

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555519	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER The Care Center on Hazeltine, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6835 Hazeltine Ave. Van Nuys, CA 91405	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>50033</p> <p>Based on interview and record review the facility failed to implement its policy and procedure titled Abuse Prohibition and Prevention Program, for one of three sampled residents (Resident 1) by failing to ensure Licensed Vocational Nurse 1 (LVN 1) was not assigned to Resident 1 after an allegation of emotional abuse was made.</p> <p>This deficient practice resulted to Resident 1 feeling uncomfortable and had the potential to place Resident 1 at risk for further abuse that could have resulted in Resident 1 needing additional care or emotional support.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 9/17/2024 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with exacerbation (an increase in the severity of the disease) and generalized muscle weakness.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 10/31/2024, the MDS indicated the resident had intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS indicated Resident 1 was dependent on staff with toileting hygiene, shower/bathing, and dressing.</p> <p>During a review of Resident 1's Change of Condition (COC- a significant change in resident's health status) form, dated 11/7/2024, timed at 8:41 a.m., the COC indicated Resident 1 reported an allegation of emotional abuse.</p> <p>During a review of the facility's Investigation Conclusion Report dated 11/13/2024 indicated Resident 1 alleged that LVN 1 (while providing care and treatment) told Resident 1 that she (Resident 1) was taking too long and that everyone was laughing at her (Resident 1). The Investigation Conclusion Report indicated LVN 1 was suspended on 11/7/2024 due to the allegation and while the investigation is ongoing. The Investigation Conclusion Report further indicated LVN 1 will no longer be assigned to Resident 1 moving forward.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a phone interview on 11/19/2024 at 9:44 a.m. with Family Member 1 (FM 1) and FM 2, FM 1 stated Resident 1 had asked Licensed Vocational Nurse 1 (LVN 1) for a kind word and LVN 1 replied that she would not say anything kind and laughed at her. FM 1 stated LVN 1 then told Resident 1 everyone makes fun of her. FM 2 stated they (FM 1 and FM 2) learned about this incident on 11/7/2024, then spoke to the Administrator (ADM) about it and ADM stated LVN 1 would no longer come into Resident 1's room or provide care for Resident 1 again. However, FM 2 stated LVN 1 did go into Resident 1's room and gave Resident 1 her medications on at least one more occasion after the discussion with ADM on 11/7/2024.</p> <p>During a concurrent interview and record review on 11/19/2024 at 12:34 p.m. with LVN 1, Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 11/2024 indicated LVN 1 administered medications to Resident 1 on 11/10/2024. LVN 1 stated she (LVN 1) was suspended on 11/7/2024, but the Director of Nursing (DON) called her the next day and said she (LVN 1) was able to come back, but she would need to bring another staff member in the room with her if she needed to care for Resident 1. LVN 1 stated she did give Resident 1 her (Resident 1's) medications on 11/10/2024 with a registered nurse (not specified) present in the resident's room with her.</p> <p>During a concurrent interview and record review on 11/19/2024 at 2:32 p.m. with the ADM, the facility's Investigation Conclusion Report dated 11/13/2024 was reviewed. The ADM stated Resident 1 preferred for LVN 1 to not be Resident 1's nurse moving forward however, he (ADM) had spoken to Resident 1 on 11/9/2024 and Resident 1 was okay with LVN 1 providing care if another staff member was present.</p> <p>During a follow-up phone interview on 11/19/2024 at 3:53 p.m. with FM 1, FM 2, and Resident 1, Resident 1 stated when she (Resident 1) spoke with ADM before LVN 1 had returned to work, she (Resident 1) told ADM she (Resident 1) did not want LVN 1 anywhere near her or in her room anymore. Resident 1 stated she was told that LVN 1 would not care for her any longer. Resident 1 stated no one informed her (including ADM) that LVN 1 might be assigned to her care and treatment, and that another staff member would be present with LVN 1. Resident 1 stated she (Resident 1) never agreed to that. Resident 1 stated she (Resident 1) felt uncomfortable because LVN 1 was assigned to her again and administered her medications after Resident 1 verbalized she (Resident 1) does not want LVN 1 anywhere near her.</p> <p>During an interview on 11/19/2024 at 4:19 p.m. with the DON, the DON stated if Resident 1 is uncomfortable with LVN 1, the facility should have not assigned LVN 1 to Resident 1. The DON further stated there would always be at least one other nurse available that could give Resident 1's medications or care for her.</p> <p>During an interview on 11/19/2024 at 4:27 p.m. with the ADM, the ADM stated if a resident is not comfortable with a nurse, the facility should accommodate the resident's needs and preference and not have the nurse work with the resident anymore.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Abuse Prohibition and Prevention Program, last revised in 4/2024, the P&P indicated it is the facility's policy to ensure protection for the health, welfare and rights of each resident residing in the facility and to assure the facility is doing all that is within its control to prevent occurrences of abuse.</p>		