STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50516 Based on observation, interview and record review, the facility failed to ensure resident's right to dignity and privacy was honored for one of one sampled resident (Resident 38) using indwelling urinary catheter (flexible tube inserted in the bladder through the urethra to drain urine), when Resident 38's indwelling urinary catheter drainage bag was not covered to ensure privacy. This deficient practice had the potential for Resident 38 to be embarrassed and affect their self-esteem. Findings: During a review of Resident 38's Admission Record (Face Sheet), the Face Sheet indicated the facility admitted Resident 38 on 11/25/2024 with diagnosis including respiratory failure (lungs are not working well causing difficult breathing). During a review of Resident 38's History and Physical (H&P), dated 11/26/2024, the H&P indicated Resident 38 had a medical history of cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), hypertension (HTN-high blood pressure), and urinary bladder neurogenic dysfunction (loss of bladder control due to brain, spinal cord, or nervous system problems). During a review of Residents 38's Minimum Data Set (MDS - a resident assessment tool), dated 2/27/2025, indicated the cognitive (ability to think and process information) skills for daily decision making was severely impaired, and required assistance of two-person physical assist for activities of daily living. Resident 38 rarely to never had the ability to make self-understood and understand others. The MDS indicated Resident 38 had an indwelling catheter. During a review of Resident 38's Care Plan titled, Altered Urinary Elimination/At Risk for UTI (urinary tract infection - bladder infection)/At Risk for Skin Breakdown, initiated on 8/29/2024, the care plan indicated an intervention to Provide privacy bag as required. During a concurrent observation and interview on 3/24/2025 at 10:53 a.m., with Licensed Vocational Nurse (LVN) 1, in Resident 38's room, Resident 38's uncovered urinary catheter drainage bag was visible from the hallway. LVN 1 stated the bag should be covered with a dignity bag (bag used to cover the urinary catheter drainage bag for privacy). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/2025 at 5:04 p.m., with Registered Nurse (RN) 5, RN 5 stated dignity was part of a resident's rights. RN 5 stated dignity also meant protecting a resident's privacy, such as covering the urinary drainage bag with a dignity bag. RN 5 stated a resident could have felt embarrassed or sad if anyone saw a urinary drainage bag uncovered. During a review of the facility's policy and procedure (P&P) titled, Standards of Care - Sub Acute, dated 3/2024, the P&P indicated, An individualized plan of care is implemented for residents requiring an indwelling catheter that includes use of a dignity cover to protect the resident's privacy and dignity. During a review of the facility's P&P titled, System-wide Patient Rights and Responsibilities Policy, dated 5/2022, the P&P indicated, You have the right to receive considerate, compassionate, confidential and respectful care. You will be treated with dignity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50516 Based on interview and record review, the facility failed to ensure to obtained informed consent (voluntary agreement to accept treatment or procedures after receiving education regarding the risks, benefits, and alternatives offered) for one of five sampled resident (Resident 25) reviewed for informed consent, prior to increasing the dose of Seroquel (medication used to help relax someone who is restless [unable to stay calm or still] or agitated [irritated]) from 50 milligrams (mg - a unit of measure) nightly dose to 75 mg. This failure had the potential to prevent Resident 25 and his responsible party from exercising their right to decline increasing the dose of Seroquel and could have increased the risk that Resident 25 could experience adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to psychotropic medications (medication that affect brain activities associated with mental processes and behavior.) Findings: During a review of Resident 25's Admission Record (Face Sheet), dated 1/2/2024, the facility admitted Resident 25 on 1/2/2024 for respiratory failure (lungs are not working well causing difficulty breathing). During a review of Resident 25's History and Physical (H&P), dated 5/29/2024, the H&P indicated Resident 25 was readmitted from the hospital to the facility on [DATE]. Resident 25 had a medical history of respiratory failure, tracheostomy (surgical incision in the windpipe for air and oxygen to enter the lungs), hypertension (HTN-high blood pressure), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool), dated 3/14/2025, indicated the cognitive (the ability to think and process information) skills for daily decision making was severely impaired, and required assistance of two or more people for physical assist for activities of daily living. The MDS also indicated Resident 25 had anxiety (feeling worried or nervous) and psychotic disorder (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and was taking antipsychotic (group of medications used to treat mental health conditions) medications. During a concurrent interview and record review on 3/27/2025 at 1:35 p.m., with Registered Nurse (RN 7) of Resident 25's Medication Order, dated 10/21/2024, the record indicated Resident 25 had an order for Seroquel 75 milligrams (mg-a unit of measure) nightly for psychosis (type of mental health condition affecting the ability to think and be aware of reality) manifested by pulling out medical devices, agitation. RN 7 stated Resident 25's Seroquel dose was increased from 50 mg to 75 mg nightly. During a concurrent interview and record review on 3/27/2025 at 1:35 p.m., with RN 7, RN 7 stated Resident 25's last Facility Verification of Informed Consent, for Seroquel was in May 2024 and it was for Seroquel 50 mg nightly. RN 7 stated Resident 25 did not have a consent for Seroquel 75 mg. RN 7 stated a consent for a psychotropic drug was needed for a new drug or for an increase in the dose. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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	During an interview on 3/27/2025 at 3:04 p.m., with RN 5, RN 5 stated psychotropic drugs were used for behavioral problems such as anxiety, restlessness (unable to stay calm) or agitation (irritable). RN 5 stated once there was an order to give a psychotropic medication, consent needed to be verified (confirmed) with the family to make sure they know what the risks and benefits were: such as becoming sleepier, getting a reaction from the medication, and to know that the goal was to improve behavior. RN 5 stated knowing what care was provided was part of respecting the resident's rights. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Drugs (Sub Acute), dated 2/2024, the P&P indicated, Informed consent is obtained prior to use of psychotropic medications from resident or family member . A psychotropic consent form is completed when any (routine or PRN) psychotropic agent is ordered. During a review of the facility's P&P titled, System-wide Patient Rights and Responsibilities, dated 5/2022, the P&P indicated, You have the right to be informed by your doctor of your diagnosis, treatment and prognosis in a way that you understand, so that you can make informed decisions regarding your care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 43988 Based on observation, interview, and record review the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) was within reach for one (1) of 1 sampled resident (Resident 35) reviewed under the Environment task. This deficient practice had the potential to result in the delay of care and services and possible injury to residents when they are unable to call for assistance. Findings: During a review of Resident 35's Face Sheet (Admission Record), the Face Sheet indicated the facility originally admitted the resident on 11/27/2023 and readmitted in the facility on 7/10/2024 with diagnoses including craniotomy (type of brain surgery where the surgeon will remove and replace part of the skull to access and treat a problem within the brain), hypertension (HTN - high blood pressure), and chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body). During a review of Resident 35's History and Physical (H&P), dated 7/12/2024, the H&P indicated Resident 35 had the presence of tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck) and was non-verbal (not speaking). During a review of Resident 35's Minimum Data Set (MDS - a resident assessment tool), dated 2/28/2025, the MDS indicated Resident 35 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 35's Morse Fall Risk Level (an assessment tool that determines a resident's likelihood of falling), dated between 3/23/2025 to 3/26/2025, the Morse Fall Risk Level indicated the resident has a low risk for falls. During an observation, on 3/24/2025, at 11:10 a.m., inside Resident 35's room, Resident 35's call light hung on the enteral feeding (EF - also known as tube feeding, a method of supplying nutrients directly into the stomach) pole. During a concurrent observation and interview, on 3/24/2025, at 11:27 a.m., inside Resident 35's room, with Licensed Vocational Nurse (LVN) 1, LVN 1 confirmed and stated Resident 35's call light was hanging on the EF pole. LVN 1 stated staff are supposed to ensure the call lights are within reach prior to leaving a resident's room so they would be able to call if they need assistance and attend to their needs timely. LVN 1 stated Resident 35's call light should have been placed within reach so the resident would be able to call for assistance and prevent a delay in meeting Resident 35's needs (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 3/24/2025, at 11:35 a.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated she must have forgotten to place the call light within the resident's reach after providing morning care to Resident 35 and prior to leaving the room. CNA 2 stated staff are supposed to place the call light within reach prior to leaving the room for the residents to be able to call for assistance. CNA 2 stated she should have placed Resident 35's call light within the resident's reach prior to leaving the room to prevent a delay in answering the resident's needs. During an interview, on 3/27/2025, at 5:00 p.m., with the Infection Preventionist (IP), the IP stated staff are supposed to place residents' call lights within reach at all times prior to leaving the room so the residents would be able to call for assistance to prevent a delay in attending to the resident's needs. The IP stated Resident 35's call light should have been placed within reach for him to be able to call for assistance and prevent delay in meeting the resident's needs. During a review of the facility's policy and procedure (P&P) titled, Standards of Care (Sub Acute), last reviewed on 3/10/2025, the P&P indicated to ensure safety, special attention should be paid to ensure call light is within resident's reach.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body, cannot be removed easily by the resident, and restricts the resident's freedom of movement or normal access to his/her body) for two (2) of four (4) sampled residents (Residents 24 and 42) reviewed for restraints by: 1. Failing to complete a restraint assessment prior to application of peek-a-boo mitten (a padded mitten restraint used to prevent patients from pulling out tubes, lines, or other medical devices) on the right hand for Resident 24. 2. Failing to complete a restraint assessment and attempt least restrictive interventions prior to application of bilateral soft wrist restraint and peek-a-boo mitten on both hands for Resident 42. These deficient practices had the potential to result in the restriction of residents' freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (a state in which a person is trapped by the bed rail in a position that they cannot move from), and death of residents. Findings: a. During a review of Resident 24's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 7/16/2020, and readmitted the resident on 3/31/2022, with diagnoses including acute respiratory failure (a condition where the respiratory system is unable to function properly, which can lead to a failure of gas exchange), traumatic brain injury (TBI - a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 24's History and Physical (H&P), dated 11/11/2024, the H&P indicated the resident was unable to make medical decisions. During a review of Resident 24's Minimum Data Set (MDS, a resident assessment tool), dated 1/28/2025, the MDS indicated Resident 24 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 24 had a limb restraint. During a review of Resident 24's physician's order dated 2/26/2025, the physician's order indicated: - May apply right peek-a-boo mitt to prevent self-harm or injury by pulling tubes or medical devices for 30 days. Release and check every two hours and monitor for skin integrity, sensation, circulation, and range of motion. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 24's care plan (CP) titled, Restraint/Seclusion Use for Patient Safety, initiated on 1/17/2024 and last revised on 3/25/2025, the CP indicated to apply device or restraint as ordered, and reassess for continued use of device, restraint and consider reduction or discontinuation quarterly and as needed as a few of the interventions to minimize and prevent injury. During a concurrent observation and interview on 3/24/2025 at 9:16 a.m., inside Resident 24's room with Registered Nurse (RN) 8, RN 8 stated Resident 24 had a right-hand mitten, and the resident moves her right arm a lot and accidentally pulls at the life sustaining tubes and lines at times. During a concurrent interview and record review on 3/26/2025 at 3:30 p.m. with the Minimum Data Set Nurse (MDSN), reviewed Resident 24's medical record including restraint assessment, physician orders, and informed consents with the MDSN. The MDSN stated there was no restraint assessment completed prior to application of the right-hand peek-a-boo mitten for Resident 24. The MDSN stated restraint assessments are supposed to be completed prior to application of a restraint or device and at least quarterly per federal regulations but the facility did not have a pre-restraint assessment. The MDSN stated the licensed nurses only complete a restraint assessment every two hours to monitor for skin integrity, sensation, circulation, and range of motion, after obtaining a physician's order and informed consent. The MDSN stated there should have been a restraint assessment completed prior to application of right-hand peek-a-boo mitten on Resident 24 to ensure appropriateness of the restraint or device use and that least restrictive measures attempted have been unsuccessful. The MDSN stated failing to complete a restraint assessment prior to application of the right-hand mitten placed Resident 24 at risk for restriction of movement which may lead to decline in physical functioning. During an interview on 3/27/2025 at 5 p.m. with the Nurse Manager (NM), the NM stated the facility did not have a restraint assessment prior to application of any device/restraints to document any least restrictive measures attempted that were unsuccessful. The NM stated there should have been a restraint assessment completed prior to application of right-hand peek-a-boo mitten on Resident 24 to ensure appropriateness of the restraint or device use and that least restrictive measures attempted have been unsuccessful. The NM stated failing to complete a restraint assessment prior to application of the right-hand mitten placed Resident 24 at risk for restriction of movement and can possibly lead to a decline in physical functioning of the right hand. During a review of the facility's recent policy and procedure (P&P) titled, Restraint Use (Sub Acute), last revised on 3/10/2025, the P&P indicated the following: - It is the policy of general acute care hospital 1(GACH 1) to guide care givers on appropriate and safe management of residents with restraints and utilization of least restrictive alternatives. - Ensure safe and ethical practice for the use of physical restraints, that no person will be restrained against their will for any period of time longer than necessary. - Restrains use shall not cause any physical injury and to ensure the least possible discomfort to the resident - The licensed nurse will assess the patient and attempt to find less restrictive alternatives to restraint. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- One time documentation is made in the electronic health record (EHR) upon initiation of restraints and includes less restrictive alternatives, resident's response, and clinical justification for restraint. b. During a review of Resident 42's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 9/4/2024 and readmitted in the facility on 12/20/2024 with diagnoses including history of stroke (loss of blood flow to a part of the brain), tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck, and ventilator-dependent respiratory failure (condition when a patient's lungs cannot breath on their own and required a machine to help breathe). During a review of Resident 42's H&P, dated 12/22/2024, the H&P indicated Resident 42 was awake and alert but did not indicate the resident's capacity to understand and make decisions. During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42 was able to make his needs known and able to understand others. The MDS further indicated Resident 42 had severely impaired cognition and required substantial/maximal assistance to total assistance from staff with all activities of daily living. The MDS indicated Resident 42 had limb restraint. During a review of Resident 42's physician's order, dated 12/20/2024, the physician's order indicated right upper extremity (RUE) and left upper extremity (LUE) soft wrist restraint and mittens due to elevate risk for interruption of treatment or unintentional injury and to release when originating behavior is no longer evident. During a concurrent observation and interview on 3/24/2025 at 10:25 a.m. inside Resident 42's room with Registered Nurse (RN) 2, RN 2 stated Resident 42 removed his tracheostomy in the past; hence, the need to apply RUE and LUE peek-a-boo mitten and soft wrist restraint. During a concurrent interview and record review on 3/26/2025 at 4 p.m. with the MDSN, reviewed Resident 42's medical record including restraint assessment, physician orders, and informed consents with the MDSN. The MDSN stated there was no restraint assessment completed prior to application of the RUE and LUE peek-a-boo mitten and soft wrist restraint for Resident 42. The MDSN stated restraint assessments are supposed to be completed prior to application of a restraint or device and at least quarterly per federal regulations but the facility did not have a pre-restraining assessment. The MDSN stated the licensed nurses only complete a restraint assessment every two hours to monitor for skin integrity, sensation, circulation, and range of motion, after obtaining a physician's order and informed consent. The MDSN stated there should have been a restraint assessment completed prior to application of the RUE and LUE peek-a-boo mitten and soft wrist restraint on Resident 42 to ensure appropriateness of the restraint or device use and that least restrictive measures attempted have been unsuccessful. The MDSN stated failing to complete a restraint assessment prior to application of the RUE and LUE peek-a-boo mitten and soft wrist restraint placed Resident 42 at risk for restriction of movement which may lead to decline in physical functioning. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/2025 a 5 p.m. with the NM, the NM stated the facility did not have a restraint assessment prior to application of any device/restraints to document any least restrictive measures attempted that were unsuccessful. The NM stated the purpose of completing a restraint assessment is to ensure the restraint/device use was appropriate and least restrictive measures have been unsuccessful. The NM stated there should have been a restraint assessment completed prior to application of RUE and LUE peek-a-boo mitten and soft wrist restraint on Resident 42 to ensure appropriateness of the restraint or device use and that least restrictive measures attempted have been unsuccessful. The NM stated failing to complete a restraint assessment prior to application of the RUE and LUE peek-a-boo mitten and soft wrist restraint placed Resident 42 at risk for restriction of movement and can possibly lead to a decline in physical functioning of the resident's both upper extremities. During a review of the facility's recent P&P titled, Restraint Use (Sub Acute), last revised on 3/10/2025, the P&P indicated the following: - It is the policy of general acute care hospital 1(GACH 1) to guide care givers on appropriate and safe management of residents with restraints and utilization of least restrictive alternatives. - Ensure safe and ethical practice for the use of physical restraints, that no person will be restrained against their will for any period of time longer than necessary. - Restrains use shall not cause any physical injury and to ensure the least possible discomfort to the resident - The licensed nurse will assess the patient and attempt to find less restrictive alternatives to restraint. - One time documentation is made in the electronic health record (EHR) upon initiation of restraints and includes less restrictive alternatives, resident's response, and clinical justification for restraint.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50516 Based on observation, interview, and record review, the facility failed to ensure a resident's Minimum Data Set (MDS - a resident assessment tool) accurately reflected resident status by failing to ensure the MDS indicated the use of physical restraints (use of manual methods or physical devices to limit an individual movements) for one of five sampled residents (Resident 25) using physical restraints. This deficient practice had the potential to negatively affect Resident 25's plan of care and the delivery of necessary care and services. Findings: During a review of Resident 25's Admission Record (Face Sheet), dated 1/2/2024, the Face Sheet indicated the facility admitted Resident 25 on 1/2/2024 for respiratory failure (lungs are not working well causing difficulty breathing). During a review of Resident 25's History and Physical (H&P), dated 5/29/2024, the H&P indicated Resident 25 was readmitted from the hospital to the facility on [DATE]. Resident 25 had a medical history of respiratory failure, tracheostomy (surgical incision in the windpipe for air and oxygen to enter the lungs), hypertension (HTN-high blood pressure), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 25's MDS, dated [DATE], the MDS indicated the cognitive (the ability to think and process information) skills for daily decision making was severely impaired and required assistance of two or more people for physical assist for activities of daily living. The MDS indicated Resident 25 had anxiety (feeling worried or nervous), psychotic disorder (a severe mental condition in which thought, and emotions are affected and cause impaired reality) and was taking antipsychotic (used to treat psychosis [impaired reality] and other mental and emotional conditions) medication. The MDS indicated Resident 25 had no restraints used. During a concurrent observation and interview on 3/24/2025 at 10:20 a.m., with Certified Nursing Assistant (CNA) 1, in Resident 25's room, CNA 1 stated Resident 25 had both mittens and wrist restraints off to relax and exercise the hands. CNA 1 stated Resident 25 had restraints because Resident 25 would try to pull out the oxygen and tracheostomy (surgical incision in the neck to allow oxygen to reach the lungs through a small tube and held by another piece) parts. During a concurrent interview and record review on 3/27/2025 at 11:15 a.m., with the MDS Nurse (MDSN), Resident 25's Physician Order, dated 11/27/2024 and 2/26/2025, were reviewed. The MDSN stated Resident 25 had Physician Orders valid for 30 days for bilateral (both) hand peek a boo (mitten that has an opening for the fingers to move) and bilateral soft wrist restraints (a type of restraint with padded strap that is placed on the wrist or ankle with Velcro) to prevent self-injury manifested by pulling tubing and other medical device. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During a concurrent interview and record review on 3/27/2025 at 11:15 a.m., with the MDSN, Resident 25's MDS Section P: Restraints and Alarms, dated 6/11/2024, 9/11/2024, 12/12/2024, and 3/14/2025, were reviewed and indicated the following: -On 6/11/2024, the MDSN stated Resident 25 had Limb restraint and Other (restraint) coded as two which indicated used daily. -On 9/11/2024, the MDSN stated Resident 25 had Limb Restraint coded as zero (not used) and Other Restraint as two (used daily). The MDS stated she was not sure how to code Resident 25's bilateral soft wrist restraints and peek a boo mitten and coded both as Other. The MDSN stated Resident 25 had a restraint assessment and order for this month (September). -On 12/12/2024, the MDSN stated Resident 25 had Limb Restraint and Other (restraint) coded as zero (not used). The MDSN stated Resident 25 had a restraint assessment and order for this month (December). -On 3/14/2025, the MDSN stated Resident 25 had Limb Restraint and Other (restraint) coded as zero (not used). The MDSN stated Resident 25 had a restraint assessment and order for this month (March). The MDSN stated the MDS Section P: Restraints and Alarms were not coded correctly on 12/12/2024 and 3/14/2025. The MDSN stated Section P should have been coded as two (used daily) on 12/12/2024 and 3/14/2025. During a review of the facility's policy and procedure (P&P) titled, Minimum Data Set (MDS) - (Sub Acute), dated 3/2024, the P&P indicated, Purpose: To comply with state and federal regulations for the documentation of care. During a review of the Centers for Medicare and Medicaid Services procedure titled Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2024, the procedure indicated, the MDS contains data elements that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. The RAI process require that the assessment accurately reflects the resident's status. The procedure indicated it was important to note that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on interview and record review, the facility failed to provide care in accordance with professional standards for two of two sampled residents (Residents 35 and 42) reviewed for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) and anticoagulant (a substance that is used to prevent and treat blood clots in blood vessels and the heart) by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin for Resident 42, and heparin (an anticoagulant) for Resident 35. The deficient practice had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin and heparin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross Reference F760 Findings: a. During a review of Resident 35's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 11/27/2023 and readmitted in the facility on 7/10/2024 with diagnoses including craniotomy (a major type of brain surgery where the surgeon will remove and replace part of the skull to access and treat a problem within the brain), hypertension (HTN - also known as high blood pressure), and chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body). During a review of Resident 35's H&P dated 7/12/2024, the H&P indicated Resident 35 had the presence of tracheostomy and was non-verbal (not speaking). During a review of Resident 35's MDS, dated [DATE], the MDS indicated Resident 35 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 35 received anticoagulant. During a review of Resident 35's physician's order, the physician's order dated 1/8/2025 indicated heparin sodium injection (porcine) solution 5000 units per milliliter (units/ml - a unit of measurement) 5000 units subcutaneously every 12 hours for DVT (deep vein thrombosis - a blood clot that forms in one or more of the deep veins in the body, usually in the legs causing leg pain or swelling) prophylaxis. During a review of Resident 35's care plan (CP) on thrombolytic therapy (the use of medications to dissolve blood clots) last revised on 3/2/2025 with a target date of 5/28/2025, the CP indicated to frequently monitor peripheral perfusion to address complications early as one of the interventions to prevent and manage risk of bleeding. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/25/2025 at 11:05 am., reviewed Resident 35's physician's order, subcutaneous administration sites for heparin from 1/8/2025 to 3/25/2025, and the MDS with the Minimum Data Set Nurse (MDSN). The MDSN stated Resident 35 received heparin, had a physician's order for heparin, and were administered as follows: Heparin 5000 units/ml injection 5000 units: - 1/20/2025 5:51 a.m. left upper quadrant - LUQ - 1/20/2025 5:03 p.m. LUQ - 3/2/2025 6:22 p.m. LUQ - 3/3/2025 5:14 a.m. LUQ - 3/7/2024 6:58 a.m. right upper quadrant - RUQ - 3/7/2025 5:39 a.m. RUQ - 3/23/2025 5:15 a.m. LUQ - 3/23/2025 17:32 LUQ The MDSN stated administration sites for anticoagulants such as heparin should be rotated per standards of practice and manufacture's guideline to prevent hardening or lumps in the skin. The MDSN stated the list of administration sites for the heparin were not rotated. The MDSN stated Resident 35's administration sites should have been rotated to prevent pain, redness, irritation, and lumps on the resident's skin. During a concurrent interview and record review on 3/27/2025 at 5:00 p.m. with Registered Nurse (RN) 8, RN 8 stated the location of administration sites for Resident 35's heparin were not rotated. RN 8 stated the nurses are supposed to rotate heparin administration sites according to standards of practice, and as indicated in the manufacturer's guideline. RN 8 stated Resident 35's administration sites for heparin should have been rotated to prevent adverse effects such as bruising, skin irritation, skin pits, lipodystrophy and amyloidosis which can affect absorption of the medication. During a review of the facility-provided manufacturer's guideline for heparin sodium injection solution dated 1/2022, the manufacturer's guideline indicated to use a different site for each injection. The manufacturer's guideline further indicated injection site irritation is one of the most common adverse reactions for the use of heparin. During a review of the facility's P&P titled, Medication Administration and Monitoring (Sub Acute), last reviewed on 3/2025, the P&P indicated the following: - Healthcare providers administering medications are responsible for knowing and understanding the dosage, indications, side effects and precautions/warnings of the medications being administered. - Injection sites for subcutaneous and intramuscular administration must be rotated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 42's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 9/4/2024 and readmitted in the facility on 12/20/2024 with diagnoses including history of stroke (loss of blood flow to a part of the brain), tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck, and ventilator-dependent respiratory failure (condition when a patient's lungs cannot breath on their own and required a machine to help breathe). During a review of Resident 42's H&P dated 12/22/2024, the H&P indicated Resident 42 was awake and alert but did not indicate the resident's capacity to understand and make decisions. During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42 was able to make his needs known and able to understand others. The MDS further indicated Resident 42 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 42 received insulin. During a review of Resident 42's physician's order, the physician's order dated 2/24/2025 indicated insulin glargine-yfgn (a long-acting insulin) injection vial eight (8) units (a unit of measurement) at bedtime for diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 42's CP on hyperglycemia last revised on 3/2/2025 with a target date of 7/31/2025, the CP indicated to provide pharmacologic therapy (drug or medication therapy) to maintain blood sugar levels within targeted range. During a concurrent interview and record review on 3/25/2025 at 11:05 am., reviewed Resident 42's physician's order, subcutaneous administration sites for insulin glargine from 2/24/2025 to 3/25/2025, and the MDS with the Minimum Data Set Nurse (MDSN). The MDSN stated Resident 42 received heparin, had a physician's order for insulin glargine, and were administered as follows: Insulin glargine-yfgn injection 8 units: - 3/12/2024 5:35 p.m. left lower quadrant - LLQ - 3/13/2025 5:34 p.m. LLQ - 3/17/2025 5:27 p.m. left upper arm - LUA - 3/18/2025 5:51 p.m. LUA The MDSN stated administration sites for insulin should be rotated per standards of practice and manufacture's guideline to prevent hardening or lumps in the skin. The MDSN stated the list of administration sites for Resident 42's insulin glargine were not rotated. The MDSN stated Resident 42's administration sites should have been rotated to prevent pain, redness, irritation, and lumps on the resident's skin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/27/2025 at 5:00 p.m. with RN 8, RN 8 stated the location of administration sites for Resident 42's insulin glargine was not rotated. RN 8 stated the nurses are supposed to rotate insulin administration sites according to standards of practice, and as indicated in the manufacturer's guideline. RN 8 stated Resident 42's administration sites for insulin glargine should have been rotated to prevent adverse effects such as bruising, skin irritation, skin pits, lipodystrophy and amyloidosis which can affect absorption of the insulin. During a review of the facility-provided manufacturer's guideline for insulin glargine (rDNA origin) 100 units/ml three (3) ml pen dated 8/26/2022, the manufacturer's guideline indicated to change (rotate) the injection site for each injection and to inject under the skin of the stomach area, buttocks, upper legs or upper arms. During a review of the facility's P&P titled, Medication Administration and Monitoring (Sub Acute), last reviewed on 3/2025, the P&P indicated the following: - Healthcare providers administering medications are responsible for knowing and understanding the dosage, indications, side effects and precautions/warnings of the medications being administered. - Injection sites for subcutaneous and intramuscular administration must be rotated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 43988 Based on observation, interview, and record review, the facility failed to ensure residents with a urinary catheter (also known as an indwelling catheter, a hollow tube inserted into the bladder to drain or collect urine) received appropriate care and services to prevent urinary tract infections (UTI - an infection in the bladder/urinary tract) for one (1) of 1 sampled resident (Resident 2) reviewed for urinary catheter or UTI by failing to ensure Resident 2's urinary catheter tubing did not have a loop while hanging on the side the bed. This deficient practice had the potential for the resident's urine not to flow freely which may lead to development of UTI. Findings: During a review of Resident 2's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 6/7/2022 and readmitted in the facility on 1/30/2025 with diagnoses including gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), neurogenic bladder (lack of bladder control due to brain, spinal cord or nerve problems), and tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck). During a review of Resident 2's History and Physical (H&P), dated 2/2/2025, the H&P indicated Resident 2 was awake and oriented but did not indicate if the resident had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 12/18/2024, the MDS indicated Resident 2 had intact cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS further indicated Resident 2 had an indwelling catheter. During a review of Resident 2's physician's order, dated 1/31/2025, the physician's order indicated: - Suprapubic catheter (a thin tube inserted directly into the bladder through a small incision in the lower abdomen to drain urine) French (Fr - a unit of measurement) 16 care every shift and as needed. Change every 45 days and as needed for neurogenic bladder. During an observation, on 3/24/2025, at 9:58 a.m., inside Resident 2's room, Resident 2's urinary drainage bag hung on the left side of the bed with a loop on the tubing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on 3/24/2025, at 10:10 a.m., inside Resident 2's room with Registered Nurse (RN) 8, RN 8 confirmed and stated Resident 2's urinary drainage bag was hanging on the side of the bed and the tubing had a dependent loop. RN 8 stated urinary drainage bags should be positioned properly so the tubing would not have a dependent loop which prevents the urine from flowing freely into the bag. RN 8 stated Resident 2's indwelling catheter tubing should not have a dependent loop as the urine will not flow freely and can back up into the bladder which may lead to UTI. During an interview, on 3/27/2025, at 5 p.m., with the Infection Preventionist (IP), the IP stated one of the practices to prevent UTI related to indwelling catheter use is to ensure the urine flow is not obstructed by keeping the tubing free of kinks or loops. The IP stated the staff are supposed to ensure the urinary catheter tubing should not have a loop. The IP stated Resident 2's urinary catheter tubing should have been positioned to prevent loops or kinks to prevent the urine from back up and cause urine infection. During a review of the facility's policy and procedure (P&P) titled, Urinary Catheter Care (Sub Acute), last reviewed 3/10/2025, the P&P indicated a purpose to provide guidelines for routine care of indwelling and suprapubic urinary catheters and should be followed by all caregivers to reduce the incidence of catheter associated UTI. The P&P further indicated the catheter urinary collection bag is always positioned below the patient's bladder without dependent loops or kinks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to ensure residents receiving enteral feeding (also known as tube feeding, a method of supplying nutrients directly into the gastrointestinal tract) received the appropriate care and services to prevent complications for three of three sampled residents (Resident 2, 35, and 41) reviewed under the tube feeding care area by failing to: 1. Change Resident 35's water flush bag according to the manufacturer's guideline. 2. Indicate the date for Resident 2's medication syringe replacement. 3. Ensure Resident 41 the accurate amount of tube feeding formula was delivered to the resident as ordered. These deficient practices had the potential to result in altered nutritional status, such as dehydration and malnutrition, and complications associated with enteral feeding, such as gastrointestinal (GI - relating to stomach and intestines) problems, such as abdominal pain and diarrhea, and for residents to experience unmet nutritional needs and place residents at risk for unintended weight loss. Findings: a. During a review of Resident 2's Face Sheet (Admission Record), the Face Sheet indicated the facility originally admitted the resident on 6/7/2022 and readmitted in the facility on 1/30/2025 with diagnoses including gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), neurogenic bladder (lack of bladder control due to brain, spinal cord or nerve problems), and tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck). During a review of Resident 2's History and Physical (H&P), dated 2/2/2025, the H&P indicated Resident 2 was awake and oriented but did not indicate if the resident had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 12/18/2024, the MDS indicated Resident 2 had intact cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). The MDS further indicated Resident 2 had a feeding tube (a soft, flexible tube inserted into the stomach or small intestine to deliver nutrition and fluids when someone can't eat or drink normally). During a review of Resident 2's physician's order, dated 10/28/2024, the physician's order indicated cyclic tube feeding Tube Feeding Formula (TFF - a liquid nutrition delivered directly into the stomach or small intestine via a feeding tube) 4 at 70 milliliter (ml - a unit of measurement for volume) per (/) hour (hr - a unit of measurement for time) start feeding at 5 p.m. until 6 a.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation, on 3/24/2025, at 9:58 a.m., inside Resident 2's room, Resident 2's medication syringe affixed with a sticker did not indicate a date of when to change the syringe. During a concurrent observation and interview, on 3/24/2025, at 10:10 a.m., inside Resident 2's room, with Registered Nurse (RN) 8, RN 8 stated Resident 2's medication syringe sticker did not indicate the date of when it should be changed. RN 8 stated the medication syringes are supposed to be changed every day and label the sticker with the date it would be changed. RN 8 stated Resident 2's medication syringe should have been labeled with the date it would be changed to ensure the syringe is clean and not contaminated as it placed the resident at risk for acquiring infection from a contaminated medication syringe. During an interview, on 3/27/2025, at 5 p.m., with the Infection Preventionist (IP), the IP stated medication syringes are changed every day and should indicate in the sticker the date it would be replaced. The IP stated Resident 2's medication syringe should have been labeled with the date it would be replaced as it was an infection issue and placed the resident at risk for acquiring infection from a contaminated medication syringe. During a concurrent interview and record review, on 3/26/2025, at 4:30 p.m., with the Nurse Manager (NM), the facility provided procedure titled, Enteral Tube Feeding, continuous, Gastrostomy, and Jejunostomy, last revised on 11/18/2024, was reviewed and the NM stated the facility follows the procedure for any enteral feeding related issues. The NM stated the procedure did not specifically indicate labeling of the medication syringe. The NM stated per facility practice, medication syringes are supposed to be changed every day and should indicate the date it will be replaced so the staff would know if it was old or new. b. During a review of Resident 35's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 11/27/2023 and readmitted in the facility on 7/10/2024 with diagnoses including craniotomy (a type of brain surgery where the surgeon will remove and replace part of the skull to access and treat a problem within the brain), percutaneous endoscopic gastrostomy tube (PEG - a feeding tube inserted directly into the stomach allow a person to receive nutrition through the stomach) dependent, and chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body). During a review of Resident 35's H&P, dated 7/12/2024, the H&P indicated Resident 35 had the presence of tracheostomy. During a review of Resident 35's MDS, dated [DATE], the MDS indicated Resident 35 had severely impaired cognition and required total assistance from staff with all ADLs. The MDS further indicated Resident 35 had a feeding tube. During a review of Resident 35's physician's order, dated 10/28/2024, the physician's order indicated continuous tube feeding renal Nepro (a therapeutic nutrition designed to meet the nutritional needs of people with kidney disease) at 35 ml/hr. During an observation, on 3/24/2025, at 11:07 a.m., inside Resident 35's room, Resident 35's water flush bag and label indicated a date of 3/23/2025 at 4 a.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview, on 3/24/2025, at 11:27 a.m., inside Resident 35's room with Licensed Vocational Nurse (LVN) 1, LVN 1 confirmed and stated Resident 35's water flush bag indicated a date of 3/23/2025 at 4 a.m. LVN 1 stated water flush bags are changed by the nurse assigned to the resident as the water flush bags were only good for 24 hours. LVN 1 stated Resident 35's water flush bag had been hanging for more than 24 hours and should have been changed according to the manufacturer's guideline as it can already be contaminated, and Resident 35 can get infection. During a concurrent observation and interview, on 3/24/2025, at 11:50 a.m., inside Resident 35's room with RN 9, RN 9 stated Resident 35's water flush bag indicated a date and time of 3/23/2025, at 4 a.m., and it had already been more than 24 hours since the bag was last changed. RN 9 stated water flush bags are changed by the nurse assigned to the residents every 24 hours according to the manufacturer's guidelines. RN 9 stated Resident 35's water flush bag should have been changed as it can already be contaminated which placed the resident at risk for acquiring infection. During an interview, on 3/27/2025, at 5 p.m., with the IP, the IP stated water flush bags are supposed to be changed every 24 hours as indicated in the manufacturer's guideline. The IP stated Resident 35's water flush bag should have been changed as the bag can already be contaminated from being used for more than 24 hours and Resident 35 can get infection from the contaminated water flush bag. During a review of the facility provide manufacturer's guideline for the Water Flush Bag (WFB) 1, undated, the manufacturer's guideline indicated the device is intended for enteral feeding only and recommended to be replaced every 24 hours. During a review of the facility provided procedure titled Enteral Tube Feeding, continuous, Gastrostomy, and Jejunostomy, last revised 11/18/2024, the procedure indicated to change the administration set according to the manufacturer's instructions to prevent bacterial growth. 38552 c. During a review of Resident 41's Face Sheet, the Face Sheet indicated the facility admitted the resident on 12/11/2024 with diagnoses including respiratory failure (a serious condition that makes it difficult to breathe) and dementia (a progressive state of decline in mental abilities). During a review of Resident 41's MDS, dated [DATE], the MDS indicated the resident had no speech, hearing highly impaired, rarely/never makes self-understood, and rarely/never had the ability to understand others. The MDS indicated the resident had function limitation in range of motion (full movement of a joint) on both sides of upper and lower extremities. The MDS indicated the resident with feeding tube while a resident of the facility. During a review of Resident 41's physician order, dated 2/26/2025, the physician order indicated TFF 3; 70 ml/hr, continuous 22 hours daily, gastrostomy, free water amount 100 ml, free water frequency every six hours. During a review of Resident 41's Follow-Up Nutrition Assessment, dated 2/22/2025, the Follow-Up Nutrition Assessment indicated the dietitian recommendations to continue TFF 3 1.2 to 70 milliliters for 22 hours daily to slow down weight loss. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 41's Flowsheet, dated 3/24/2025 to 3/25/2025, the Flowsheet indicated the following tube feeding intake: - 3/24/2025 at 6 a.m., 794 ml - 3/24/2025 at 6 p.m., 770 ml - 3/25/2026 at 6 a.m., 776 ml. During a review of Resident 41's care plan focusing on enteral nutrition, dated 12/17/2024, the care plan indicated interventions including minimizing unnecessary disruptions to feeding and using enteral nutrition protocol to optimize delivery. During a concurrent observation and interview, on 3/25/2025, at 8:34 a.m., with RN 9, inside Resident 41's room, the tube feeding connected to Resident 41 indicated TFF 3 labeled with the date 3/25/2025, start time 2 a.m., and set at 70 ml/hr in a one-liter container. RN 9 stated about 750 ml of fluid was left in the TFF 3 container. RN 9 stated 146 ml of formula was administered. RN 9 stated the next shift clears the amount in the tube feeding machine when they start their shift. RN 9 stated the start date and time was when the new TFF 3 was started, 3/25/2025 at 2 p.m. RN 9 stated the total time from 2 a.m. to 8:30 a.m. is 6 hours and 30 minutes. RN 9 stated when the tube feeding formula rate is set to 70 ml/hr, there should be about 455 ml delivered and should have about 545 ml left in the bag. RN 9 stated they also account for pausing the tube feeding during ADLs or repositioning which takes about 10 to 15 minutes. During a concurrent interview and record review, on 3/25/2025, at 8:38 a.m., with RN 9, Resident 41's Flowsheet, dated between 3/24/2025 to 3/25/25, nursing notes, dated between 3/24/2025 to 3/25/2025, and physician orders were reviewed. RN 9 stated there was no documentation to account for the 205 ml difference left in the bag. RN 9 stated there should have been a documentation why TFF 3 still had that much formula left in the bag. RN 9 stated there were no new orders to hold Resident 41's tube feeding formula. During an interview, on 3/27/2025, at 5:42 p.m., with RN 7, RN 7 stated at the start of the primary nurse's shift they check the tube feeding machine regarding the timing, the rate, and clear the amount delivered and monitor how much the resident's intake is. RN 7 stated the primary nurse can set up the machine to deliver the amount of formula at a set time and once the time has been reached, the machine will alarm. RN 7 stated if there is discrepancy with the amount left in the formula bag the primary nurse should have documented the reason why it has that much left and should have notified the resident's physician and the resident's family about it. RN 7 stated they should have notified the physician because there is no order for bolus or to increase the rate to catch up to the amount the resident is supposed to receive. RN 7 stated they can hold it for a short amount of time when the staff is providing ADLs or repositioning the resident. RN 7 stated the importance of following the order is to ensure the resident receives the amount of nutrients and vitamins as ordered to keep the resident in a healthy condition. RN 7 stated when the set amount of tube feeding formula is not received by Resident 41, the resident could potentially lose weight and may not get enough vitamins, minerals, or calories which can lead to malnutrition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Reference (Ref) 1 titled, Enteral tube feeding, continuous, gastrostomy and jejunostomy, last reviewed and approved on 3/10/2025, the Ref 1 indicated implementation included the following: - Verify the practitioner's order including administration method, volume, rate, and type, volume, and frequency of water flushes. - Make sure the enteral formula container is labeled with the date and time that the formula was hung, administration route, rate, and duration. - Frequently monitor the gravity drip rate or enteral feeding pump infusion rate to ensure accurate delivery of the enteral formula. During a review of the facility's policy and procedure (P&P) titled, Enteral Feedings, last reviewed and approved on 3/10/2025, the P&P indicated it is the purpose of this policy to provide nourishment to residents who are unable to meet their nutritional needs orally. The P&P indicated enteral formulas/supplements are ordered by the physician or dietitian when directed by the physician. The P&P indicated enteral formula administration and handling guidelines are found in the Ref 1 Procedures for nursing to follow tube feeding administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview and record review, the facility failed to ensure three of five sampled residents (Resident 24, Resident 38, and Resident 40) investigated under the respiratory care area oxygen (type of gas our body needs in order to function) therapy equipment was maintained, and standard infection control practices were followed by failing to ensure: 1. Resident 24 and Resident 38's oxygen tubing did not touch the floor. 2. Resident 40's humidification bottle was labeled and changed per the facility established schedule. 3. Resident 38's Yankauer suction tool (long plastic tool used to remove secretions [thick or thin sticky fluids from the mouth and throat]) was labeled with the date when it was opened. These deficient practices had the potential for Resident 24, Resident 38, and Resident 40 to develop complications such as infection. Findings: 1a. During a review of Resident 24's Face Sheet (Admission Record), the Face Sheet indicated the facility originally admitted the resident on 7/16/2020, and readmitted the resident on 3/31/2022, with diagnoses including acute respiratory failure (a condition where the respiratory system is unable to function properly, which can lead to a failure of gas exchange), traumatic brain injury (TBI - a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 24's History and Physical (H&P), dated 11/11/2024, the H&P indicated the resident is unable to make medical decisions. During a review of Resident 24's Minimum Data Set (MDS - a resident assessment tool), dated 1/28/2025, the MDS indicated Resident 24 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 24 had tracheostomy (a surgical procedure that creates an opening in the trachea [windpipe] in the front of the neck) and was on continuous oxygen therapy (a treatment that supplies oxygen at higher levels than normal room air). During a review of Resident 24's physician's orders, dated 12/30/2024, the Order Summary Report indicated an order of may suction resident for increase secretion three times a day (TID) as needed. During an observation, on 3/24/2025, at 9:16 a.m., inside Resident 24's room, Resident 24 laid in bed with the resident's tracheostomy connected to oxygen at two (2) liters per minute (liters/min - a unit of measurement) via tracheostomy mask with the oxygen tubing touching the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview, on 3/24/2025, at 9:40 a.m., with the Infection Preventionist (IP), inside Resident 24's room, the IP confirmed and stated Resident 24's oxygen tubing was touching the floor. The IP stated oxygen tubing is not supposed to be touching the floor. The IP stated the tubing is supposed to be changed to a shorter one if the tubing is too long to prevent the tubing from touching the floor. The IP stated Resident 24's oxygen tubing should not be touching the floor as the floor is dirty and contaminated and can place the resident at risk for acquiring an infection. During a review of the facility's policy and procedure (P&P) titled, Standards of Care (Sub Acute), last reviewed on 3/10/2025, the P&P indicated the licensed nurse will carry out safety procedures for proper infection control practices, isolation techniques, use of restraints and side rails and care of the environment should be followed as indicated. 1b. During a review of Resident 38's Face Sheet, the Face Sheet indicated the facility admitted Resident 38 on 11/25/2024 with a diagnosis including respiratory failure (lungs are not working well causing difficult breathing). During a review of Resident 38's, dated 11/26/2024, the H&P indicated Resident 38 had a medical history of tracheostomy, cerebrovascular accident (CVA - stroke, loss of blood flow to a part of the brain), hypertension (HTN - high blood pressure), and urinary bladder (stores urine) neurogenic (brain, spinal cord, and/or nervous system) dysfunction (not working properly). During a review of Residents 38's MDS, dated [DATE], the MDS indicated Resident 38 had severe cognitive impairment and required assistance of two-person physical assist for ADLs. The MDS indicated Resident 38 received oxygen therapy, suctioning, and tracheostomy care. During a review of Resident 38's Care Plan (CP) titled, Device-Related Complication Risk (Artificial Airway), initiated on 8/29/2024, the CP interventions included: Provide oral (mouth) care regularly, evaluate need for suctioning to minimize risk of airway obstruction (blockage), and apply O2 (oxygen)/ventilation (moving air in and out of lungs). During a concurrent observation and interview, on 3/24/2025, at 1:45 p.m., with Licensed Vocational Nurse (LVN) 1, in Resident 38's room, the oxygen tubing from Resident 38's tracheostomy site at the neck to the oxygen humidifier (adds moisture to oxygen) on the wall, coiled on the floor. LVN 1 stated the oxygen tubing should not touched the floor because the floor was contaminated (dirty). During an interview, on 3/27/2025, at 8:38 a.m., with Registered Nurse (RN) 4, RN 4 stated it was important to keep oxygen tubing off the floor for infection control. RN 4 stated we need to prevent tubing from being on the floor because the resident could get an infection such as ventilator (breathing machine) associated pneumonia ([NAME] - lung infection from using the ventilator through a tube inside the mouth and throat, or through a tracheostomy). During a review of the facility's P&P titled, Standards of Care - Sub Acute, dated 3/2024, the P&P indicated, Licensed nurse will carry out safety procedures as outlined in the P&P for proper infection control practices, isolation techniques, use of restraints and side rails, and care of the resident's environment should be followed as indicated. 44244 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 40's H&P, dated 9/27/2024, the H&P indicated the facility originally admitted the resident on 9/26/2024 with diagnoses including squamous cell carcinoma (a type of cancer) of the neck, chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood) with hypoxia (low oxygen in the tissues), tracheotomy, and ventilator dependence. During a review of Resident 40's MDS, dated [DATE], the MDS indicated the facility originally admitted the resident on 9/26/2024 and most recently admitted on [DATE]. The MDS further indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident used a mechanical ventilator and received oxygen therapy. During a review of Resident 40's Order Report, dated 3/26/2025, the Order Report indicated a physician's order for humidified O2 via T-piece (a device use to help tracheostomy breathing) during waking hours as tolerated with supervision and family on bedside (start at 60 minutes, increase duration daily if possible). Place back on ventilator support if in distress. Titrate (adjust) O2 to maintain 92 percent (%, a measurement), add humidifier, dated 11/15/2024. During a review of Resident 40's CP on presence of an artificial airway, initiated 9/27/2024, the CP indicated to provide humidification. During an observation, on 3/24/2025, at 10:30 a.m., inside Resident 40's room, supplemental oxygen via oxygen tubing and a humidifier bottle connected to Resident 40. Resident 40's oxygen humidifier bottle did not indicate the date it was last changed. During a concurrent observation and interview, on 3/24/2025, at 10:35 a.m., with RN 8, RN 8 entered Resident 40's room, turned on the light, and stated humidification bottles are changed by the night shift and should be labeled with the date the bottle was changed. RN 8 stated Resident 40's humidification bottle was not labeled, and RN 8 did not know when the bottle was last changed. During a concurrent observation, interview, and record review, on 3/24/2025, at 10:40 a.m., with Respiratory Therapist (RT) 1, the Subacute Supply Change and Equipment Check Schedule was reviewed. RT 1 confirmed and stated oxygen humidification bottles are changed every three days and the bottles are labeled with the date the bottle was last changed. RT 1 assessed Resident 40's oxygen humidification bottle and stated the bottle did not indicate the date it was last changed. RT 1 stated there was no documentation indicating Resident 40's humification bottle was changed within the last three days. RT 1 stated if Resident 40's humidification bottle was not labeled with the date, then RT 1 did not know when the bottle was last changed. During an interview, on 3/27/2025, at 8:35 a.m., with the Nurse Manager (NM), the NM stated oxygen humidification bottles are changed every three days and must be labeled with the date last changed. The NM stated it was important to label with the date to communicate when the bottles were last changed and to identify when the bottle needs to be changed next. The NM stated when Resident 40's oxygen humidification bottle did not indicate the date it was last changed, there was a risk the bottle was used for an extended amount of time causing an infection control issue. The NM stated Resident 40 is connected to a ventilator system and when the humidification bottle was not changed, there was a potential for the resident to develop a respiratory infection. The NM stated the facility policy and procedures regarding infection control were not followed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility provided, Subacute Supply Change and Equipment Check Schedule, last reviewed 4/2024, the Subacute Supply Change and Equipment Check Schedule indicated the RT is responsible for ventilator patients. The bubble humidifier (humidification bottle) is changed by the day shift when the water level is 25 % or every three days. During a review of the facility's policy and procedure (P&P) titled, Standard Precautions and Transmission-Based Precautions, last reviewed 3/10/2025, the P&P indicated standard precautions is the primary practice used for the prevention of the spread of disease and infections. Standard precautions are used in the care of all patients regardless of their diagnosis or presumed infection status. All caregivers including clinical and non-clinical caregivers are expected to follow appropriate precautions. Ensure single use items are discarded properly. 50516 3. During a concurrent observation and interview on 3/24/2025 at 1:45 p.m., with LVN 1, in Resident 38's room, Resident 38's Yankauer suction tool was opened and had yellow secretions inside. LVN 1 stated the Yankauer did not have a date of when it was opened or needed to be changed. LVN 1 stated I don't know when it was opened. LVN 1 stated the Yankauer should be changed every day and as needed and should be dated when it was opened or needed to be changed. During an interview on 3/27/2025 at 8:38 a.m., with Registered Nurse (RN) 4, RN 4 stated if oxygen equipment was not changed on the right date or time, it could cause an infection for the resident. During a review of the facility's policy and procedure (P&P) titled, Standards of Care - Sub Acute, dated 3/2024, the P&P indicated, licensed nurse will carry out safety procedures as outlined in the P&P for proper infection control practices, isolation techniques, use of restraints and side rails, and care of the resident's environment should be followed as indicated. During a review of the facility's procedure titled Subacute (more specialized care than a general skilled nursing facility) Supply Change and Equipment Check Schedule, undated, the procedure indicated to change the Yankauer weekly and PRN (as needed) when soiled (caking [dried or hardened substance] present).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 38552 Based on interview and record review, the facility failed to specify an indication (the reason) for the use of a hypoglycemic medication (lowers blood sugar) for one of five sampled residents (Resident 41) during a review of unnecessary medications when insulin (a hormone that removes excess sugar from the blood) lispro (fast-acting insulin) did not have an indication. This deficient practice had the potential to result in not medically necessary treatments potentially leading to ineffective diabetes management. Findings: During a review of Resident 41's Face Sheet, the Face Sheet indicated the facility admitted the resident on 12/11/2024 with diagnoses including respiratory failure (a serious condition that makes it difficult to breathe) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 41's Minimum Data Set (MDS-a resident assessment tool), dated 2/25/2025, the MDS indicated the resident had no speech, hearing was highly impaired, rarely/never made self understood, and rarely/never understood The MDS indicated the resident was taking medications in high-risk drug classes which includes hypoglycemics. During a concurrent interview and record review on 3/25/2025 at 3:50 p.m. with Registered Nurse (RN) 2, Resident 41's physician orders were reviewed. RN 2 stated Resident 41 received the following insulins: - Glargine (long-acting insulin) 100 unit per milliliter (ml-a unit of measurement), 25 units (0.25 ml) subcutaneous (SQ- situated or applied under the skin) for diabetes, routine, order dated 12/22/2024. - Lispro 0-12 units, SQ, two times daily, order dated 12/11/2024. RN 2 stated there was no indication noted on the use of Lispro. During an interview on 3/27/2025 at 5:35 p.m., with RN 7, RN 7 stated medication order components would need to have the medication name, dose, route, timing, blood sugar levels, and diagnosis. RN 7 stated the purpose of the diagnosis is to know what it is they are giving it for and if the primary nurse is not familiar about the medication they should ask and clarify with the physician what they are giving it for. RN 7 stated this is part of the medication rights. During a review of the facility's policy and procedure (P&P) titled, Medication Administration and Monitoring (Sub Acute), last revised and approved on 3/10/2025, the P&P indicated before administering the medication, the eMAR is reviewed and to always observe the seven-rights of medication administration: the right drug, the right patient, the right time, the right dose of the drug, the right route, the right reason (indication), and the right documentation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on interview and record review, the facility failed to ensure residents are free of any significant medication errors for two of two sampled residents (Residents 35 and 42) reviewed for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) and anticoagulant (a substance that is used to prevent and treat blood clots in blood vessels and the heart) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin and heparin (an anticoagulant) administration sites. The deficient practice had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin and anticoagulants (a substance that is used to prevent and treat blood clots in blood vessels and the heart) such as lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (a rare disease that occurs when a protein called amyloid builds up in organs). Cross Reference F658 Findings: a. During a review of Resident 35's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 11/27/2023 and readmitted in the facility on 7/10/2024 with diagnoses including craniotomy (a major type of brain surgery where the surgeon will remove and replace part of the skull to access and treat a problem within the brain, hypertension (HTN - also known as high blood pressure), and chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body). During a review of Resident 35's History and Physical (H&P) dated 7/12/2024, the H&P indicated Resident 35 had the presence of tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck and was non-verbal (not speaking). During a review of Resident 35's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/28/2025, the MDS indicated Resident 35 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 35 received anticoagulant. During a review of Resident 35's physician's order, the physician's order dated 1/8/2025 indicated heparin sodium injection (porcine) solution 5000 units per milliliter (units/ml - a unit of measurement) 5000 units subcutaneously every 12 hours for DVT (deep vein thrombosis - a blood clot that forms in one or more of the deep veins in the body, usually in the legs causing leg pain or swelling) prophylaxis. During a review of Resident 35's care plan (CP) on thrombolytic therapy (the use of medications to dissolve blood clots) last revised on 3/2/2025 with a target date of 5/28/2025, the CP indicated to frequently monitor peripheral perfusion to address complications early as one of the interventions to prevent and manage risk of bleeding. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/25/2025 at 11:05 am., reviewed Resident 35's physician's order, subcutaneous administration sites for heparin from 1/8/2025 to 3/25/2025, and the MDS with the Minimum Data Set Nurse (MDSN). The MDSN stated Resident 35 received heparin, had a physician's order for heparin, and were administered as follows: Heparin 5000 units/ml injection 5000 units: - 1/20/2025 5:51 a.m. left upper quadrant - LUQ - 1/20/2025 5:03 p.m. LUQ - 3/2/2025 6:22 p.m. LUQ - 3/3/2025 5:14 a.m. LUQ - 3/7/2024 6:58 a.m. right upper quadrant - RUQ - 3/7/2025 5:39 a.m. RUQ - 3/23/2025 5:15 a.m. LUQ - 3/23/2025 17:32 LUQ The MDSN stated administration sites for insulin and anticoagulants such as heparin should be rotated per standards of practice and manufacture's guideline to prevent hardening or lumps in the skin. The MDSN stated the list of administration sites for the heparin were not rotated. The MDSN stated Resident 35's administration sites should have been rotated to prevent pain, redness, irritation, and lumps on the resident's skin. The MDSN stated not rotating the administration sites for the insulin is not following the standards of practice and manufacturer's guideline and can be considered a medication error which may lead to an adverse reaction to the medicine. During a concurrent interview and record review on 3/27/2025 at 5:00 p.m. with Registered Nurse (RN) 8, RN 8 stated the location of administration sites for Resident 35's heparin were not rotated. RN 8 stated the nurses are supposed to rotate heparin administration sites according to standards of practice, and as indicated in the manufacturer's guideline. RN 8 stated Resident 35's administration sites for heparin should have been rotated to prevent adverse effects such as bruising, skin irritation, skin pits, lipodystrophy and amyloidosis which can affect absorption of the medication. RN 8 stated not rotating the administration sites for the heparin is not following the standards of practice and manufacturer's guideline and can be considered a medication error. During a review of the facility-provided manufacturer's guideline for heparin sodium injection solution, dated 1/2022, the manufacturer's guideline indicated to use a different site for each injection. The manufacturer's guideline further indicated injection site irritation is one of the most common adverse reactions for the use of heparin. During a review of the facility's policy and procedure (P&P) titled, Medication Administration and Monitoring (Sub Acute), last reviewed on 3/2025, the P&P indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Healthcare providers administering medications are responsible for knowing and understanding the dosage, indications, side effects and precautions/warnings of the medications being administered. - Injection sites for subcutaneous and intramuscular administration must be rotated. During a review of the facility's P&P titled, Medication Error Reporting, last reviewed on 3/10/2025, the P&P indicated a medication event/error is defines as any preventable event (actual/potential) that may cause or lead to inappropriate medication use and/or patient harm while medication is in the control of health care professional, patient or consumer. Medication errors can occur within any of the following steps in the medication management process including prescribing, order communication, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use. b. During a review of Resident 42's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 9/4/2024 and readmitted in the facility on 12/20/2024 with diagnoses including history of stroke (loss of blood flow to a part of the brain), tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck, and ventilator-dependent respiratory failure (condition when a patient's lungs cannot breath on their own and required a machine to help breathe). During a review of Resident 42's History and Physical (H&P) dated 12/22/2024, the H&P indicated Resident 42 was awake and alert but did not indicate the resident's capacity to understand and make decisions. During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42 was able to make his needs known and able to understand others. The MDS further indicated Resident 42 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 42 received insulin. During a review of Resident 42's physician's order, the physician's order dated 2/24/2025 indicated insulin glargine-yfgn (a long-acting insulin) injection vial eight (8) units (a unit of measurement) at bedtime for diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 42's care plan (CP) on hyperglycemia last revised on 3/2/2025 with a target date of 7/31/2025, the CP indicated to provide pharmacologic therapy (drug or medication therapy) to maintain blood sugar levels within targeted range. During a concurrent interview and record review on 3/25/2025 at 11:05 am., reviewed Resident 42's physician's order, subcutaneous administration sites for insulin glargine from 2/24/2025 to 3/25/2025, and the MDS with the Minimum Data Set Nurse (MDSN). The MDSN stated Resident 42 had a physician's order for insulin glargine, and were administered as follows: Insulin glargine-yfgn injection 8 units: - 3/12/2024 5:35 p.m. left lower quadrant - LLQ (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 3/13/2025 5:34 p.m. LLQ - 3/17/2025 5:27 p.m. left upper arm - LUA - 3/18/2025 5:51 p.m. LUA The MDSN stated administration sites for insulin and anticoagulants should be rotated per standards of practice and manufacture's guideline to prevent hardening or lumps in the skin. The MDSN stated the list of administration sites for Resident 42's insulin glargine were not rotated. The MDSN stated Resident 42's administration sites should have been rotated to prevent pain, redness, irritation, and lumps on the resident's skin. The MDSN stated not rotating the administration sites for the insulin is not following the standards of practice and manufacturer's guideline and can be considered a medication error. During a concurrent interview and record review on 3/27/2025 at 5:00 p.m. with Registered Nurse (RN) 8, RN 8 stated the location of administration sites for Resident 42's insulin glargine were not rotated. RN 8 stated the nurses are supposed to rotate insulin administration sites according to standards of practice, and as indicated in the manufacturer's guideline. RN 8 stated Resident 42's administration sites for insulin glargine should have been rotated to prevent adverse effects such as bruising, skin irritation, skin pits, lipodystrophy and amyloidosis which can affect absorption of the insulin. RN 8 stated not rotating the administration sites for the insulin is not following the standards of practice and manufacturer's guideline and can be considered a medication error. During a review of the facility-provided manufacturer's guideline for insulin glargine (rDNA origin) 100 units per milliliter (units/ml - a unit of measurement) three (3) ml pen dated 8/26/2022, the manufacturer's guideline indicated to change (rotate) the injection site for each injection and to inject under the skin of the stomach area, buttocks, upper legs or upper arms. During a review of the facility's P&P titled, Medication Administration and Monitoring (Sub Acute), last reviewed on 3/2025, the P&P indicated the following: - Healthcare providers administering medications are responsible for knowing and understanding the dosage, indications, side effects and precautions/warnings of the medications being administered. - Injection sites for subcutaneous and intramuscular administration must be rotated. During a review of the facility's P&P titled, Medication Error Reporting, last reviewed on 3/10/2025, the P&P indicated a medication event/error is defines as any preventable event (actual/potential) that may cause or lead to inappropriate medication use and/or patient harm while medication is in the control of health care professional, patient or consumer. Medication errors can occur within any of the following steps in the medication management process including prescribing, order communication, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 43988 Based on observation, interview, and record review, the facility failed to ensure safe provision of pharmaceutical services during the inspection of one (1) of three (3) medication carts (Medication Cart 1) reviewed during the Medication Storage and Labeling task by failing to discard Resident 1's medication in the bubble pack (a packaged container with compartments that can contain medications) with a broken seal and covered with paper tape. This deficient practice had the potential for medication error and contaminate medications stored inside the medication cart. Findings: During a concurrent observation and interview, on 3/26/2025, at 8:33 a.m., during an inspection of Medication Cart 1, in the presence of Registered Nurse (RN) 8, RN 8 confirmed and stated Resident 1's cyanocobalamin (a manufactured version of vitamin B12 used to treat and prevent vitamin B12 deficiency anemia [low levels of this vitamin in the body]) had a broken seal and was stored in Medication Cart 1. RN 8 stated the process prior to dispensing a medication from a bubble pack includes the licensed nurses (LNs) comparing the medication label in the bubble pack with the medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) first. RN 8 stated if a medication was dispensed by accident from the bubble pack, the medication should be discarded immediately at the designated bin inside the medication room and not taped back in the bubble pack. RN 8 stated the seal from Resident 1's bubble pack was broken and covered with clear plastic tape. RN 8 stated the medications for slot numbers 5 and 13 should have been discarded once removed from the bubble pack and not taped back as the medication had been contaminated. RN 8 stated it could not be the right medication that was placed back in the bubble pack and placed the Resident 1 at risk for receiving the incorrect medication which can be a medication error. During an interview, on 3/27/2025, at 5:30 p.m., with the Nurse Manager (NM), the NM stated she was made aware by RN 8 of the issue with the cyanocobalamin. The NM stated the cyanocobalamin should have been discarded in the designated bin inside the medication room if dispensed by accident. The NM stated the LN are supposed to compare the medication label in the bubble pack with the MAR first prior to dispensing a medication from the bubble pack. The NM stated dispensing a medication and taping it back to the bubble pack is not an acceptable practice as the medication was already contaminated, the nurses would not know if the correct medicine was placed back in the bubble pack, and the resident receives the correct medication. During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, last reviewed 3/10/2025, the P&P indicated: - Medications and biologicals are stored safely, securely, and properly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. - Medication storage conditions are monitored on a routine basis and corrective action are taken if problems are identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen by failing to: 1. Ensure towels were stored in clean towel bins, sanitation buckets, or dirty towel bins when not in use. 2. Ensure food items in the walk-in Refrigerators #2 and #5 were labeled according to facility policy. 3. Ensure the personal property of staff was not stored in the kitchen area next to an uncovered serrated knife and food items. 4. Ensure Refrigerator #10 and the Subacute Resident Refrigerator/Freezer temperatures were maintained per facility policy and procedure. These deficient practices had the potential to result in harmful bacterial growth and cross contamination (the process by which bacteria, microorganisms, or chemicals are unintentionally transferred from one substance or object to another, with harmful effect) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 10 of 45 medically compromised residents who received food and ice from the kitchen. Findings: a. During an Initial Kitchen Tour, on [DATE], at 8 a.m., with the Interim Director of Hospitality Services (IDHS) and Food Service Attendant 1 (FSA 1), the IDHS stated the facility uses white towels to sanitize the kitchen. The IDHS stated all towels should only be stored in clean towel bins prior to use, red sanitizer buckets when in use, or dirty towel bins after use. The IDHS stated no towels should be left out in the tray line area to prevent cross contamination from one surface to another while staff is performing tasks in the kitchen. Observed the following in the tray line area: 1. A white towel placed on the top of FSA 1's black rolling cart. The IDHS stated the towel was used and should not be on the cart. FSA 1 stated at approximately 6:30 a.m., FSA 1 used the towel and placed the dirty towel on the cart. FSA 1 stated she should not have placed the dirty towel on the cart. FSA 1 stated dirty towels should not be left on carts because the towel could be soiled with bacteria that could potentially contaminate the tray line area. FSA 1 stated there was no reason why she left the towel on the cart and stated she should not have. 2. Two white towels placed on an unattended black rolling cart. The IDHS stated she did not know if the towels were used. The IDHS stated the towels should not be placed on the unattended cart. The IDHS removed the towels and placed them in the dirty towel bin. The IDHS stated the towels could be dirty and cause cross contamination resulting in foodborne illness in residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on [DATE], at 1:35 p.m., with the Clinical Nutrition Manager (CNM), the facility provided Health and Safety Code (HSC) regarding equipment, utensils, and linens was reviewed. The CNM stated the facility does not have a specific policy regarding the use of towels in the kitchen, but it is a standard of practice to never keep towels in the kitchen area unless they are in a sanitization bucket. The CNM reviewed the HSC and stated the kitchen staff did not follow the HSC when towels were left out in the kitchen. During a review of the facility provided HSC document titled, Article 5. Linens, dated effective [DATE], the HSC indicated wiping cloths that are used repeatedly are held in a sanitizing solution of an approved concentration. Working containers of sanitizing solutions for storage of in-use wiping cloths shall be used in a manner to prevent contamination of food, equipment, utensils, and linens. Soiled linens shall be kept in receptacles and transported to prevent contamination of food, clean equipment, and clean utensils. During a review of the facility policy and procedure (P&P) titled, Safety and Sanitation Standards, effective date [DATE], the P&P indicated safety and sanitation standards are followed to ensure the provision of safe food to the customers. Each employee is responsible for maintaining a clean and safe work area throughout their shift. b. During an Initial Kitchen Tour, on [DATE], at 8 a.m., with the IDHS and FSA 1, the IDHS stated staff have a locker to store their personal belongings and personal knives when not in use. The IDHS stated no personal items should be in the kitchen because there is a potential of cross contamination resulting in foodborne illness in residents. The top shelf of FSA 1's black rolling cart contained a box of substitute sugar packets, a box of seasoning packets, a cellphone, a wireless headphone case, and a serrated knife. The IDHS stated FSA 1 should have stored the cell phone and headphone case in FSA 1's locker. The IDHS stated FSA 1's knife should have been covered and securely stored in the designated storage area when not in use, but FSA 1 stored the uncovered knife on the cart next to FSA 1's personal items. FSA 1 stated the cell phone and headphone case belonged to her and personal items should not be stored in the kitchen. FSA 1 stated she uses the knife to cut fruit and the knife should not be stored uncovered and next to personal items because the phone and headphone case could contaminate the knife and other food items with bacteria. FSA 1 stated there was no reason why she stored the knife and personal items in the cart. During a concurrent interview and record review, on [DATE], at 1:35 p.m., the CNM reviewed the facility provided HSC regarding personal belongings. The CNM stated some kitchen staff bring personal knives to use in the facility kitchen and the knives should be stored properly when not in use. The CNM stated all cell phones and headphone cases should always be stored in the staff members locker and not in the kitchen or tray line area. The CNM stated the facility did not have a specific policy regarding personal items and uncovered knives in the kitchen, but it was a standard of practice based on the HSC. The CNM stated FSA 1 did not follow the facility practice when the knife, cell phone, and headphone case were stored on the cart in the tray line area. During a review of the facility provided HSC document titled, Article 4. Employee Storage Areas dated effective [DATE], the HSC indicated lockers or other suitable facilities shall be located in a designated room or area where contamination of food, equipment, utensils, and linens cannot occur. No personal effects are stored in any area used for the storage or preparation of food. A safety knife holder shall be provided to avoid loose storage of knives. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled, Dress Code, effective date [DATE], the P&P indicated the purpose of the P&P was to avoid contamination of food. As appropriate and available, a locker will be assigned for employee use. Cell phones are not permitted at workstations. During a review of the facility P&P titled, Safety and Sanitation Standards, effective date [DATE], the P&P indicated safety and sanitation standards are followed to ensure the provision of safe food to the customers. Each employee is responsible for maintaining a clean and safe work area throughout their shift. c. During an Initial Kitchen Tour, on [DATE], at 8 a.m., with the IDHS, observed the facility walk in refrigerators with the IDHS. The IDHS stated the facility labels food items that are stored in the refrigerators to facilitate the first in, first out method (rotation method used to minimize waste and ensure food safety by preventing spoilage) and to ensure expired food is discarded and not served to residents. The IDHS stated it was important to label and discard expired food because there is a potential that expired foods served to resident may cause foodborne illness. Observed the following: 1. In Refrigerator #5, two unopened, prepackaged egg salad sandwiches by Manufacture 1(Mfr. 1), labeled , d+[DATE]. The IDHS stated the sandwiches expired on [DATE] and should not have been stored in the refrigerator available to be served to residents. The IDHS stated the staff should have discarded the expired sandwiches and they did not. The IDHS stated when the expired sandwiches were left in the refrigerator, there was a potential that the expired sandwiches could be served to residents causing illness. 2. In Refrigerator # 5, there was one unlabeled large pan of cooked meat that was partially uncovered with the contents exposed to air. The IDHS stated the pan contained leftover chicken breasts and was unlabeled. The IDHS stated she did not know when the pan was placed in the fridge because it was not labeled. The IDHS stated it was important to label leftovers with the item contents and date of expiration to ensure staff knows what the food is and to ensure expired food is not served to residents. 3. In Refrigerator #2, one opened container labeled sour cream. The IDHS stated the expiration date on the container was not legible. The IDHS stated the facility uses the expiration on the container to know when to discard the sour cream. The IDHS stated because the expiration date was not legible, she did not know if the sour cream was expired. The IDHS stated if an expiration date is not legible then the sour cream should be thrown out. During a concurrent interview and record review, on [DATE], at 1:35 p.m., the CNM reviewed the facility P&P regarding food storage labeling and leftovers. The CNM stated the kitchen floor stocking staff should discard any unlabeled, illegibly labeled, or expired foods from the refrigerators to ensure expired food that may be sour, rotted, or moldy is not served to residents. The CNM stated when expired food is served to residents it may affect the nutritional value of food and cause the residents to not feel well. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled, Label and Dating, effective date [DATE], the P&P indicated the Food and Nutrition Services shall ensure that foods are labeled, dated, and stored appropriately. The purpose of the P&P was to ensure proper storage and safety of the department's food supply. The following procedures and checks are done regularly to prevent any possible contamination or spoilage of food: i. Caregivers are to remove any expired item and ensure that foods are safely stored. ii. All food supplies shall be rotated on a first-in, first-out, basis. This will ensure the oldest product is used first. iii. The pull date, is the last date that an item can be used. The product will be pulled on the morning following its pull date, and disposed of. Items prepared on premises, will carry a pull date to ensure maximum freshness. Where items are pull-dated by the manufacture, items will be pulled accordingly. iv. Products will be dated via the following acceptable mechanisms. a) Label with the following information will be used to label and date foods for holding and storage: i) Item name ii) Use by date (pull date) iii) Employee signature v. All prepared items will receive a three day pull date. During a review of the facility P&P titled, Label and Dating, Attachment A; Pull Dates, effective date [DATE], the P&P attachment indicated the following pull dates: Product: sour cream has a pull date of the date on the container. Product: cooked chilled chicken has a pull date of three days. Product: Mfr. 1 Sandwiches have a pull date of two days. During a review of the facility P&P titled, Leftovers, effective date [DATE], the P&P indicated leftover food is given a three day pull date to ensure proper usage, storage, and safety of the department leftover's food. Food portions not utilized in the service of a meal will be refrigerated in a shallow covered container labeled and dated with a three day pull date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d.1. During an Initial Kitchen Tour, on [DATE], at 8 a.m., with the IDHS, observed the facility walk in refrigerators with the IDHS. The IDHS stated the facility maintains refrigerators at an acceptable temperature range of 32 to 41 degrees Fahrenheit (F, a unit of measurement for temperature) to ensure the quality of the food and to prevent food borne illness in residents . The IDHS stated refrigerator # 10 is used during tray line and the thermometer indicated the refrigerator was 41 degrees. The IDHS reviewed Refrigerator #10's Temperature Log for ,d+[DATE] and noted the refrigerator was out of the acceptable temperature range for the p.m. shift (evening shift) on the following dates: - On [DATE], the temperature was 42 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 48 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 42 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 42 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 44 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 44 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 44 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 44 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 44 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 45 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 44 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 44 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 42 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 46 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 52 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 50 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 50 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 42 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 42 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 44 F, no corrective actions/comments are indicated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On [DATE], the temperature was 42 F, no corrective actions/comments are indicated. The IDHS further stated she did not know why Refrigerator #10 was out of the acceptable temperature range only on the p.m. shift. During a concurrent interview and record review, on [DATE], at 10:45 a.m., with the CNM, the facility provided Work Order email, dated [DATE], and Refrigerator #10's Temperature Log, for ,d+[DATE], were reviewed. The CNM noted Refrigerator #10 was out of the acceptable temperature range for the p.m. shift (evening shift) on the following dates: - On [DATE], the temperature was 44 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 42 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 42 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 44 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 42 F, no corrective actions/comments are indicated. The CNM further stated, on [DATE], at 6:43 p.m., the evening kitchen supervisor entered a work order indicating Refrigerator #10 was out of the temperature control limits and needed service. The CNM stated there was no follow up to the work order. The CNM stated the refrigerator was taking too long to reach acceptable temperature ranges after the evening tray line and should have been removed from the kitchen service, but it was not removed. The CNM stated a refrigerator should consistently provide an acceptable temperature range for food safety. The CNM stated the food safety temperature zone is below 41 degrees to prevent bacterial growth. The CNM stated when Refrigerator #10 was not maintained at a temperature between 32 to 41 F, it could have potentially resulted in bacterial growth causing food borne illnesses in residents. During a review of the facility P&P titled, Refrigerator/Freezer Temperature Logs, effective date [DATE], the P&P indicated all refrigerators and freezers must be monitored and the temperature documented to ensure the proper storage of food. The purpose of the policy was to ensure that food is safe and is being held n compliance with public health regulations. Temperatures will be checked daily in the main kitchen and patient units. All temperatures are documented on the appropriate temperature log with the recorder's initials. Acceptable temperature ranges are 32 to 41 F for refrigerators and below 0 F for freezers. When refrigerators and freezer temperatures are out of range, the following action step occur: a) Circle the out-of-range temperature in red ink b) Check the internal temperature of the food contained in the affected refrigerator and/or freezer, if the foods' temperature is out of the acceptable range, discard. c) Write an action plan on the temperature log, if more room is needed, turn the temperature log over and record the date and remainder of the action plan. d) Contact plant operations for repair as indicated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e) Follow up to ensure the action plan has been completed. d.2. During a Subacute Kitchen Tour, on [DATE], at 9 a.m., with the Clinical Educator (CE), observed the subacute refrigerators with the CE. The CE stated the Subacute refrigerator was maintained and monitored by the facility kitchen staff. The CE stated the acceptable temperature range for the refrigerator was between 32 and 41 F. The CE reviewed the Subacute Refrigerator's Temperature Log for ,d+[DATE] and noted the refrigerator was out of the acceptable temperature range on the following dates: - On [DATE], the temperature was 20 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 24 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 25 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 30 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 28 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 30 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 25 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 30 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 30 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 30 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 30 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 30 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 25 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 25 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 25 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 30 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 30 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 30 F, no corrective actions/comments are indicated. - On [DATE], the temperature was 30 F, no corrective actions/comments are indicated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On [DATE], the temperature was 30 F, no corrective actions/comments are indicated. During a concurrent interview and record review, on [DATE], at 1:35 p.m., with the CNM, the CNM reviewed the Subacute Refrigerator's Temperature Log for ,d+[DATE]. The CNM stated the CNM was made aware the Subacute refrigerator was out of acceptable temperature range with no corrective actions indicated. The CNM stated the Subacute freezer log also indicated the freezer was out of the acceptable temperature range of below 0 F on the following dates: - On [DATE], the temperature was +10 F, no corrective actions/comments are indicated. - On [DATE], the temperature was +10 F, no corrective actions/comments are indicated. The CNM further stated the importance of reporting when the temperature is out of range is to ensure the refrigerator/freezer is checked and functioning properly. The CNM stated when the subacute refrigerator's temperature was too low it could have potentially resulted in quality issues like the liquids freezing. The CNM stated residents must be served the intended appropriate texture and consistency of foods. The CNM stated when the items do not remain frozen in the freezer, it may result in quality issues from foods defrosting and refreezing. During a review of the facility P&P titled, Refrigerator/Freezer Temperature Logs, effective date [DATE], the P&P indicated all refrigerators and freezers must be monitored and the temperature documented to ensure the proper storage of food. The purpose of the policy was to ensure that food is safe and is being held in compliance with public health regulations. Temperatures will be checked daily in the main kitchen and patient units. All temperatures are documented on the appropriate temperature log with the recorder's initials. Acceptable temperature ranges are 32 to 41 F for refrigerators and below 0 F for freezers. When refrigerators and freezer temperatures are out of range, the following action step occur: a) Circle the out-of-range temperature in red ink b) Check the internal temperature of the food contained in the affected refrigerator and/or freezer, if the foods' temperature is out of the acceptable range, discard. c) Write an action plan on the temperature log, if more room is needed, turn the temperature log over and record the date and remainder of the action plan. d) Contact plant operations for repair as indicated e) Follow up to ensure the action plan has been completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on interview and record review, the facility failed to fully develop and implement an antibiotic (antimicrobial, medicine that inhibits the growth of or destroys microorganisms) stewardship program (ASP- a coordinated program that promotes the appropriate use of drugs used to treat infections, including antibiotics as a part of its overall Infection Prevention and Control Program (IPCP) for one of six sampled residents (Resident 3) reviewed under Infection Control facility task by: a. Failing to establish protocols to identify signs and symptoms of infections among residents to assess whether they met evidence-based national standard criteria for initiating antibiotic treatment b. Failing to identify Resident 3's use of levofloxacin (antibiotic) indicated for urinary tract infection (UTI- an infection in the bladder/urinary tract). These deficient practices had the potential to result in increased risk of inappropriate antibiotic use, potentially leading to adverse outcomes (complications arising from an intervention or condition) such as antibiotic resistance (the acquired ability of bacterial pathogens to withstand the effects of antimicrobial agents, reducing treatment efficacy) to Resident 3. Cross-reference F881 Findings: During a review of Resident 3's Face Sheet, the Face Sheet indicated the facility admitted the resident on 2/17/2025 with diagnoses including acute hypoxic respirator (a condition where the lungs cannot get enough oxygen into the blood) and hyperlipidemia (abnormally high fat). During a review of Resident 3's MDS, dated [DATE], the MDS indicated the resident's initial start date at the facility on 10/29/2024. The MDS indicated the resident had adequate hearing and unclear speech. The MDS indicated the resident made self understood and sometimes understood others. The MDS indicated the resident was dependent on staff with toileting, oral hygiene, shower/bathing self, lower body dressing, and personal hygiene. The MDS indicated the resident was taking antibiotics. During a review of Resident 3's physician order, dated 3/4/2025, the physician order indicated levofloxacin (Levaquin) tablet 500 milligrams (mg-a unit of measurement) per gastrostomy tube (g-tube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) for UTI, daily, end date 3/10/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and review on 3/27/2025 at 10:41 a.m. with the Infection Preventionist (IP), Resident 3's physician order, nursing progress notes, and registered nurses' plan of care, antibiotic tracking sheet (a document or tool used to monitor and record prescribed antibiotics and usage patterns [how often, how much, and what reason it's prescribed]), and Loeb's minimum criteria (evidence-based national standard criteria for initiating antibiotic treatment designed to reduce inappropriate prescribing by outlining minimum clinical signs and symptoms suggesting an infection) for initiating antibiotic therapy were reviewed. The Plan of Care indicated, on 3/1/2025 at 11:25 a.m., Resident 3 was noted with increased heart rate and had a temperature of 101.1 degrees Fahrenheit (F - a unit of measurement). The IP stated she uses the antibiotic tracking sheet and the Loeb's minimum criteria for initiating antibiotic therapy as a guide that she uses to monitor and review new or changes in antibiotic orders and uses Loeb's criteria, but this is not indicated in their policy. The IP stated they do not have a standard protocol in using the Loeb's criteria that shows which residents have met or have not met the criteria. The IP stated when Loeb's criteria is used for Resident 3's use of levofloxacin for UTI without urinary catheter, the resident would not have met the criteria because the resident only have increased heart and fever as signs and symptoms of infection. The IP stated the Loeb's minimum criteria for UTI includes either one of the following criteria: acute dysuria (discomfort or pain when urinating) or temperature greater than 100 F, and one or more of the following new or worsening symptoms: urgency, suprapubic pain (pain above pelvic bone), urinary incontinence, frequency, gross hematuria (visible blood in the urine), and costovertebral angle tenderness (pain in the upper back near the ribs). During a concurrent interview and record review on 3/27/2025 at 10:50 a.m. with the IP, the facility's P&P titled, Antimicrobial Stewardship (AMS) Program, last reviewed and approved on 3/10/2025, was reviewed. The IP stated the P&P did not indicate the protocol on the use of antibiotic tracking sheet and the use of Loeb's criteria to assess the residents for any infection. The IP stated she should have mentioned to the Manager of Infection Prevention (MIP) about the use of antibiotic tracking sheet and the use of Loeb's minimum criteria in initiating antibiotic therapy when they reviewed their P&Ps. During an interview on 3/27/2025 at 1:57 p.m. with the IP, the IP stated when the resident does not meet the Loeb's minimum criteria, she would notify the resident's physician that the resident did not meet the criteria to initiate the antibiotic then document on the resident's chart what she did and what the physician's response was. During a concurrent interview and record review on 3/27/2025 at 2:12 p.m. with Registered Nurse (RN) 2, Resident 3's nursing progress notes, plan of care, and physician orders were reviewed. RN 2 stated he was covering for the IP when Resident 3 had the order for levofloxacin for UTI. RN 2 stated he notified the primary nurse about the resident's laboratory results that were ordered, and he (RN 2) does not use any standardized criteria when reviewing antibiotics. During an interview on 3/27/2025 at 3:17 p.m. with the MIP, the MIP stated she was not aware of the Centers of Medicare and Medicaid Services (CMS- a federal agency that administers major healthcare programs) of the regulation antibiotic stewardship regulation requirements to be implemented. The MIP stated they have an ASP which they collaborate with the antimicrobial stewardship pharmacist. The MIP stated they purpose of the ASP is to administer antibiotics in the least amount of duration, and to make sure the antibiotic ordered had the appropriate frequency and dose to prevent multidrug resistance organisms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's P&P titled, Antimicrobial Stewardship (AMS) Program, last reviewed and approved on 3/10/2025, the P&P indicated it is the facility's policy to implement a comprehensive AMS program to evaluate judicious use of antimicrobials. The P&P indicated the purpose of the P&P is to optimize antibiotic therapy to improve clinical outcomes while minimizing unintended consequences of antimicrobial use, such as drug toxicity (drug causing harm) and emergence of resistance. During a review of the facility P&P titled, Department Policy Guidelines, last reviewed and approved on 3/10/2025, the P&P indicated the policy's purpose was to provide guidelines for the creation and/or review of policies, and to outline the approval process. Departmental policies and procedures are created, approved, maintained and archived in a consistent and timely manner, following a standardized approval and maintenance process. The "Policy Owner is the Director/Manager of each department, as they are responsible for the creation, review, revision, removal, and/or archive of their department's policies. The Policy Owner is responsible for updating policy. All clinical content is to be reviewed and revised by licensed caregivers and/or department Directors/Managers. Ensure policy content and formatting accuracy. Check that policy content is correct and applies to the department/unit's current practices. Ensure the policy is within scope of practice, and in accordance with Nurse Practice Act. Confirm that the policy contains the most current and evidence-based information. All departments are required to review their departmental policies according to the following timelines, and as needed for regulatory purposes. It is the responsibility of the department manager to ensure that appropriate documentation is maintained for any Standardized Procedures used in their department/area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review the facility failed to implement and maintain an infection control program by failing to ensure Registered Nurse (RN) 9, accompanied by the Nurse Practitioner (NP) and Medical Doctor (MD), implemented Contact Precautions (an infection control measure aimed to prevent spread of infection by direct or indirect contact by the use of personal protective equipment [PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments]) during rounding in the residents room for one of five sampled residents (Resident 39) reviewed under the Infection Control task area. This deficient practice had the potential to result in the spread of infectious microorganisms amongst staff, residents, and visitors. Findings: During a review of Resident 39's History and Physical (H&P), dated 3/27/2025, the H&P indicated the resident was readmitted to the facility on [DATE] with diagnoses that included prostate (a gland in the male reproductive system) cancer, chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood) with tracheostomy (opening surgically created through the front of the neck and into the trachea [windpipe]), and percutaneous endoscopic gastrostomy (PEG or GT - a tube placed directly into the stomach to give direct access for supplemental feeding, hydration or medicine) placement. During a review of Resident 39's Minimum Data Set (MDS - a resident assessment tool), dated 1/24/2025, the MDS indicated the resident was originally admitted to the facility on [DATE]. The MDS further indicated the resident sometimes had the ability to make self-understood and sometimes understood others. The MDS indicated the resident was dependent on staff for oral and personal hygiene, bathing, dressing, toileting, and mobility. During a review of Resident 39's Physician Orders, dated 11/18/2024, the Physician Orders indicated a physician's order for contact isolation for Carbapenem-resistant pseudomonas aeruginosa (CRPA - an infectious bacteria spread through contact with contaminated surfaces, healthcare workers, or equipment); multidrug-resistant pseudomonas aeruginosa (MDRA - infectious bacteria that are resistant to the effects of multiple types of antibiotics [medication used to treat bacteria]) During an observation, on 3/24/2025, at 10:55 a.m., Resident 39's entry to the room had a contact isolation sign posted. The sign indicated before entering the room, all staff and visitors must put on a gown and gloves. RN 9, Resident 39's NP and MD were inside Resident 39's room not wearing gowns. RN 9, the NP, and the MD exited the resident's room after speaking with Resident 39's family member. During an interview, on 3/24/2025, at 11 a.m., with RN 9 upon exiting Resident 39's room, RN 9 stated Resident 39 had a contact isolation sign at the entry to the room because the resident was on contact isolation. RN 9 stated gloves and a gown should be donned (put on) before entering the resident's room. RN 9 stated that RN 9, the NP, and the MD did not don gowns prior to entering or while inside the resident's room because they were not touching the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 3/27/2025, at 11:44 a.m., with the facility Infection Preventionist (IP), the IP stated Resident 39 was diagnosed with CRPA. The IP stated CRPA can be spread amongst staff, residents, and visitors by touching surfaces contaminated with secretions or when secretions unexpectedly exit a resident's mouth or tracheostomy tubing during a cough. The IP stated to prevent the spread of CRPA, anyone entering the resident's room must don a disposable gown to prevent contamination of the staff or visitor's clothing. The IP stated staff and visitors should don a gown even if they do not intend to touch the resident or any environmental surfaces. The IP stated the gown prevents any cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) from Resident 39 to any of the other residents that the NP, MD, or RN 7 visit during their rounds. During an interview, on 3/27/2025, at 8:35 a.m., with the Nurse Manager (NM), the NM stated facility residents are at increased risk of infection and wearing a gown prevents the spread of infection between residents. The NM stated when RN 9, the NP, and the MD did not don gowns while inside Resident 39's room, the facility policy and procedures regarding contact isolation were not followed. During a review of the facility's policy and procedure (P&P) titled, Standard Precautions and Transmission-Based Precautions, last reviewed 3/10/2025, the P&P indicated standard precautions are the primary practice used for the prevention of the spread of disease and infections. Standard precautions are used in the care of all residents regardless of their diagnosis or presumed infection status. All caregivers including clinical and non-clinical caregivers are expected to follow appropriate precautions. Contact precautions are used in addition to standard precautions. Use contact precautions for residents known or suspected to be infected or colonized with epidemiologically important / significant microorganisms that can be transmitted, by direct / indirect contact. For the resident who appears to have a disease requiring contact precautions, it is important to institute the appropriate precautions immediately. The appropriate sign should be posted on the resident's door. In addition to standard precautions, wear a gown providing 360-degree coverage to protect skin and prevent soiling and / or contamination of clothing. [NAME] PPE when entering a resident's room based on the anticipated interaction with the resident and environment. Remove / doff PPE before leaving the resident's room. During a review of the facility's P&P titled, [Regional] Standard Precautions and Transmission-Based Precautions, Appendix A last reviewed 3/10/2025, the P&P indicated contact precautions are recommended in long term care facilities for carbapenem resistant organisms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 38552 Based on interview and record review, the facility failed to fully develop and implement an antibiotic (antimicrobial, medicine that inhibits the growth of or destroys microorganisms) stewardship program (ASP- a coordinated program that promotes the appropriate use of drugs used to treat infections, including antibiotics as a part of its overall Infection Prevention and Control Program (IPCP) for one of six sampled residents (Resident 3) reviewed under Infection Control facility task by: 1. Failing to establish protocols to identify signs and symptoms of infections among residents to assess whether they met evidence-based national standard criteria for initiating antibiotic treatment 2. Failing to identify Resident 3's use of levofloxacin (antibiotic) indicated for urinary tract infection (UTI- an infection in the bladder/urinary tract). These deficient practices had the potential to result in increased risk of inappropriate antibiotic use, potentially leading to adverse outcomes (complications arising from an intervention or condition) such as antibiotic resistance (the acquired ability of bacterial pathogens to withstand the effects of antimicrobial agents, reducing treatment efficacy). Cross Reference F835 Findings: During a review of Resident 3's Face Sheet, the Face Sheet indicated the facility readmitted the resident on 2/17/2025 with diagnoses including acute hypoxic respirator (a condition where the lungs cannot get enough oxygen into the blood) and hyperlipidemia (abnormally high fat). During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 2/5/2025, the MDS indicated the resident's initial start date at the facility on 10/29/2024. The MDS indicated the resident had adequate hearing and unclear speech. The MDS indicated the resident made self understood and sometimes understood others. The MDS indicated the resident was dependent on staff with toileting, oral hygiene, shower/bathing self, lower body dressing, and personal hygiene. The MDS indicated the resident was taking antibiotics. During a review of Resident 3's physician order, dated 3/4/2025, the physician order indicated levofloxacin (Levaquin) tablet 500 milligrams (mg-a unit of measurement) per gastrostomy tube (g-tube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) for UTI, daily, end date 3/10/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and review on 3/27/2025 at 10:41 a.m. with the Infection Preventionist (IP), Resident 3's physician order, nursing progress notes, and registered nurses' plan of care, antibiotic tracking sheet (a document or tool used to monitor and record prescribed antibiotics and usage patterns [how often, how much, and what reason it's prescribed]), and Loeb's minimum criteria (evidence-based national standard criteria for initiating antibiotic treatment designed to reduce inappropriate prescribing by outlining minimum clinical signs and symptoms suggesting an infection) for initiating antibiotic therapy were reviewed. The Plan of Care indicated, on 3/1/2025 at 11:25 a.m., Resident 3 was noted with increased heart rate and had a temperature of 101.1 degrees Fahrenheit (F - a unit of measurement). The IP stated she uses the antibiotic tracking sheet and the Loeb's minimum criteria for initiating antibiotic therapy as a guide to monitor and review new or changes in antibiotic orders and uses Loeb's criteria, but this is not indicated in their policy. The IP stated they do not have a standard protocol in using the Loeb's criteria that shows which residents have met or have not met the criteria. The IP stated when Loeb's criteria is used for Resident 3's use of levofloxacin for UTI without urinary catheter, the resident would not have met the criteria because the resident only have increased heart and fever as signs and symptoms of infection. The IP stated the Loeb's minimum criteria for UTI includes either one of the following criteria: acute dysuria (discomfort or pain when urinating) or temperature greater than 100 F, and one or more of the following new or worsening symptoms: urgency, suprapubic pain (pain above pelvic bone), urinary incontinence, frequency, gross hematuria (visible blood in the urine), and costovertebral angle tenderness (pain in the upper back near the ribs). During a concurrent interview and record review on 3/27/2025 at 10:50 a.m. with the IP, the facility's policy and procedure (P&P) titled, Antimicrobial Stewardship (AMS) Program, last reviewed and approved on 3/10/2025, was reviewed. The IP stated the P&P did not indicate the protocol on the use of antibiotic tracking sheet and the use of Loeb's criteria to assess the residents for any infection. The IP stated she should have mentioned to the Manager of Infection Prevention (MIP) about the use of antibiotic tracking sheet and the use of Loeb's minimum criteria in initiating antibiotic therapy when they reviewed their P&Ps. During an interview on 3/27/2025 at 1:57 p.m. with the IP, the IP stated when the resident does not meet the Loeb's minimum criteria, she would notify the resident's physician that the resident did not meet the criteria to initiate the antibiotic then document on the resident's chart what she did and what the physician's response was. During a concurrent interview and record review on 3/27/2025 at 2:12 p.m. with Registered Nurse (RN) 2, Resident 3's nursing progress notes, plan of care, and physician orders were reviewed. RN 2 stated he was covering for the IP when Resident 3 had the order for levofloxacin for UTI. RN 2 stated he notified the primary nurse about the resident's laboratory results that were ordered, and he (RN 2) does not use any standardized criteria when reviewing antibiotics. During an interview on 3/27/2025 at 3:17 p.m. with the MIP, the MIP stated she was not aware of the Centers of Medicare and Medicaid Services (CMS- a federal agency that administers major healthcare programs) of the regulation antibiotic stewardship regulation requirements to be implemented. The MIP stated they have an ASP which they collaborate with the antimicrobial stewardship pharmacist. The MIP stated the purpose of the ASP is to administer antibiotics in the least amount of duration, and to make sure the antibiotic ordered had the appropriate frequency and dose to prevent multidrug resistance organisms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Antimicrobial Stewardship (AMS) Program, last reviewed and approved on 3/10/2025, the P&P indicated it is the facility's policy to implement a comprehensive AMS program to evaluate judicious use of antimicrobials. The P&P indicated the purpose of the P&P is to optimize antibiotic therapy to improve clinical outcomes while minimizing unintended consequences of antimicrobial use, such as drug toxicity (drug causing harm) and emergence of resistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on interview and record review, the facility failed to document that pneumococcal vaccine was offered for the resident and education was provided to the family/decision-maker per its pneumococcal vaccine (an injected medicine that can protect against and often prevent pneumococcal [a type of bacteria] infections [when the immune system fights off the bad germs to get better]) policy and procedures (P&P) for one of five sampled residents (Resident 19) reviewed for immunizations under Infection Control facility task. This deficient practice had the potential to result in increased risk for pneumococcal infections which may lead to serious health complications such as pneumonia (an infection that inflames the lungs' air sacs), meningitis (inflammation of brain and spinal cord membranes, typically caused by an infection), and bloodstream infections. Findings: During a review of Resident 19's Face Sheet, the Face Sheet indicated the resident was admitted on [DATE] with diagnoses including respiratory failure (a serious condition that makes it difficult to breathe on your own) 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 Resident 19's Minimum Data Set (MDS- a resident assessment tool), dated 1/30/2025, the MDS indicated the resident rarely/never made self understood and rarely/never understood others. During a concurrent interview and record review on 3/27/2025 at 9:37 a.m. with the Infection Preventionist (IP), Resident 19's Immunization Summary, plan of care, and nursing progress notes were reviewed. The IP stated there was no documentation that pneumococcal vaccine was offered for the resident, and that education was provided to the resident's family/decision-maker. The IP stated Registered Nurse (RN) 2 was covering for her during the time they were reviewing residents eligible to receive pneumococcal vaccines. During a concurrent interview and record review on 3/27/2025 at 2:12 p.m. with RN 2, Resident 19's plan of care and nursing progress notes were reviewed. RN 2 stated he missed documenting the discussion he had with Resident 19's family member where she (Resident 19's family member) consented for the resident to receive the pneumonia vaccine. RN 2 stated he was supposed to document and enter the order on the same day after the discussion with the family member. During an interview on 3/27/2025 at 5:57 p.m. with RN 7, RN 7 stated the purpose for offering and providing education of pneumococcal vaccine is for prevention especially many residents in their facility are at a higher risk of contracting pneumonia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road, Mission Hills, CA 91345 Mission Hills, CA 91345

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Vaccines (Influenza and Pneumococcal) - (Sub Acute), last reviewed and approved on 3/10/2025, the P&P indicated it is the facility's policy to reduce potential for transmitting and/or contracting influenza and/or pneumonia among Sub-Acute (for residents needing services that are more intensive than those typically received in long-term care but less intensive than acute care) residents. The P&P indicated before offering the pneumococcal immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; offer each resident a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; indicate in the resident's medical record, includes documentation indicating, minimum, of the following: provide resident or resident's legal representative education regarding benefits and potential side effects of pneumococcal immunization.