of multiple attempted elopements. The Progress Notes Psychiatric Narrative Note indicated Resident 1 required close monitoring and was currently placed on one-to-one supervision to ensure safety. During a review of Resident 1's Progress Notes dated 2/1/2026 at 7:55AM, the Progress Notes indicated there was an altercation between two residents (Resident 1 and Resident 2). The Progress Notes indicated Resident 2 pushed Resident 1 out of Resident 2's room. The Progress Notes indicated Resident 1 and Resident 2 grabbed each other. During a review of Resident 2's admission Record indicated, the admission Record indicated the facility admitted Resident 2 on 9/25/2025 with diagnoses including but not limited to schizophrenia (severe</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 056489	If continuation sheet Page 1 of 2

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>mental disorder, making it difficult to distinguish reality from imagination) and Major depressive order (mood disorder characterized by persistent sadness). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 made herself understood and understood others. The MDS indicated Resident 2 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 was independent with mobility and ADLs. During phone interview on 2/9/2026 at 12:49 PM, with Certified Nursing Assistant 1 (CNA1), CNA1 stated she (CNA1) was familiar with Resident 1. CNA1 stated Resident 1 had mood swings (mental health issues) and might have been confused when he (Resident 1) entered another resident's room (Resident 2). CNA1 stated Resident 1 could be in a better place with more supervision. CNA1 stated she (CNA1) saw Resident 2 pushed Resident 1 out of her room on 2/1/2026. During a concurrent interview and record review on 2/9/2025, at 3:45 PM, with the Director of Nursing (DON), Resident 1's Care Plan Report was reviewed. The DON stated Resident 1's Care Plan Report dated 9/29/2025 and revised 2/1/2026 indicated Resident 1 was at risk for attempting elopement as evidenced by two attempts to leave the facility. The DON stated the one-to-one was not reflected in the Care Plan Report. During a concurrent interview and record review on 2/9/2025 at 4:01 PM, with the DON, Resident 1's Progress Note Psychiatric Narrative Note dated 1/17/2026 was reviewed. The DON stated the Progress Note Psychiatric Narrative Note indicated Resident 1 required close monitoring and was placed on one- to-one supervision to ensure safety. The DON stated that Resident 1 required supervision. The DON stated the psychiatrist's plan indicated to continue the one-on-one supervision. The DON stated the one-on-one supervision was not done on 2/1/2026. The DON stated the facility failed to provide supervision. During a review of the facility's policy and procedure (P&P) titled Safety and Supervision of Residents, last reviewed on 1/16/2025, the P&P indicated the facility strived to make the environment as free from accident hazards as possible. The P&P indicated that resident safety and supervision and assistance to prevent accidents were facility-wide priorities. The P&P indicated the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive. During a review of the P&P titled Care Plans, Comprehensive Person-Centered, last reviewed on 1/16/2025, the P&P indicated the 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 P&P indicated assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. During a review of the facility's P&P titled Wandering [move about aimlessly or without any destination and Elopements], last reviewed on 1/16/2025, the P&P indicated the facility will identify who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.</p>		