

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  08/14/2025
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)
F 0552  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments.  (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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to obtain an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for antipsychotic medication (medication that affects brain activity and is used to treat mental health disorders) administration for one of two sampled residents (Resident 11) by failing to: -Ensure to complete an informed consent form (a formal conversation and a signed document that acknowledges the resident's understanding and agreement to the medication treatment plan) for the following medications: - risperidone (Risperdal, a medication used to treat schizophrenia [a mental illness that is characterized by disturbances in thought])-quetiapine (Seroquel, a medication used to treat schizophrenia) -valproic acid (a medication used to treat bipolar disorder [sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs]). These failures had the potential for Resident 11 to experience adverse effects (a harmful, unintended result caused by taking medication) from taking risperidone, quetiapine, and valproic acid; and affected the ability of Resident 11 to exercise her right to be informed of, participate in, and refuse treatment. Findings: During a review of Resident 11's admission Record (a document that collects essential information about a resident when they enter a healthcare facility), the admission Record indicated the facility readmitted Resident 11 on 5/22/2025 with diagnoses that included schizophrenia and bipolar disorder. During a review of Resident 11's Order Summary Report (a document that lists a resident's current medical orders) with an order date of 5/22/2025, the Summary Report indicated for Resident 11 to take Risperidone 2 milligrams (mg, unit of measurement) one tablet by mouth at bedtime for schizophrenia, Seroquel oral tablet 100 mg one tablet by mouth at bedtime for schizophrenia, valproic acid oral solution 250 mg/5 milliliters (mL, unit of volume) 10 mL by mouth in the morning for mood disorder (characterized by significant disturbances in a person's emotional state, often causing prolonged periods of sadness, irritability, or mania that interfere with daily life), and valproic acid oral solution 250 mg/5 mL 15 mL by mouth at bedtime for mood disorder. During a review of Resident 11's History and Physical (H&amp;P, a medical document that includes medical history and physical examination findings) dated 5/23/2025, the H&amp;P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool) dated 5/23/2025, the MDS indicated the resident exhibited impaired memory recall. The MDS indicated Resident 11 was taking antipsychotic medication. During a review of Resident 11's Informed Consents: Risks and Benefits of Antipsychotic Medications forms dated 5/23/2025, the Informed Consents: Risks and Benefits of Antipsychotic Medications forms indicated the resident consented to taking Risperidone, Seroquel, and valproic acid. The Informed Consents: Risks and Benefits of Antipsychotic Medications forms indicated verbal consent from resident in the signature box designated for resident representative. The Informed Consents: Risks and Benefits of Antipsychotic Medications forms did not indicate the signature of the resident or a Responsible Party (RP, an individual who is responsible for handling a resident's finances and medical care). During an interview on 8/14/2024 at 12:20 PM, with the Director of Nursing (DON), the DON stated Resident 11 did not have the capacity to provide informed consent for antipsychotic medications. The DON stated the facility was required to obtain an informed consent prior to the administration of antipsychotic medications. During an interview on 8/14/2025 at 12:27 PM, with the Medical Director (MD), MD stated the facility did not obtain informed consent from Resident 11 or Resident 11's RP for the administration of Risperidone, Seroquel, or valproic acid. During an interview on 8/14/2025 at 1:40 PM with the DON, the DON stated the consent forms for Risperidone, Seroquel, and valproic acid were completed inaccurately and did not reflect Resident 11's cognitive capacity to consent to medication therapy. During a review of the facility's policy and procedure (P&amp;P) titled, Psychotropic Medication Use, dated February 2025, the P&amp;P indicated psychotropic medication is any medication that affects brain activity associated with mental processes and behavior including antipsychotics. The P&amp;P indicated prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal: non-pharmacological alternatives, the indication and rationale for recommendation, the potential risks and benefits, and the resident's/representative's right to accept or decline the treatment.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>Based on interview and record review, the facility failed to ensure to provide an advanced directive (a legal document indicating resident preference on end-of-life treatment decisions) to the Responsible Party (RP, an individual who is responsible for handling a resident's finances and medical care) for one of three sampled residents (Resident 70). This failure had the potential for Resident 70 to receive unwanted medical treatments or experience a delay in medical care and had the potential to affect Resident 70's ability to exercise her right to formulate an advanced directive. Findings: During a review of Resident 70's admission Record (a document that collects essential information about a resident when they enter a healthcare facility), dated 8/13/2025, the admission Record indicated the facility admitted Resident 70 on 7/30/2025 with a diagnoses that included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), lack of expected normal physiological development (developmental delay or failure to reach expected physical, cognitive, or behavioral milestones), and surgical aftercare (provided to support recovery, prevent complications, and manage pain and wound healing following surgery) following colostomy surgery (surgical procedure that creates an opening in the abdomen to divert stool to an external bag). During a review of Resident 70's Minimum Data Set (MDS, a resident assessment tool) dated 7/30/2025, the MDS indicated the resident had severely impaired cognition (impairment in the ability to think, understand, and reason). The MDS indicated Resident 70 was taking antipsychotic medication (used primarily to treat symptoms of psychosis [a mental state characterized by a disconnect from reality, often involving hallucinations, delusions, and disorganized thinking]) and antianxiety medication (used to treat anxiety). During a review of Resident 70's medical records (official documentation of a resident's health information and care), the medical records did not contain an advanced directive or advanced directive planning. During an interview on 8/12/2025 at 3:38 PM with the Social Services Director (SSD), the SSD stated she (SSD) contacted Resident 70's Regional Center Service Coordinator (RCSC, a professional who helps individuals with developmental disabilities access and manage services and support) on 8/6/2025 to request signed copies of the Physician Orders for Life-Sustaining Treatment (POLST-treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency) form and the Request for admission and Authorization for Treatment and Medication form. The SSD stated she (SSD) did not inquire whether Resident 70 had executed an advanced directive. The SSD stated that she (SSD) did not provide Resident 70's RCSC advanced directive information. During an interview on 8/13/2025 at 9:36 AM, Resident 70's RCSC stated the facility did not inquire whether Resident 70 had executed an advanced directive. The RCSC stated the facility did not provide her (RSC) with advanced directive information or include her (RSC) in advanced directive planning. During a review of facility's policy and procedure (P&amp;P) titled Advanced Directives, dated 1/16/2025, the P&amp;P indicated the resident has the right to formulate an advanced directive. The P&amp;P indicated upon admission the resident or representative is provided with written information concerning the right to formulate an advanced directive. The P&amp;P indicated if the resident is incapacitated and unable to receive information about her or his right to formulate an advanced directive, the information may be provided to a resident's legal representative. The P&amp;P indicated the resident information about whether the resident has executed an advanced directive is displayed prominently in the medical record.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the resident's environment promoted and enhanced their quality of life when her bed mattress was placed directly on the floor for one of one sampled resident (Resident 70). This failure had the potential to result in Resident 70 acquiring a healthcare-associated infection (infections acquired during healthcare delivery and are not present at the time of admission), experiencing physical safety hazards and psychological harm; and affected the quality of care provided to Resident 70. Findings: During a review of Resident 70's admission Record (a document that collects essential information about a resident when they enter a healthcare facility), dated 8/13/2025, the record indicated Resident 70, a [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis that included metabolic encephalopathy (brain dysfunction caused by underlying medical conditions that disrupt the body's metabolism [the process by which the body converts food into energy]), dysphagia (difficulty swallowing), and surgical aftercare (provided to support recovery, prevent complications, and manage pain and wound healing following surgery) following colostomy surgery (surgical procedure that creates an opening in the abdomen to divert stool to an external bag). During a review of Resident 70's Minimum Data Set (MDS, a resident assessment tool) dated 7/30/2025, the MDS indicated the resident was completely dependent on assistance from medical staff for self-care needs (eating, oral care, showering, toileting, dressing, and putting on/taking off footwear) and mobility. MDS indicated Resident 70 had a surgical wound. During a review of Resident 70's Care Plan Report (a document that outlines a person's individual health and social care needs and the specific actions and support required to meet those needs), dated 8/12/2025, the report indicated Resident 70 needed a safe environment with a high-low bed (a fully adjustable bed with head, foot, and height adjustability) in low position while resident is in bed. The report indicated Resident 70 had impaired bed mobility and needed bedrails to assist with mobility. The report indicated Resident 70 required perineal care (cleaning the genital and anal area) and surgical wound care (the process of managing a surgical incision to promote healing, prevent infection, and minimize complications). During a review of Resident 70's Care Plan Report, dated 8/12/2025, the report indicated Preadmission Screening and Resident Review (PASARR, a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) Level 2 Evaluation (a person-centered evaluation that is completed for anyone identified by the Level 1 Screening as having a serious mental illness, intellectual disability, developmental disability, or related condition) determined Resident 70 required nursing facility services due to her medical condition and/or schizophrenia and bipolar disorder. During an observation on 8/11/2025 at 10:01 AM in Resident 70's room, Resident 70 was lying on a bed mattress placed directly on the floor without a bed frame or bedrails. During an interview on 8/12/2025 at 9:45 AM with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated transferring Resident 70 from a mattress placed on the floor could result in discomfort. CNA 4 stated transferring Resident 70 from a mattress placed directly on the floor with a mechanical lift was unsafe, the lift may become unstable and topple, creating a risk of fall and injury to the resident. CNA 4 stated the placement of the mattress directly on the floor compromised Resident 70's quality of care by restricting the ability of staff to provide appropriate care. During an interview on 8/12/2025 at 10:08 AM with CNA 5, CNA 5 stated Resident 70 ate meals in bed positioned against the Wall for support. CNA 5 stated the facility had high-low beds that could be positioned very near to the ground. During an interview on 8/14/2025 at 11:11 AM with the Director of Staff Development (DSD), DSD stated the facility cannot ensure Resident 70's bed was in the lowest setting if the mattress was not placed on a height-adjustable bedframe. During the interview on 8/14/2025 at 11:11 AM with the DSD, DSD stated the facility had not provided training on care for individuals with intellectual disabilities since Resident 70's admission. The DSD stated the facility had not provided training on care practices associated with floor-level mattress placement. During an interview on 8/14/2025 at 1:24 PM with the Director of Nursing (DON), DON stated alternative safety interventions that did not involve placing Resident 70's mattress on the floor were available. The DON stated Resident 70 may have felt she was not treated equally to other residents. During a review of the facility's policy and procedures (P&amp;P) titled, Dignity, dated 1/16/2025, the P&amp;P indicated each resident shall be cared for in a manner that promotes her or his sense of well-being and feelings of self-worth and self-esteem. The P&amp;P indicated staff are expected to treat cognitively impaired residents with dignity and sensitivity. The P&amp;P</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to develop and implement a care plan for one of 19 sampled residents (Resident 34) for fall prevention to address the resident's preference of raising his bed to the bed's maximum height. This deficient practice had the potential for Resident 34 to fall and sustain an injury. Findings: During a review of Resident 34's admission Record, the admission Record indicated the facility admitted the resident on 3/7/2025 with diagnoses that included lack of coordination, unsteadiness on feet, idiopathic aseptic necrosis (a medical condition where bone tissue dies because of a disruption in its blood supply, and no known cause for this disruption can be identified) of right femur (thigh bone), left wrist drop (you can't lift your left wrist or fingers, and your hand hangs down limply), other cord compression (pressure on your spinal cord - tube of tissue that carries nerve signals from your brain to the rest of your body and back), spinal stenosis cervical region (a narrowing of the spinal canal in the neck that can cause pain, numbness, tingling, difficulty walking, stiffness, and weakness), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and sciatica (pain, numbness, or tingling in the leg caused by the sciatic nerve, the body's longest nerve, getting pinched or injured in the lower back) right side. During a review of Resident 34's Care Plan Report dated 3/10/2025, the Care Plan Report indicated Resident 34 was at risk for falls related to poor balance, unsteady gait (pattern of walking), decreased functional status (reduced ability to do the things you need to take care of yourself and live independently), attempts to exit the bed, and attempts to stand unassisted. The Care Plan Report indicated interventions to assess the resident's joint mobility upon admission, quarterly and/or when significant change of condition. The Care Plan Report indicated interventions for the resident to have a call light (a device used by a patient to signal his or her need for assistance) within reach and for the staff to answer promptly. The Care Plan Report indicated interventions for the licensed nursing staff to monitor the resident for sedation (drowsiness), unsteady standing, and sitting balance. Inform MD (medical doctor). During a review of Resident 34's nursing Progress Notes dated 5/22/2025 at 11:54 PM, the Progress Notes indicated, a Certified Nursing Assistant (CNA unidentified) informed the Charge Nurse (CN unidentified) that the resident's bed was in the highest position and the resident requested batteries for his control (unidentified). The Progress Notes indicated the CN (unidentified) went in the resident's room and saw the resident's bed in the highest position. During a review of Resident 34's Nursing-Fall Risk Evaluation dated 6/12/2025, the Nursing-Fall Risk Evaluation indicated Resident 34 had a balance problem while standing and a balance problem while walking. The Nursing-Fall Risk Evaluation indicated Resident 34 required the use of assistive devices such as a walker (is a type of mobility aid that offers stability and support while walking), cane, w/c (wheelchair), or furniture. During a review of Resident 34's Minimum Data Set (MDS - a resident assessment tool), dated 6/24/2025, the MDS indicated Resident 34 had the ability to make himself understood and had the ability to understand others. The MDS indicated Resident 34 used a wheelchair. The MDS indicated Resident 34 needed partial/moderate assistance with shower/bathing self. The MDS indicated the facility did not attempt to evaluate Resident 34's ability to tub/shower transfer (how a person with limited mobility safely moves into and out of a shower or bathtub) due to medical condition or safety concerns. During a concurrent observation and interview on 8/11/2025 at 10:19 AM with Resident 34 and Certified Nursing Assistant 2 (CNA 2), Resident 34's bed was noted to be in the highest position and Resident 34's call light was out of reach hanging behind and above Resident 34's bed. Resident 34 stated he (Resident 34) could not see very well, and he put his bed to the highest position. CNA 2 stated Resident 34's call light was not where the resident could reach it and the resident would not be able to call for help. During an interview on 8/13/2025 at 8:02 AM with the Director of Nursing (DON), the DON stated the resident had the ability to control his bed himself and did not comply (follow the rules) with keeping his (Resident 34) bed in a low position for safety. The DON stated Resident 34 was at risk for falls. During a concurrent interview and record review on 8/13/2025 at 8:28 AM with the DON, Resident 34's care plan dated 3/10/2025 was reviewed. The DON stated the care plan indicated there was no care plan for Resident 34 raising his bed. The DON stated the facility did not start the care plan regarding Resident 34's non-compliance (not following the rules) with raising his bed. During a review of the facility policy and procedure titled, Care Plans, Comprehensive Person-Centered, reviewed 1/16/2025, the policy and procedure indicated the facility develops and implements a comprehensive, person-centered care plan for each resident. The policy and procedure indicated assessments of residents are ongoing and care plans are revised as information about</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to review/revise the care plans for two of two sampled residents (Resident 5 and Resident 27) by failing to: 1. Ensure to review/revise Resident 5's care plan when Resident 5's Foley catheter (a flexible tube inserted into the bladder to drain urine) was discontinued. 2. Ensure to review/revise Resident 27's care plan for smoking. This failure had the potential to result in a delay in care and interventions for Resident 5 and Resident 27. Findings: 1. During a review of Resident 5's admission Record, the admission Record indicated the facility admitted Resident 5 on 7/31/2025 with diagnoses that included diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing), acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), and dementia (a progressive state of decline in mental abilities). During a review of Resident 5's physician orders, dated 8/11/2025, the physician orders indicated to discontinue Resident 5's Foley catheter. During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool) dated 8/12/2025, the MDS indicated Resident 5 has severe cognitive impairment (a condition where someone experiences significant difficulty with cognitive functions like memory, learning, concentration, and decision-making, to the point where they can no longer live independently). During a concurrent interview and record review on 8/12/2025 at 11 AM with Registered Nurse 1 (RN 1), Resident 5's Care Plan dated 7/31/2025 was reviewed. The Care Plan Indicated Resident 5 had a Foley catheter. RN 1 stated the care plan should have been reviewed and updated to reflect that Resident 5 did not have a foley catheter. RN 1 stated care plans should be individualized based on each resident's care. 2. During a review of Resident 27's admission Record, the admission Record indicated Resident 1 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included Type 2 DM with foot ulcer (a slow-healing open sore on the foot of someone with diabetes), complete traumatic amputation (when a body part, like a finger, toe, arm, or leg, is entirely ripped or torn away from the rest of the body in an accident) of two or more left lesser toes, hyperlipidemia (excess of fats in your blood), essential primary hypertension (high blood pressure that develops gradually over time and has no known single cause), unsteadiness of feet, lack of coordination (you have trouble controlling your movements, making them jerky, unsteady, or clumsy instead of smooth and precise), and nicotine dependence (your body and mind become so used to nicotine [the addictive chemical in tobacco] that you feel a compulsive need for it). During a review of Resident 27's VB-IDT (interdisciplinary team - a group of different healthcare experts who work closely together to create a single, coordinated treatment plan for a resident) Smoking/Vaping Risk Evaluation (helps the facility determine how they can help a resident who smokes) dated 5/1/2025 at 3:15 PM, the evaluation indicated Resident 27 was not able to light cigarette with lighter or match without difficulty and handles it securely and safely. The evaluation indicated Resident 27 needed to be assessed (evaluated) by the IDT for possible requirements that the resident may smoke only if supervised, such as wearing a protective apron, or follow other specifically identified guidelines. The evaluation indicated the outcome section was left blank. The evaluation indicated Resident 27 was a supervised smoker with an intervention to monitor Resident 27 for unsafe smoking practices. During a review of Resident 27's MDS dated [DATE], the MDS indicated Resident 27 had the ability to understand others and make himself understood. The MDS indicated Resident 27 used tobacco. During a review of Resident 27's Care Plan Report dated 5/18/2023, the Care Plan Report indicated Resident 27 was a supervised smoker at risk for injury and respiratory distress (someone is having difficulty breathing, making it hard to get enough air) non-compliance (not following the rules) with apron (a special fire-resistant cover worn by people, often wheelchair users, to protect their clothes and surrounding furniture from). The Care Plan Report indicated smoking materials were stored in a safe place out of view of the residents. The Care Plan Report indicated the resident's visitor, and family would be advised not to give cigarettes to any residents until they check with nursing. During a review of Resident 27's Progress Note dated 8/11/2025, the Progress Note indicated Resident 27 was found with an unused cigarette inside his room at the bedside drawer. The progress note indicated Resident (Resident 27) stated, My Godbrother gave it to me when he came (unknown date). During a concurrent observation and interview on 8/11/2025 at 10:53 AM with Certified Nursing Assistant 2 (CNA 2) in Resident 27's room, an unused cigarette was observed left unattended on Resident 27's bedside cabinet. CNA 2 stated she (CNA2) observed the cigarette on Resident 27's bedside cabinet and stated he (Resident 27) gets mad when the facility tried to take away</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide appropriate treatment to prevent a urinary tract infection (UTI, an infection in the bladder/urinary tract) for one of 19 sampled residents (Resident 5), when there was missing documentation of a post void residual (PVR, the amount of urine remaining in the bladder after urination) every six hours as ordered by the physician. This failure had the potential to result in Resident 5 developing a UTI. Findings: During a review of Resident 5's Face Sheet (admission record), the Face Sheet indicated Resident 5 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing), acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), and dementia (a progressive state of decline in mental abilities). During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), the MDS indicated Resident 5 has severe cognitive impairment (a condition where someone experiences significant difficulty with cognitive functions like memory, learning, concentration, and decision-making, to the point where they can no longer live independently). During a record review of Resident 5's physician orders dated 8/11/2025 timed at 10:18 AM, the physician orders indicated, .PVR every 6 hours for 24 hours. If greater than 300 cubic centimeters (cc, a unit of volume in the metric system), re-insert Foley catheter (a flexible tube inserted into the bladder to drain urine) every 6 hours for 1 day. During a concurrent interview and record review on 8/12/2025 at 11:24 AM with Registered Nurse (RN) 1, Resident 5's Treatment Administration Record (TAR, a legal document within the medical record that provides a comprehensive account of treatments administered to a patient by healthcare professionals), dated 8/12/2025 was reviewed. The TAR indicated the Resident 5's PVR measurements on 8/11/2025 at 12 PM, 8/11/2025 at 6 PM, and 8/12/2025 at midnight. There was no PVR measurement documented on 8/12/2025 at 6 AM. RN 1 stated there should have been a PVR charted on 8/12/2025 at 6 AM because Resident 5 could have been retaining urine, which could lead to infection. During a review of the facility's policy and procedure (P&amp;P) titled, Acute Condition Changes - Clinical Protocol, dated 1/16/2025, the P&amp;P indicated, The staff will monitor and document the resident/patient's progress and responses to treatment, and the physician will adjust treatment accordingly.</p>		

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NAME OF PROVIDER OR SUPPLIER  Hollywood Premier Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5401 Fountain Ave. Los Angeles, CA 90029	

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to maintain safe resident smoking practices for two of three sampled residents (Resident 27 and Resident 79) investigated under the smoking care area by failing to: 1. Ensure Resident 27 did not to store smoking materials (cigarettes) in his room without supervision. 2. Ensure to provide Resident 79 with a smoking apron, ash tray, and an appropriate place to discard his used unlit cigarette butt (the end of a cigarette) while Resident 79 smoked outside the patio on 8/12/2025 at 9:37 AM. These failures had the potential for Resident 27 and Resident 79 to sustain injuries such as cigarette burns. Findings: 1. During a review of Resident 27's admission Record, the admission Record indicated Resident 1 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with foot ulcer (a slow-healing open sore on the foot of someone with diabetes), complete traumatic amputation (when a body part, like a finger, toe, arm, or leg, is entirely ripped or torn away from the rest of the body in an accident) of two or more left lesser toes, hyperlipidemia (excess of fats in your blood), essential primary hypertension (high blood pressure that develops gradually over time and has no known single cause), unsteadiness of feet, lack of coordination (you have trouble controlling your movements, making them jerky, unsteady, or clumsy instead of smooth and precise), and nicotine dependence (your body and mind become so used to nicotine [the addictive chemical in tobacco] that you feel a compulsive need for it). During a review of Resident 27's VB-IDT (interdisciplinary team - a group of different healthcare experts who work closely together to create a single, coordinated treatment plan for a resident) Smoking/Vaping Risk Evaluation (helps the facility determine how they can help a resident who smokes) dated 5/1/2025 at 3:15 PM, the evaluation indicated Resident 27 was not able to light cigarette with lighter or match without difficulty and handles it securely and safely. The evaluation indicated Resident 27 needed to be assessed (evaluated) by the IDT for possible requirements that the resident may smoke only if supervised, such as wearing a protective apron, or follow other specifically identified guidelines. The evaluation indicated the outcome section was left blank. The evaluation indicated Resident 27 was a supervised smoker with an intervention to monitor Resident 27 for unsafe smoking practices. During a review of Resident 27's Minimum Data Set (MDS, a resident assessment tool) dated 5/14/2025, the MDS indicated Resident 27 had the ability to understand others and make himself understood. The MDS indicated Resident 27 used tobacco. During a review of Resident 27's Care Plan Report dated 5/18/2023, the Care Plan Report indicated Resident 27 was a supervised smoker at risk for injury and respiratory distress (someone is having difficulty breathing, making it hard to get enough air) non-compliance (not following the rules) with apron (a special fire-resistant cover worn by people, often wheelchair users, to protect their clothes and surrounding furniture from). The Care Plan Report indicated smoking materials were stored in a safe place out of view of the residents. The Care Plan Report indicated the resident's visitor, and family would be advised not to give cigarettes to any residents until they check with nursing. During a review of Resident 27's Progress Note dated 8/11/2025, the Progress Note indicated Resident 27 was found with an unused cigarette inside his room at the bedside drawer. The progress note indicated Resident (Resident 27) stated, My Godbrother gave it to me when he came (unknown date). During a concurrent observation and interview on 8/11/2025 at 10:53 AM with Certified Nursing Assistant 2 (CNA 2) in Resident 27's room, an unused cigarette was observed left unattended on Resident 27's bedside cabinet. CNA 2 stated she (CNA2) observed the cigarette on Resident 27's bedside cabinet and stated he (Resident 27) gets mad when the facility tried to take away his cigarettes. During a concurrent observation and interview on 8/11/2025 at 10:59 AM with Licensed Vocational Nurse 5 (LVN 5) in Resident 27's room, an unused cigarette was observed left unattended on Resident 27's bedside cabinet. LVN 5 stated she (LVN5) observed the cigarette on Resident 27's bedside cabinet and stated Resident 27 was not supposed to have cigarettes at the bedside. During an interview on 8/12/2025 at 10:08 AM with Resident 27, Resident 27 stated he (Resident 27) got his cigarettes from the Activity Director (AD). Resident 27 preferred not to respond whether he (Resident 27) would keep cigarettes in his room. During an interview on 8/12/2025 at 2:29 PM with the Director of Nursing (DON), the DON could not provide an answer why the facility allowed Resident 27 to keep cigarettes in his room. During an interview on 8/12/2025 at 2:53 PM with Family Member 1 (FAM 1), FAM 1 stated he (FAM1) would bring cigarettes to the facility for Resident 27 for years. FAM 1 stated he (FAM1) would bring Resident 27</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure that one of four sampled residents (Resident 50) received her 6AM dose of hydrocodone-acetaminophen (a pain medication to treat moderate to severe pain) on 8/11/2025. This failure had the potential to result in Resident 50 experiencing unrelieved pain. Findings:During a review of Resident 50's Facesheet (admission Record), dated 8/11/2025, the Facesheet indicated Resident 50, a [AGE] year old female, was admitted to the facility on [DATE], with diagnosis that included systemic lupus erythematosus (a condition where the body's immune system attacks its own healthy tissues and organs), chronic pain syndrome (a condition where someone experiences persistent pain), and unspecified dementia (a non-specific type of dementia where a person's thinking, memory and reasoning declines). During a review of Resident 50's Minimum Data Set (MDS, an assessment tool used to screen a resident), dated 8/1/2025, the MDS indicated Resident 50 experiences occasional pain.During a review of Resident 50's Physician Pain Management Note, dated 8/11/2025, the Physician's Pain Management Note indicated Resident 50 rated her pain an 8 out of 10 on the numerical pain scale and the pain had gotten worse over time.During a review of Resident 50's Order Report, dated 8/13/2025, the Order Report indicated the medication hydrocodone-acetaminophen 10-325 milligrams (mg, a unit of measure) one tablet by mouth every 8 hours for chronic pain syndrome was ordered. During a review of Resident 50's Medication Administration Record (MAR), dated 8/13/2025, the MAR indicated Resident 50 did not receive the 6 AM dose of hydrocodone-acetaminophen on 8/11/2025. During an interview on 8/11/2025 at 9:43 AM, with Resident 50, Resident 50 stated the medication hydrocodone-acetaminophen was the only medication that helped her with her pain and that it was not always available upon request. Resident 50 stated it has been an ongoing issue with the medication not being available. During a concurrent interview and record review on 8/13/2025 at 12:20 PM, with LVN 5, the nurses progress note, dated 8/11/2025 was reviewed. The nurse's progress note indicated the nurse was waiting for the medication hydrocodone-acetaminophen to be delivered by the pharmacy. LVN 5 stated when a nurse needs a medication that is not available, then the process is for the nurse to call pharmacy and get access to the emergency kit. During a concurrent interview and record review on 8/13/2025 at 12:59 PM, with Director of Nursing (DON), the nurses progress note, dated 8/11/2025 was reviewed. The nurse's progress note indicated the nurse was waiting for the medication hydrocodone-acetaminophen to be delivered by pharmacy. The DON stated the nurse should have called the pharmacy to get access to retrieve the hydrocodone-acetaminophen medication from the emergency kit. DON stated that when a resident does not receive their pain medication it can cause increased pain and the resident can become upset. During a review of the facility's policy and procedure (P&amp;P) titled, Pain Management, dated 5/3/2023, the P&amp;P indicated that effective pain management is achieved with around the clock medication.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the medication bubble packs for three of 87 sampled residents (Resident 26, Resident 59, and Resident 69) were labeled with expiration dates. This failure had the potential to result in the administration of expired or deteriorated medications to the residents. Findings: During a review of Resident 26's Face Sheet (admission record), the Face Sheet indicated Resident 26 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), hypothyroidism (a condition in which the thyroid gland does not make and release enough hormone into the bloodstream), and diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 26's Minimum Data Set (MDS, a resident assessment tool) dated 6/16/2025, the MDS indicated Resident 26 required moderate assistance with activities of daily living. During a review of Resident 59's Face Sheet, the Face Sheet indicated Resident 59 was admitted to the facility on [DATE] with diagnoses that included polyosteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), muscle weakness, and dementia (a progressive state of decline in mental abilities). During a review of Resident 59's MDS dated [DATE], the MDS indicated Resident 59 has severe cognitive impairment (a condition where someone experiences significant difficulty with cognitive functions like memory, learning, concentration, and decision-making, to the point where they can no longer live independently). During a review of Resident 69's Face Sheet, the Face Sheet indicated Resident 69 was admitted to the facility on [DATE] with diagnoses that included schizophrenia, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 69's MDS dated [DATE], the MDS indicated Resident 69 required substantial to maximal assistance with activities of daily living. During a concurrent observation and interview on 8/13/2025 at 12 PM with Licensed Vocational Nurse (LVN) 1 in station one, Medication Cart (MC) 1 contained two medication bubble packs of rivastigmine (a medication used to treat dementia) 1.5 milligram (mg, a unit of measurement) capsules prescribed for Resident 59 with no expiration dates. LVN 1 stated there were no expiration dates on the two bubble packs. LVN 1 stated it was important to maintain expiration dates for the bubble packs because administering expired medications could cause possible harm to Resident 59. During a concurrent observation and interview on 8/13/2025 at 12:40 PM with LVN 2 in station two, MC 2 contained one medication bubble pack of trihexyphenidyl (a medication used to treat Parkinson's disease [a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements]) 5 mg tablets prescribed for Resident 69 and one bubble pack of lurasidone (a medication used to treat schizophrenia) 40 mg tablets prescribed for Resident 26 with no expiration dates. LVN 2 stated there were no expiration dates on the two bubble packs. LVN 2 stated it was important to maintain expiration dates for the bubble packs, so staff do not administer expired medications to Resident 69 and Resident 26. During a review of the facility's policy and procedure (P&amp;P) titled, Medication Labeling and Storage, dated 1/16/2025, the P&amp;P indicated, .The medication label includes, at a minimum. expiration date, when applicable.</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>(continued on next page)</p>

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to provide appropriate assistance to residents using special eating equipment for two of four sampled residents by: 1. Failing to place the plate guard (a crescent shaped dining aid designed to help prevent food from falling off the edge of a plate while eating) in the correct position for Residents 28 and 73. 2. Failing to provide the correct assistive eating device for Resident 73. These failures had the potential to cause inadequate nutrition, weight loss, loss of dignity and confidence for Residents 28 and 73. Findings: 1. During a review of Resident 28's admission Record, (undated), the admission Record indicated the facility admitted the resident on 9/13/24, with diagnoses including but not limited to generalized muscle weakness, dementia (a loss of brain function that occurs with certain diseases), and encephalopathy (a disease or condition that affects the brain's structure or function, causing it to not work properly). During a review of Resident 28's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 9/30/2024, the MDS indicated resident has functional limited range of motion (a body part can't move as far or in as many directions as it should) in both arms. During a review of Residents 28's care plan, initiated 9/26/24, the care plan indicated the resident was at a risk for nutrition and weight loss. May use PLATEGUARD during meal to prevent food spillage and ease in scooping food off plate. During review of Resident 28's physician order, dated 7/11/2025, the physician order indicated, May use PLATEGUARD during meal to prevent food spillage and ease in scooping food off plate. During a review of Residents 28 's Occupational Therapy Treatment Encounter Note(s), dated 8/13/25, The note indicated, Caregiver educated on proper use/positioning of plate guard during mealtimes in order to promote [patient] independence with self-feeding, w/ good carryover of task. 2. During a review of Resident 73's admission Record, (undated), the admission Record indicated the facility admitted the resident on 8/28/20, with diagnoses including but not limited to epilepsy (sudden and temporary disturbances in brain activity that cause changes in behavior, movement, or consciousness) and dementia. During a review of Resident 73's MDS dated [DATE], the MDS indicated Resident 73 has no impairment on both upper and lower extremities. Resident 73 needs set-up or clean up assistance for eating. During review of Resident 73's physician order, dated 11/23/2022, the physician order indicated, May have Divided plate during mealtime. During review of Resident 73's care plan, initiated 9/26/24, the care plan indicated, the resident had a potential nutritional problem related to diet restrictions. Provide divided plate (a regular plate with built-in walls or barriers that create separate sections) during mealtime. During a review of Resident 73's, Occupational Therapy Treatment Encounter Note(s), dated 8/13/25, The note indicated, Caregiver educated on proper use/positioning of plate guard during mealtimes in order to promote [patient] independence with self-feeding, w/ good carryover of task. During a concurrent observation and interview on 8/11/25 at 12:30 PM with Licensed Vocational Nurse (LVN) 4 in the activity/dining room, Resident 28 and 73's plate guard was in the incorrect position on their plate. The opening to the plate guard faced Resident 28 and 73 and food spilled onto the table. Resident 73 had a regular plate with plate guard instead of divided plate as ordered by physician. LVN 4 stated the assistive eating devices were incorrect for Residents 28 and 73. LVN 4 stated the plate guards are used to help residents pick up their food easier and were in the wrong position. LVN 4 stated the residents could spill food on themselves, hurting their dignity and possibly burning themselves with hot food. During an interview on 8/14/25 at 8:45 AM with the Rehabilitation Supervisor (PT), PT stated residents are observed at least monthly to determine if residents need an assistive device such as a plate guard. PT stated education on proper usage of assistive devices is provided to Certified Nursing Assistants (CNA), Licensed Vocational Nurses (LVN), and residents prior to first use. PT stated if an assistive device is used incorrectly, PT will educate staff and document in the electronic health record (EHR) under Caregiver Treatment Education. During a review of the facility's policy and procedure (P&amp;P) titled, Assistive Devices and Equipment, reviewed 1/16/25, the P&amp;P indicated Staff and volunteers are trained and demonstrate competency on the use of devices and equipment prior to assisting or supervising residents.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to store food with a food label and/or date in one of four food storage areas. This failure had the potential to result in a foodborne illness (illness caused by the ingestion of contaminated food or beverages) for the residents. Findings: During a concurrent observation and interview on 8/11/2025 at 8:23 AM with the Dietary Supervisor (DS) in the facility kitchen, the following items were found in the freezer: 1. 16 light brown meat patties in a freezer bag with no food label or date. 2. A package of unopened frozen beef chorizo with manufacture date 10/24/2024 with no expiration date or best used by date. 3. Frozen ham in a freezer bag dated 5/28/2025 with no expiration date or best used by date. 4. A clear bag of chopped white pieces of meat with no food label or date. 5. A freezer bag with meat had a food label whose ink had faded, making the name and date unreadable. During a concurrent observation and interview on 8/11/2025 at 8:23 AM with the DS, the DS stated there should be a label on the bags with the name of contents and dates because the residents could be at risk of an allergic reaction or a food borne illness. During a review of the facility's policy and procedure (P&amp;P) titled, Food Storage, last reviewed 1/16/25, the P&amp;P indicated, All opened and partially used foods shall be dated, labeled and sealed before being returned to the storage area.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to follow infection control (a set of practices and procedures used to prevent the spread of infections, particularly in healthcare settings) practices for three of six sampled residents (Resident 2, Resident 70 and Resident 85), and for laundry services by failing to: - Ensure Certified Nursing Assistant 1 (CNA 1) washed/sanitized (clean it well enough to reduce germs to a safe, healthy level) her (CNA1) hands before and after she (CNA1) assisted Resident 2 on 8/11/2025 at 9:52 AM. -Ensure Resident 70's mattress and bed linen were not in direct contact with the facility's floor. -Ensure Certified Nursing Assistant 4 (CNA4) disinfected (cleaned) Resident 70's call light that was on the floor before CNA4 placed the call light (a device used by a patient to signal his or her need for assistance) on Resident 70's mattress on 8/12/2025 at 10:35 AM. -Ensure Resident 85's laundry was not folded in a non-designated (the hallway) for folding laundry. -Ensure the facility's linen was not left uncovered in a hallway These failures placed the residents at risk for infections. Findings: 1. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 6/25/2025 with diagnoses that included dependence on renal (kidney) dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), long-term use of insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication), unspecified cirrhosis of the liver (permanent scarring that damages your liver and interferes with its functioning , but the exact cause is not yet known or documented), gastro-esophageal reflux disease (a condition where stomach contents flow back up into the esophagus, the tube that carries food from the mouth to the stomach), essential primary hypertension (HTN - high blood pressure), peripheral vascular disease (a circulation problem where blood vessels outside the heart and brain are narrowed or blocked, most commonly in the legs and feet, causing pain, numbness, or slow-healing sores), polyneuropathy (w [NAME] many nerves outside of your brain and spinal cord, called peripheral nerves, are damaged and start to malfunction), anemia in chronic kidney disease (damaged kidneys can't make enough of a hormone called erythropoietin, which tells your body to make oxygen-carrying red blood cells), viral hepatitis (an infection that causes swelling and damage to the liver), and type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) During a review of Resident 2's Care Plan Report (a document that outlines a person's individual health and social care needs and the specific actions and support required to meet those needs), dated 2/14/2025, the Care Plan Report indicated Resident 2 was at risk for Multidrug Resistant Organism (MDRO,- bacteria that resist treatment with more than one antibiotic) due to right upper chest permcath (a soft, flexible tube placed into a large vein in your chest or neck to create a reliable, long-term access point for dialysis treatments). The Care Plan Report indicated for the staff to utilize (use) gowns and gloves for high-contact resident care activities to minimize or reduce the risk of developing/transmission of infection (when germs move from an infected person, animal, or the environment to a person). The Care Plan Report indicated an intervention (any action taken to help a patient and achieve a specific health goal) for the staff to clean their hands, including before entering and when leaving the room. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 7/15/2025, the MDS indicated Resident 2 had the ability to understand others and had the ability to make himself understood. During a concurrent observation and interview on 8/11/2025 at 9:52 AM in Resident 2's room, CNA 1 was assisted Resident 2's roommate (Resident 77) and then moved to assist Resident 2 without washing/sanitizing her (CNA 1) hands. CNA 1 stated she (CNA1) did not wash/sanitize her hands because Resident 2 called right away. CNA 1 stated she (CNA1) did not touch Resident 2 and that she (CNA1) took his (Resident 2) water pitcher out of the room. CNA 1 stated not washing/sanitizing her hands could cause an infection control risk. During an interview on 8/14/2025 at 7:11 AM with the Director of Nursing (DON), the DON stated it would be an infection control issue if a CNA (any CNA at the facility) did not wash or sanitize their hands when caring for resident. The DON stated the facility staff should wash or sanitize their hands before and after helping residents. 2. During a review of Resident 70's admission Record, the admission Record indicated the facility admitted Resident 70 on 7/30/2025 with diagnoses that included surgical aftercare (provided to support recovery, prevent complications, and manage pain and wound healing following surgery) following colostomy surgery (surgical procedure that creates an opening in the abdomen to divert stool to an external bag) During a review of Resident 70's MDS dated 11/11/2024 the MDS</p>		

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  08/14/2025
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 0911</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure one of 35 residents` rooms (room [ROOM NUMBER]) did not accommodate more than four residents. This failure had the potential to result in inadequate space to provide safe nursing care and privacy for Resident 17, Resident 19, Resident 55, and Resident 64. Findings: During a review of the facility's untitled letter (room waiver request) to the Department of Public Health dated 6/18/2025, the room waiver request letter indicated the facility requested to waive room [ROOM NUMBER]'s size requirement. The room waiver request letter indicated there was ample (enough) room to accommodate wheelchairs, and other medical equipment as well as space for mobility and movement of ambulatory residents. The room waiver request letter indicated there was adequate space for nursing care, and the health and safety of the residents, and did not impede (delay or prevent) the ability of any resident in the room to allow his/her highest practicable wellbeing. During an initial tour observation on 8/11/2025 at 2 PM, room [ROOM NUMBER] had five resident beds. During an observation on 8/11/2025 at 2 PM, four residents (Resident 17, Resident 55, Resident 19, and Resident 64) were observed in the room with sufficient space for the residents to be able to go in and out of the room as well as enough space for therapy and equipment. During an interview on 8/11/2025 at 2:02 PM with Resident 55 and Resident 64, Resident 55 and Resident 64 stated they (Resident 55 and Resident 64) did not have complaints regarding not having enough space in the room. During the survey from 8/11/2025 to 8/14/2025, it was observed that the nursing staff (in general) had full access to provide treatment, administer medications, and assist residents to perform their individual routine activities of daily living. The Department is recommending continuation of the room waiver request.</p>		

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NAME OF PROVIDER OR SUPPLIER  Hollywood Premier Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5401 Fountain Ave. Los Angeles, CA 90029	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of 19 sampled resident (Resident 34) had the call light (a device used by a patient to signal his or her need for assistance) within reach. This failure had the potential for Resident 34 not to be able to call for assistance and had the potential not to meet Resident 34's needs. Findings: During a review of Resident 34's admission Record, the admission Record indicated the facility admitted the resident on 3/7/2025 with diagnoses that included right side sciatica (pain that travels from the buttocks down the leg), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), spinal stenosis (a narrowing of the spinal canal, the bony tunnel that protects the spinal cord and nerves in your back) cervical region (neck), idiopathic aseptic necrosis of the right femur (a condition where the bone death of the right thigh bone happens for no known reason because a loss of blood supply), other cord compression (something is squeezing or putting pressure on your spinal cord), unsteadiness on feet, left wrist drop (your left hand hangs limply or droops, and you have difficulty straightening your wrist and fingers), and other lack of coordination (you have trouble controlling your movements, making them jerky, unsteady, or clumsy instead of smooth and precise). During a review of Resident 34's History and Physical (H&amp;P-a comprehensive document that records a patient's medical history and a detailed physical examination performed by a healthcare professional) dated 3/8/2025, the H&amp;P indicated Resident 34 had the capacity to understand and make decisions. During a review of Resident 34's Care Plan Report (a personalized roadmap for how a person will receive the help they need, covering their medical conditions, medications, and daily support needs) dated 3/10/2025, the Care Plan Report indicated Resident 34 was at risk for falls related to poor balance and unsteady gait (walk). The Care Plan Report indicated the nursing intervention was for Resident 34 to have the call light within reach and for the staff (in general) to answer the call light promptly (with no delay). During a review of Resident 34's Minimum Data Set (MDS - a resident assessment tool) dated 3/20/2025, the MDS indicated Resident 34 had the ability to understand others and had the ability to make himself understood. The MDS indicated Resident 34 used a walker or wheelchair. The MDS indicated Resident 34 was dependent on toileting, shower/bathing, upper/lower body dressing, taking off/putting on footwear, personal hygiene, going from sitting to lying position, and going from lying to sitting on the side of the bed. The MDS indicated Resident 34 needed partial/moderate assistance to roll left and right on the bed. The MDS indicated the facility did not attempt to get Resident 34 from chair/bed to chair transfer (the ability to transfer to and from a bed to a chair) due to medical condition or safety concerns. During a concurrent observation and interview on 8/11/2025 at 10:19 AM with Certified Nursing Assistant 2 (CNA 2), inside Resident 34's room, Resident 34's call light was observed hanging behind the head of the resident's bed. CNA 2 stated the call light was not within Resident 34's reach. CNA 2 stated Resident 34 would not be able to call for help or assistance if the call light was not within the resident's reach. During an interview on 8/13/2025 at 7:38 AM with the Director of Nursing (DON), the DON stated if Resident 34's call light was not within reach, the resident could not call for help. During a review of the facility's policy and procedure (P&amp;P) titled Answering the Call Light, dated 1/16/2025, indicated the purpose of the P&amp;P is to ensure timely responses to the resident's requests and needs. The P&amp;P indicated the facility would ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.</p>		