STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555165	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Skilled Nursing and Wellness Center	5125 Monte Vista St. Los Angeles, CA 90042

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537 Based on observation, interview, and record review, the facility failed to ensure one of two sampled Resident (Resident 1) received treatment and care in accordance with facility's policies and procedures by failing to: 1. Call alternate transportation to ensure Resident 1 receive hemodialysis (HD-a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) treatment as ordered and as scheduled on 2/12/2025. 2. Transcribe the order for Resident 1 to be monitored for fluid overload (too much fluid in the body which can raise the blood pressure [BP-the pressure of blood on the walls of the arteries as the heart pumps blood around the body] and force the heart to work harder and can also make it hard to breathe) after missing the HD treatment on 2/12/2025. 3. Administer BP medications on 2/12/2025 as ordered by the physician. These failures resulted in Resident 1 missing scheduled HD treatment and transfer to General Acute Care Hospital (GACH) on 2/12/2025 due to shortness of breath, chest pain, and elevated BP, which could potentially lead to prolonged hospitalization , harm, and/or death. Findings: 1. During a review of Resident 1's Admission Record, the Admission Record indicated the facility initially admitted the resident on 6/30/2021 and readmitted on [DATE] with diagnoses that included but not limited to end stage renal disease (ESRD-irreversible kidney failure), dependence on HD, hypertension (HTN-high blood pressure), atrial fibrillation (Afib-a condition where the upper chambers of the heart [atria] beat irregularly and rapidly), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555165	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 12/27/2024, the MDS indicated Resident 1 had intact cognitive skills for daily decision making. The MDS also indicated Resident 1 was independent (Resident completes the activity by themselves with no assistance from a helper) with eating, required set up or clean up assistance (Helper sets up or cleans up, Resident completes activity. Helper assists only prior to or following the activity) with oral and toileting hygiene, upper body dressing and putting on/taking off footwear. The MDS further indicated Resident 1 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with shower/bathing self, lower body dressing, and personal hygiene. During a review of Resident 1's Order Summary, dated 2/3/2025, the Order Summary indicated the following: Dialysis at Dialysis Center 1 every Monday-Wednesday-Fridays; with order date of 1/15/2025. Transportation arrangement for wheelchair van, 7 AM pick up and chair time of 8:30 AM; with order date of 1/15/2025. During a review of Resident 1's Order Summary, dated 2/3/2025, the Order Summary indicated: Amlodipine Besylate oral tablet 10 milligram (mg-a unit or mass or weight in the metric system equivalent to a thousandth of a gram), give one tablet by mouth one time a day for HTN. Hold for systolic BP below 110 millimeters of mercury (mmHg- a unit of pressure measurement, most used to measure BP) or heart rate below 60 beats per min (bpm-number of times the heart beats in a one-minute period); with order date of 1/29/2025. Losartan potassium oral tablet 25 mg, give one tablet by mouth in the morning for HTN. Hold if systolic BP is below 110 mmhg or heart rate below 60 bpm; with order date of 1/29/2025. During a concurrent interview and review on 2/25/2025 at 1:53 PM with Licensed Vocational Nurse 1 (LVN1), the Progress Notes for Resident 1, dated 2/12/2025, was reviewed. The Progress Notes indicated at 9:04 AM, a Situation, Background, Assessment, and Recommendation (SBAR-a structured communication framework used in healthcare to facilitate clear and concise communication between healthcare professionals) was documented by LVN 1. The SBAR indicated LVN 1 notified the Physician (also known as MD-Doctor of Medicine) that Resident 1 missed HD treatment due to transportation issues and HD treatment was rescheduled for the next day. The SBAR indicated the MD ordered to monitor Resident 1 for any signs and symptoms (s/s, observable and measurable manifestations of a disease or condition that can be detected by a health professional) of fluid overload. LVN 1 stated the MD order to monitor the resident for s/s of fluid overload was not and should have been transcribed in the Order Summary (a concise overview of a patient's medical orders, treatments, and procedures, often presented in a chronological manner to facilitate quick understanding and efficient care). Per LVN 1, she informed LVN 4, who was passing medications on 2/12/2025 during the 7 AM to 3 PM shift that Resident 1's HD was rescheduled for next day. LVN 1 also stated unable to provide documented evidence that Resident 1 was monitored for s/s of fluid overload. LVN 1 stated it was important to document findings, so the rest of the Healthcare team were aware of what was being monitored. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Highland Park Skilled Nursing and Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5125 Monte Vista St. Los Angeles, CA 90042	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and review of Resident 1's Change of Condition (COC) notes on 2/25/2025 at 2 PM with LVN 1, LVN 1 stated as written on the COC notes, she called the transportation company (TC) three times. LVN 1 stated she called TC before 7:30 AM on 2/12/2025 to confirm pick up for Resident 1. LVN 1 stated according to TC, they could not find a driver. LVN 1 called the TC again at 8 AM and at 8:30 AM but was made aware that the TC company still did not have a driver. LVN 1 stated she had notified the HD Center of the transportation delay for Resident 1. LVN 1 stated the HD Center rescheduled Resident 1's HD (after the 8:30 AM call) for the next day as they were already full on 2/12/2025. LVN 1 then notified the MD and LVN 4 who was passing medications that Resident 1 would not be going for her HD treatment. LVN 1 stated she did not call alternate transportation as this TC company was the assigned TC by Resident 1's health insurance. LVN 1 stated that MD was notified and gave orders to monitor for fluid overload. LVN 1 stated MD was made aware that HD had been rescheduled for the next day. During a concurrent interview and record review on 2/25/2025 at 2:47 PM with LVN 2, the SBAR documented by LVN 2 on 2/12/2025 at 7:45 PM was reviewed. The SBAR indicated BP of 224/123 taken at 7:30 PM, Respiratory rate (RR-number of breaths taken per minute) of 21 taken at 7:49 PM, Pulse oximetry (non-invasive method of measuring the saturation of oxygen (O2-a colorless, odorless gas that is essential for life) in a person's blood) of 96% taken at 6:19 AM at room air. LVN 2 stated he next saw Resident 1 around 4 PM to 5 PM on 2/12/2025 during medication pass. LVN 2 observed Resident 1 as being off and quiet, which was unusual of Resident 1. LVN 2 stated he made rounds around 7 PM and Resident 1 complained of SOB and chest pain. LVN 2 stated Resident 1 was short of breath, in tripod position (a posture where a person leans forward while supporting their upper body with their hands or forearms on a surface such as a table, bed, or their knees which can help with breathing by optimizing the use of the neck and upper chest muscles to get more air into the lungs). LVN 2 stated after checking Resident 1's vital signs (measurements of the body's most basic functions, such as breathing, heart rate, BP, and temperature), he placed Resident 1 on O2 at 2 liters per minute (LPM-flow rate of O2 delivered to a patient by cannula or mask per minute) by O2 mask (medical device that delivers oxygen covering the nose and mouth) using an oxygen concentrator (a medical device that increases the amount of O2 in the air you breathe) for comfort. LVN 2 stated he was not sure what the flow rate of O2 should be when using an O2 mask. During a concurrent interview and record review on 2/25/2025 at 3:05 PM with LVN 1, the Medication Administration Record (MAR-a report detailing the drugs administered to a patient by a healthcare professional) was reviewed. The MAR indicated amlodipine (a medication used to treat HTN and chest pain) and losartan (medication used to treat HTN and heart failure) were initialed by LVN 4 with chart code 9 (9=Other/see progress notes). LVN 1 stated the code 9 means medications were not given and see progress notes for the reason. LVN 1 stated she informed LVN 4 that Resident 1 would not be going to her HD treatment as scheduled, so Resident 1's BP medications should have been given and not held. LVN 1 stated there was no progress notes that indicated the reason for not giving the medications. LVN 1 stated that if the BP meds were given as ordered, this could have prevented Resident's 1's BP to be at 224/123 at 7:30 PM. (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview on 2/25/2025 at 3:25 PM with the Director of Nursing (DON), the DON stated Resident 1 missed the HD treatment and had subsequent change in condition later in the day, on 2/12/2025. The DON stated, MD was made aware that Resident 1 missed the scheduled HD treatment on 2/12/205 and was rescheduled the next day. The DON stated MD ordered to monitor resident for s/s of fluid overload. The DON stated it was important for residents on HD to make it to their scheduled HD treatments as it could cause fluid overload and other conditions that could result in transfer to acute hospital.

During an interview on 2/26/2025 at 1:45 PM with the Admissions Coordinator (AC), AC stated he was in charge of setting up transportation for residents requiring dialysis. AC stated he arranged Resident 1's wheelchair accessible van transportation to HD with the TC that was contracted with Resident 1's insurance. AC stated there was a list of alternate or back up transportation in the appointment book at the Nurses' Station. AC stated licensed staff should have called for an alternate transportation to ensure Resident 1 did not miss HD treatments and avoid negative impact on the resident's health and wellbeing

During a concurrent interview and record review on 2/26/2025 at 3:05 PM with LVN 1, the Progress Notes documented by LVN 2 dated 2/12/2025 at 11:04 PM (late entry) was reviewed. LVN 1 stated that Resident 1 had SOB and chest pain, paramedics were called and arrived at 7:21 PM and subsequently transferred to GACH.

During an interview on 2/26/2025 at 5:10 PM with Registered Nurse 1 (RN 1), RN 1 stated that BP medications should have been given on 2/12/2025 by LVN 4 as Resident 1 missed her HD appointment due to no transportation. RN 1 also stated that BP medications were held on HD days to prevent a low BP during HD. RN 1 stated Resident 1 should have received BP medications as ordered after HD was cancelled on 2/12/2025.

During a review of Resident 1's GACH emergency room records dated 2/12/2025 at 9:07 PM, the GACH records indicated Resident 1's chief complaints were SOB and chest pain, was quite hypertensive in the field and was given Nitroglycerin (used to treat episodes of chest pain caused by coronary artery disease [narrowing of blood vessels that supply blood to the heart]) x 3 doses. GACH records also indicated Resident 1 presented with chest pain and SOB consistent with fluid overload from missed HD, was extremely hypertensive initially, and was given intravenous (refers to a way of giving a drug or other substance through a needle or tube inserted into a vein) Lasix (medication used to treat excessive fluid accumulation caused by congestive heart failure and renal failure) for bilateral pleural effusions consistent with fluid overload. GACH records further indicated diagnoses made in the emergency roiagnom on [DATE] at 9:17 PM was acute hypoxic respiratory failure requiring bilevel positive airway pressure (BIPAP-a noninvasive ventilator that helps you breathe), acute renal failure (sudden loss of the ability of the kidneys to excrete wastes, concentrate urine, conserve electrolytes, and maintain fluid balance) and hypertensive urgency (a situation where BP is very high [180/110 mmHg or higher] requiring prompt medical attention).

During a review of GACH Nephrology (concerns the diagnosis and treatment of kidney diseases) Consult Notes, dated 2/12/2025, Resident 1's acute medical issues were:

1. Acute fluid overload

(continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Bilateral pleural effusions (having an abnormal buildup of fluid in the space surrounding both lungs [the pleural space]) and pulmonary edema (a condition where too much fluid builds up in the lungs, making it difficult to breathe). 3. Marked dyspnea (noticeably or severely difficult or labored breathing) due to fluid overload Nephrologist ordered a stat (from the Latin word statim, meaning immediately) HD to prevent Resident 1 from requiring intubation (a medical procedure where a tube in inserted through the mouth or nose into the trachea [windpipe] to help a person breathe when they cannot do so on their own) and mechanical ventilation (a medical procedure where a machine, called a ventilator, helps a person breathe by moving air into and out of their lungs when they are unable to do so on their own). During a review of the facility's Policy and Procedures (P&P), titled, Referrals to outside Services, revised 1/22/2025, the P&P indicated its purpose was to provide residents with outside services as required by physician orders or the care plan. The P&P also indicated that as necessary, the Social Services Department can coordinate transportation to outside services for residents. During a review of the facility's P&P, titled Dialysis Care, revised 10/1/2018, the P&P indicated: 1. The facility will arrange for dialysis care as ordered by the attending physician. 2. The facility will arrange for dialysis care for such residents on a weekly basis. 3. The facility will arrange transportation to and from the dialysis provider, as well as for meals (if necessary), medication administration, and a method of communication between the dialysis provider and the facility. During a review of the facility's P&P titled Medication - Administration, revised 1/22/2025, the P&P indicated its purpose was to ensure the accurate administration of medications for residents in the facility. The P&P also indicated in its procedure that medications and treatments will be administered as prescribed to ensure compliance with dose guidelines. The P&P further indicated that whenever a medication is held for any reason, the hour it was held must be initialed and circled in the MAR by the responsible Licensed Nurse and the Licensed Nurse will document in the back of the MAR, noting the time and reason the medication was held.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49537 Based on observation, interview and record review, the facility failed to provide an environment free of accident hazards for one of one sampled resident (Resident 1) by failing to ensure Licensed Vocational Nurse (LVN) 2 did not leave medications at the bedside table. This deficient practice had the potential to result in accidental ingestion of the medications by other residents and cause complications from taking medications not prescribed for the residents. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated that the facility initially admitted the resident on 6/30/2021 and readmitted on [DATE] with diagnoses that included but not limited to end stage renal disease (ESRD-irreversible kidney failure), dependence on hemodialysis (HD-a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), hypertension (HTN-high blood pressure), atrial fibrillation (Afib-a condition where the upper chambers of the heart [atria] beat irregularly and rapidly), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 12/27/2024, the MDS indicated Resident 1 had intact cognition (the mental process of thinking, understanding and making decisions). The MDS also indicated that Resident 1 was independent (Resident completes the activity by themselves with no assistance from a helper) with eating, required set up or clean up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with oral and toileting hygiene, upper body dressing and putting on/taking off footwear. The MDS further indicated that Resident 1 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with shower/bathing self, lower body dressing, and personal hygiene. During a review of Resident 1's Progress Notes, effective date of 2/15/2025 8:00 AM, a late entry indicated the resident cannot accurately tell time to know when medications need to be taken. The notes also indicated Resident 1 does not understand that skipping/choosing not to take a medication dose was a refusal of medication and she must notify staff. The Progress Notes indicated the resident was not capable of administering oral medications. The Progress Notes also indicated the resident was not approved for self-administration of medications. During a concurrent observation and interview on 2/26/2025 at 4:50 PM inside Resident 1's room, Resident 1 was observed lying in bed resting and observed one capsule, one white tablet and one yellow tablet, unlabeled and in one medication cup left uncovered and left on top of Resident 1's bedside table. Resident 1 stated she did not take the medications yet as she was waiting for her food. Certified Nurse Aide (CNA) 1, who was also present in the room, stated Resident 1 likes to take her medications with food. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/26/2025 at 5 PM with LVN 1 inside Resident 1's room, LVN 1 verified one capsule, one white tablet and one yellow tablet were left at the bedside table of Resident 1, unlabeled and uncovered. LVN 1 stated, licensed staff should not leave medications on the bedside table of residents even if the resident asked the licensed staff to leave the medications with the resident. LVN 1 stated leaving medications at the bedside was against the facility's policy and taught in nursing school. LVN 1 stated that if residents refused to take the medications during medication pass, medications should be kept in the medication cart, labeled with resident's name and the time and should not be left at the resident's bedside table. LVN 1 stated that this was dangerous as it posed a risk for accidental ingestion of these medications by Resident 1's roommates and other confused residents that may wander (to go about place to place usually without purpose) into Resident 1's room. During an interview on 2/26/2025 at 5:10 PM with the Registered Nurse Supervisor (RN 1), RN 1 stated medications should not be left at the bedside for residents to take at a later time. RN 1 stated medications should be kept in the medication cart, labeled with resident's name, date and time. RN 1 stated leaving medications at the bedside is not according to our policy and has been taught in nursing schools. RN 1 also stated Resident 1 had roommates that could potentially take the medications accidentally and other confused residents could come in Resident 1's room and take the medications which can lead to injuries or illness. During a review of the facility's P&P titled Resident Safety, 4/15/2021, the P&P indicated the purpose as to provide a safe and hazard free environment. The P&P further indicated any facility staff member who identifies an unsafe situation, practice or environmental risk factors should immediately notify their supervisor or charge nurse. During a review of the facility's Policy and Procedure (P&P) titled Medication - Administration MAR-a report detailing the drugs administered to a patient by a healthcare professional, revised 1/22/2025, the P&P indicated if a resident was refusing to take medications, the Licensed Nurse will attempt to give the medications several times but if resident continues to refuse after one hour, the refused medications will be destroyed. Licensed Nurse should notify the physician and document in the medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 49537 Based on observation, interview and record review, the facility failed to ensure the Daily Posted Nurse Staffing (Nurse Staffing Information- refers to the actual hours of work performed per patient day by a direct caregiver) for 2/14/2025 to 2/25/2025 were posted in accordance with the facility's policy titled Nursing Department - Staffing, Scheduling & Postings. This deficient practice had the potential for residents and visitors not to be accurately informed of the census and staffing for the facility. Findings: During an observation on 2/25/2025 at 1:24 PM by the bulletin board outside the Director of Nursing's (DON) office, the Census and Direct Care Service Hours Per Patient Day (DHPPD or Nurse Staffing Information) form that was posted was dated 2/12/2025 (8 days ago). No other DHPPD forms were observed posted on the bulletin board. During a concurrent interview and record review on 2/26/2025 at 4:30 PM with RN 1 (who was covering for the DON in her absence), the photo documentation of DHPPD dated 2/12/2025 that was posted on 2/25/2025 was reviewed. RN 1 confirmed that the photo taken on 2/25/2025 of the posted DHPPD form was dated 2/12/2025. RN 1 stated, DHPPD should be updated and posted daily at the beginning of each shift, and the DHPPD posting today should have been one that was dated 2/25/2025 with staffing information for that day and not 2/12/2025. RN 1 stated she did not know why the DHPPD form was not posted for each day since 2/12/2025. RN 1 stated it was important to calculate the projected and actual number of hours to know if there was enough staffing for the day so that we can look for staff to cover if we were short staffed and to make sure there was enough staff to take care of all the residents for that day. During a review of the Policy and Procedure (P&P) titled Nursing Department - Staffing, Scheduling & Postings, revised 1/22/2025, the P&P indicated its purpose as to ensure that adequate number of nursing personnel are available to meet resident needs. The P&P further indicated the facility will post the following information on a daily basis: 1. Facility name 2. The current date 3. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: a. Registered Nurses b. Licensed Vocational Nurses c. Certified Nurse Aides (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	d. Resident Census The P&P also indicated the facility will post the nurse staffing date specified above, on a daily basis at the beginning of each shift.