| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555380 | A. Building<br>B. Wing | 12/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Encino Hospital Medical Center D/P Snf | 16237 Ventura Blvd<br>Encino, CA 91436 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>38549<br><br>Based on observation, interview, and record review, the facility failed to:<br><br>1. Ensure Certified Nursing Assistant 2 (CNA 2) was not standing over a resident while feeding the resident for one (Resident 9) out of two sampled residents investigated for the care area of dignity.<br><br>This deficient practice violated the resident`s rights to be treated with respect and dignity which had the potential to affect the resident`s sense of self-worth and self-esteem.<br><br>2. Based on interview and record review, the facility failed to ensure a facility staff knocked and asked permission prior to entering a resident`s room for one of one resident (Resident 19) investigated under Resident Rights.<br><br>This deficient practice violated the resident`s rights to be treated with respect and dignity which had the potential to affect the resident`s sense of self-worth and self-esteem.<br><br>Findings:<br><br>1. During a review of Resident 9's Face Sheet, the Face Sheet indicated the facility admitted the resident on 2/5/2016 with diagnoses including multiple cerebrovascular accidents (CVA - stroke, loss of blood flow to a part of the brain), bilateral (both sides) lower extremity paraplegia (loss of movement and/or sensation, to some degree, of the legs), and right upper extremity paralysis (loss of muscle function).<br><br>During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 11/5/2024, the MDS indicated the resident had intact cognition (thought processes) and was dependent on staff for most activities of living (ADLs - activities such as bathing, dressing, and toileting a person performs daily).<br><br>On 12/2/2024 at 12:15 p.m., during an observation, observed CNA 2 standing over Resident 9 while feeding him. Observed a chair in the room. Observed the resident's bed to be in a low position.<br><br>On 12/2/2024 at 2:46 p.m., during an interview, CNA 2 verified the observation and stated she should have moved the resident's up to a higher position so that the resident was at eye level with her.<br><br>(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: 555380 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/04/2024 |
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| NAME OF PROVIDER OR SUPPLIER Encino Hospital Medical Center D/P Snf | | STREET ADDRESS, CITY, STATE, ZIP CODE 16237 Ventura Blvd Encino, CA 91436 | |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/4/2024 at 2:05 p.m., during an interview, when asked what could potentially result from not having the resident at eye level during feeding, the Director of Nursing (DON) stated the resident did not like to have his bed moved and did not like it when CNAs sat next to his bed while feeding him.<br><br>During a review of Resident 9's care plans (a document that outlines a person's health needs, current medical conditions, and the specific treatments or support required to manage their care), no care plan was found indicating the resident's preference to not have his bed raised or not have CNAs sit beside his bed during feeding.<br><br>On 12/4/2024 at 2:21 p.m., during an interview, when asked if he ever told staff that he did not like his bed raised or did not like for CNAs to sit beside him while feeding him, Resident 9 stated, I never said that. The resident stated he would not mind either way if his bed was raised or if the CNA sat next to his bed while feeding.<br><br>During a review of the facility's policy and procedure titled, Patient Rights and Responsibilities, last reviewed and revised on 5/2024, the policy indicated that patients have the right to receive considerate and respectful care, and to be made comfortable.<br><br>38469<br><br>2. During a review of Resident 19's Admission Record, the Admission Record indicated the facility admitted the resident on 8/22/2024, with diagnoses including respiratory failure (a serious condition that occurs when the lungs have difficulty getting enough oxygen into the blood, or when there is too much carbon dioxide in the blood) and status epilepticus (a seizure lasting more than five minutes, or multiple seizures within five minutes without regaining consciousness).<br><br>During a review of Resident 19's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 11/13/2024, the MDS indicated Resident 19's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired. The MDS further indicated that Resident 19 was totally dependent on staff for toileting, shower, dressing and personal hygiene.<br><br>During an observation on 12/02/2024 at 11:00 a.m., observed Respiratory Therapist (RT1) enter Resident 19`s room without knocking and asking permission to go inside the room.<br><br>During an interview on 12/02/2024 at 1:04 p.m., with RT1, RT 1 stated that he went to Resident 19`s room to administer breathing treatment and forgot to knock and ask permission prior to entering the resident`s room. RT1 stated that it is proper to knock to show respect and ensure privacy and dignity. RT1 stated that not knocking on the resident`s door is a violation of Resident 19`s rights as a patient.<br><br>During an interview on 12/04/2024 at 9:16 a.m., with Registered Nurse 1 (RN 1), RN 1 stated that staff should knock on the door, introduce themselves and ask permission to enter the resident`s room. RN 1 stated the resident may feel disrespected if staff enter the room without asking permission and knocking on the door.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER: Encino Hospital Medical Center D/P Snf | | STREET ADDRESS, CITY, STATE, ZIP CODE: 16237 Ventura Blvd Encino, CA 91436 | |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility`s policy and procedures titled Patient Rights and Responsibilities, last reviewed on May 2024, indicated that the patient has the right to personal privacy . |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>50033<br><br>Based on interview and record review, the facility failed to implement its abuse prohibition policy by failing to report immediately, but no later than two hours after the allegation was made, an allegation of staff to resident abuse (the willful infliction of injury with resulting physical harm, pain, or mental anguish) to the State Survey Agency (California Department of Public Health), ombudsman, and local law enforcement for one of three sampled residents (Resident 8).<br><br>This deficient practice had the potential to result in a delay of an onsite investigation of abuse.<br><br>Findings:<br><br>During a review of Resident 8's History and Physical (H&P), dated 1/1/2024, the H&P indicated Resident 8 was admitted to the facility in December 2008 with diagnoses including but not limited to encephalitis (inflammation of the brain), cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), and ventilator (a medical device to help support or replace breathing) dependent respiratory failure.<br><br>During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool), the MDS indicated Resident 8 could not speak and can sometimes understand others and make herself understood. The MDS further indicated Resident 8 was dependent on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).<br><br>During an interview on 12/2/2024 at 1:12 p.m. with the family member (FM 1) of another resident, FM 1 stated while she (FM 1) was standing outside of Resident 8's room a couple of weeks ago, she (FM 1) saw Resident 8 with bruises on the arm. FM 1 further stated she thinks a night shift staff did something to Resident 8 to cause the bruising.<br><br>During an interview on 12/2/2024 at 2:05 p.m. with the Manager of Subacute (MOS), the surveyor informed the MOS of the allegation of abuse to Resident 8, which caused bruising to the resident's arm.<br><br>During an interview on 12/3/2024 at 8:35 a.m. with the MOS, the MOS stated the charge nurse assessed Resident 8 and found no signs of bruising. The MOS stated nothing was reported to any agencies as there is currently no bruising, nor has there been any recently, and there is no known incident that could have caused any bruising.<br><br>During an interview on 12/3/2024 at 10:05 a.m. with MOS and the Chief Nursing Officer (CNO), surveyor informed the CNO and the MOS that there was an allegation of abuse by a night staff to Resident 8, which caused bruising to the resident's arm.<br><br>During a concurrent interview and record review on 12/3/2024 at 2:52 p.m. with the SW, the SW provided a fax confirmation time stamped 12/3/2024 2:50 p.m. of a report of suspected dependent adult/elder abuse to the ombudsman's office notifying them of the allegation of abuse.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 12/4/2024 at 8:12 a.m. with the SW, the facility's policy and procedure (P&P) titled, Abuse, Elder & Dependent Adult, revised April 2024, was reviewed. The P&P indicated, For incidents that involved abuse or results in serious bodily injury, call the local law enforcement agency, Long Term Care Ombudsman and the Department of public health Services Licensing and Certification immediately but not later than two hours after the alleged incident and within 24 hours for all other cases. The SW stated she is responsible for completing the report of suspected dependent adult/elder abuse form and reporting the alleged abuse. SW 1 stated she (SW 1) thought she could notify one entity within 24 hours and the rest later. After review of the P&P, SW 1 confirmed the allegation should have been reported to the ombudsman, the Department of Public Health, and law enforcement within two hours as indicated in the policy.<br><br>During a concurrent interview and record review on 12/4/2024 at 1:42 p.m. with the MOS and CNO, reviewed the facility's P&P titled, Abuse, Elder & Dependent Adult, revised April 2024, that indicated For incidents that involved abuse or results in serious bodily injury, call the local law enforcement agency, Long Term Care Ombudsman and the Department of Health Services Licensing and Certification immediately but not later than two hours after the alleged incident and within 24 hours for all other cases. The MOS and ADM stated the allegation of abuse should be reported as indicated in this policy.<br><br>During an interview on 12/4/2024 at 3:23 p.m. with the SW, SW stated if she received an allegation of abuse she would report to the ombudsman, law enforcement and the Department of Public Health within two hours so the allegation of abuse can be investigated quickly and to prevent any further distress to the resident.<br><br>During a review of the facility's P&P titled Abuse, Elder & Dependent Adult revised April 2024, the P&P indicated For incidents that involved abuse or results in serious bodily injury, call the local law enforcement agency, Long Term Care Ombudsman and the Department of Health Services Licensing and Certification immediately but not later than two hours after the alleged incident and within 24 hours for all other cases. The P&P further indicated Reports of abuse or results in serious bodily injury are to be made immediately within two hours to the local law enforcement agency, Long Term Care Ombudsman and the Department of Health Services Licensing and Certification and within 24 hours for all other cases and follow-up written report (SOC 341) must be sent. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>38469<br><br>Based on observation, interview and record review, the facility failed to ensure Certified Nursing Assistant 1 (CNA 1) did not transfer a resident from the wheelchair to the bed using a mechanical lift (a device used to assist with transfers and movement) without assistance from another staff for one of one sampled resident investigated under the accident care area (Resident 14).<br><br>This deficient practice had the potential for the resident to sustain a serious injury in the event of a fall incident.<br><br>Findings:<br><br>During a review of Resident 14's Face Sheet, the Face Sheet indicated that the facility admitted the resident on 9/09/2024 with diagnoses that included encephalopathy (a general term for a brain disorder or disease that can be caused by a number of things, including injury, disease, drugs, or chemicals) and respiratory failure (a serious condition that occurs when the lungs have difficulty getting enough oxygen into the blood, or when there is too much carbon dioxide in the blood).<br><br>During a review of Resident 14's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/22/2024, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired and required two staff for toileting, shower, dressing and for personal hygiene.<br><br>During an observation and interview on 12/02/2024 at 1:41 p.m., observed Certified Nurse Assistant bringing in a mechanical lift inside Resident 14`s room. CNA 1 then closed the privacy curtain of Resident 14. CNA 1 stepped out of the room and was asked what she did inside the resident`s room. CNA 1 stated that she transferred Resident 14 from the wheelchair to his bed. CNA 1 stated she did the transfer by herself because the other CNAs were busy. CNA 1 stated that there should be two staff assisting the resident during transfers when using a mechanical lift.<br><br>During an interview on 12/02/2024 at 2:14 p.m., CNA 2 stated that Resident 14 requires two person assistance with transfer using a mechanical lift for the safety of the resident and staff. CNA 2 stated that with mechanical lift transfer, one person will attach the hook on one side and the other person will attach the hook on the other side. CNA 2 stated that one person will hold and support the resident and the other person will move the mechanical lift. CNA 2 stated that the resident can fall resulting in injury, if only one person will operate the mechanical lift during a transfer. CNA 2 stated that Resident 14 could have suffered a fall because of the unsafe transfer. CNA 2 stated that they are trained in using the mechanical lift.<br><br>During an interview with Registered Nurse 1 (RN 1) on 12/04/2024 at 9:16 a.m., RN 1 stated that transferring a patient using the mechanical lift requires two-person assistance. RN 1 stated that transferring Resident 14 using a mechanical lift by one person is not safe and can increase the resident's risk of accidents resulting in a fall or serious injuries.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of the facility`s policy and procedures (P&P), titled Mechanical Lift, last reviewed on 5/2024, the P&P indicated that It is the policy of this facility that the Mechanical Lift will be utilized for resident transfers only .Assistance of two personnel will be used with Mechanical Lift. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469<br><br>Based on observation, interview, and record review, the facility failed to follow safe food handling practices by failing to ensure:<br><br>1. Food stored in the resident unit refrigerator was labeled with the resident`s name, room number, date of preparation and discarded after two days.<br><br>2. The refrigerator in the resident's unit has a thermometer.<br><br>These deficient practices had placed two of two residents (Resident 9 and 21) at risk for foodborne illnesses (an infection or irritation of the gastrointestinal tract [including the stomach and intestines] caused by food or beverages that contain harmful bacteria/germs, chemicals, or other organisms) with common symptoms such as nausea, vomiting, stomach cramps, and diarrhea.<br><br>Findings:<br><br>1. During a review of Resident 9's History and Physical (H&P), the H&P indicated the facility admitted the resident on 2/5/2016 with history of respiratory failure and cerebrovacular accident (CVA-medical conditon that occurs when blood flow to the brain is suddenly interrupted).<br><br>During a review of Resident 9's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 11/05/2024, the MDS indicated that the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS also indicated the resident is dependent on staff for eating, oral hygiene, toileting hygiene, shower, upper body dressing, lower body dressing, putting on and taking off footwear and personal hygiene.<br><br>b. During a review of Resident 21's Physician Orders, the Physician Orders indicated Resident 21 was admitted to the facility on [DATE] with diagnoses including generalized weakness and heart failure (a serious condition that occurs when the heart is unable to pump enough blood and oxygen to the body's organs).<br><br>During a review of Resident 21's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 9/17/2024, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS indicated the resident required substantial/maximal assistance from staff for shower, lower body dressing, putting on and taking off footwear and partial moderate assistance from staff for toileting hygiene, upper body dressing and personal hygiene.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation of the patient unit refrigerator and concurrent interview on 12/04/2024 at 09:45 a.m., with the Activity Director (AD), observed inside the refrigerator an unknown food item wrapped in foil without a label. The AD also confirmed that there is no thermometer inside the refrigerator. The AD the food item should have been dated and labeled with the resident's name. The AD stated the unlabeled food item if ingested could cause foodborne illnesses. The AD stated that it should be discarded immediately as it is not safe to be consumed by the residents. The AD stated that the temperature of the refrigerator must be maintained according to the facility policy's to ensure food stored in the refrigerator remains safe and does not spoil.<br><br>During an interview on 12/04/2024 with the Director of Nursing (DON), the DON stated that families or visitors can bring food for the residents. The DON stated that there is a designated refrigerator to store the resident's food and the food should be dated and labeled with the resident`s name. The DON stated that dating the food item, will ensure it is discarded after one to two days. The DON also stated that there should be a thermometer in the refrigerator to make sure the temperature is kept within the proper range to prevent food spoilage and protect the two residents who are on oral feeding, from food borne illnesses.<br><br>During a review of the facility`s policy and procedure (P&P) titled Food and Nutrition Services, last revised on February 2023, the P&P indicated that If perishable food is brought in but not eaten right away it may be stored in the refrigerator .food is labeled with patient`s name, room number and date of preparation and food is discarded two days after food is dated .<br><br>During a review of the facility`s policy and procedure titled Refrigerators, Food-Patient Units, last revised on June 2024, the P&P indicated that Food refrigerators and freezers are used only for patient food . temperature norms are as follows: refrigerators are less than or equal to 41 degrees Fahrenheit; freezers are less than or equal to zero (0) degrees Fahrenheit . |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>38549<br><br>Based on observation, interview, and record review, the facility failed to ensure Certified Nursing Assistant 1 (CNA 1) performed hand hygiene (the practice of cleaning your hands to prevent the spread of disease and infection) after doffing (to take off) her gown, touching a soiled linen cart, and leaving a resident's room for one (Resident 9) out of six sampled residents investigated under the care area of infection control.<br><br>This deficient practice had the potential to place residents at increased risk of contracting an infection.<br><br>Findings:<br><br>During a review of Resident 9's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility admitted the resident on 2/5/2016 with diagnoses including multiple cerebrovascular accidents (CVA - stroke, loss of blood flow to a part of the brain), bilateral (both sides) lower extremity paraplegia (loss of movement and/or sensation, to some degree, of the legs), and right upper extremity paralysis (loss of muscle function).<br><br>During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 11/5/2024, the MDS indicated the resident had intact cognition (thought processes) and was dependent on staff for most activities of living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). The MDS also indicated that the resident received tracheostomy (a surgical procedure that creates an opening in the neck and inserts a tube into the windpipe to help with breathing) care while a resident.<br><br>On 12/3/2024 at 10:26 a.m., during an observation, observed CNA 1 inside Resident 9's room doffing her gown, placing it inside the soiled linen cart, and exiting the resident's room without performing hand hygiene. Observed CNA 1 going into another room without first performing hand hygiene.<br><br>On 10/3/2024 at 10:45 a.m., during an interview with CNA 1, CNA 1 confirmed that she did not perform hand hygiene after doffing her gown and exiting Resident 9's room.<br><br>On 10/4/2024 at 1:48 p.m., during an interview with the Director of Nursing (DON), the DON stated it was important for staff to perform hand hygiene after doffing their gowns and exiting residents' rooms for infection control.<br><br>During a review of the facility's policy and procedure titled, Hand Hygiene, last reviewed and revised on 3/2024, the policy indicated that hospital personnel shall wash their hands to prevent the spread of infections between handling of individual patients and on leaving an isolation area or after handling articles from an isolation area. |