STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555519	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Care Center on Hazeltine, LLC	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on interview and record review the facility failed to protect the resident's right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm by one resident towards another) for one of three sampled residents (Resident 33) when on 11/3/2024 at 7:00 a.m., Resident 47 (roommate) threw a cup at Resident 33 hitting Resident 33's forehead. This deficient practice resulted in Resident 33 being subjected to physical abuse by Resident 47 while under the care of the facility. Resident 33 sustained a laceration (a deep cut or tear in the skin) on the forehead and required transfer to General Acute Care Hospital 1 (GACH 1). Resident 1 received sutures (a stitch or a row of stitches holding together the edges of a wound). Based on the Reasonable Person Concept (the usual behavior of an average person under the same circumstances), due to Resident 33's severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and medical condition, an individual subjected to physical abuse may have physical pain, psychological pain (mental or emotional) effects including feelings of hopelessness (a feeling or state of despair or lack of hope), helplessness (the belief that there is nothing that anyone can do to improve a bad situation, and humiliation (the feeling of being ashamed or losing respect for own self). Findings: a. During a review of Resident 33's Face Sheet (admission record), the Face Sheet indicated the facility admitted Resident 33 on 10/06/2023 with diagnoses including dementia (a progressive state of decline in mental abilities) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 33's Minimum Data Set (MDS - a resident assessment tool), dated 10/10/2024, the MDS indicated Resident 33 had severely impaired cognition. The MDS indicated Resident 33 was dependent (helper does all the effort; resident does none of the effort to complete the activity) on staff with dressing, toileting, and personal hygiene. (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: 555519	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 33's Situation, Background, Assessment, Recommendation Report (SBAR- a form used to facilitate prompt communication regarding a change in a resident's health condition), dated 11/3/2024, the SBAR indicated on 11/3/2024 at 7:00 a.m., Resident 33's roommate (Resident 47) acted aggressively towards Resident 33, hit the resident (Resident 33) with a plastic cup which caused Resident 33 to sustain a laceration measuring four (4) centimeters (cm, a unit of measure in length). The SBAR indicated a Certified Nursing Assistant (CNA [CNA 4]) found Resident 33 bleeding on his face. The SBAR indicated 911 (emergency number used to request emergency assistance) was called due to the laceration continuously bleeding, paramedics (a person who is trained to give medical help in emergency situations) came at 7:18 a.m. and took over the care. During a review of Resident 33's Nursing Progress Notes, dated 11/3/2024, the Nursing Progress Notes indicated on 11/3/2024 at 7:18 a.m., the paramedics came and took over Resident 33's care. The Nursing Progress Note indicated the paramedics took Resident 33 to GACH 1 for further evaluation. During a review of Resident 33's GACH 1 emergency room Discharge Summary, dated 11/3/2024, the discharge summary indicated Resident 33 received treatment for a four cm forehead laceration between the eyes, which was repaired with sutures. During a review of Resident 33's Nursing Progress Notes, dated 11/3/2024 at 2:05 p.m., the Nursing Progress Notes indicated Resident 33 returned from GACH 1 with six stitches on the mid (middle area) forehead. During a review of Resident 33's Physician's Orders, dated 11/3/2024, the Physician Orders indicated an order to cleanse the mid forehead laceration with sutures with normal saline (a salty solution used for cleaning wounds), pat dry, paint with betadine (used to reduce the risk of infection), and cover with a dry dressing (a dressing that absorbs moisture from a wound), every day shift for 14 days. During a review of Resident 33's Care Plan (CP) for Abuse, created 11/03/2024, the CP indicated Resident 33 received physical aggression (any behavior which involves attacking another person with the intent of harming) from the roommate. The care plan indicated a goal that Resident 33 will not have any negative outcomes related to the altercation through the next review. The care plan indicated interventions including informing local law enforcement, notifying the physician, and for nursing department to monitor for signs of emotional distress (a general term for a range of negative emotional reactions that can result from a stressful event or situation). b. During a review of Resident 47's Face Sheet, the Face Sheet indicated the facility admitted Resident 47 on 8/28/2024 and readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 47's MDS, dated [DATE], the MDS indicated Resident 47 had intact cognition. The MDS indicated Resident 47 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying as resident completes an activity) with oral hygiene, dressing, and wheeling self in wheelchair. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 47's SBAR, dated 11/3/2024, the SBAR indicated Resident 47 initiated physical aggression towards another resident. The SBAR indicated Resident 47 complained the roommate (Resident 33) repeatedly called him the N-word, which upset him and verbalized (told) throwing the plastic cup at the roommate (Resident 33). The SBAR indicated when Resident 47 was asked if he is aware that the roommate is bleeding because of the laceration Resident 33 sustained from his (Resident 47's) action; Resident 47 stated, I don't care, nobody can call me the N-word. During a review of Resident 47's Social Services Progress Note, dated 11/4/2024, the Social Services Progress Note indicated the Social Services Director (SSD) spoke with Resident 47 regarding the incident on 11/3/2024 with his old roommate (Resident 33). The Social Services Progress Note indicated that Resident 47 stated that he (Resident 47) threw his empty coffee cup at his roommate (Resident 33) because he (Resident 33) repeatedly called him (Resident 47) the N-word and he (Resident 47) felt insulted, so he threw the cup at him (Resident 33). During a review of Resident 47's CP for Physical Aggression, created 11/3/2024, the CP indicated Resident 47 will not have any negative outcomes related to altercation through next review date. The Care Plan indicated interventions to provide one-to-one (when one staff is assigned to monitor one resident at all times) monitoring by a CNA. During an interview with Licensed Vocational Nurse 3 (LVN 3) on 11/05/2024 at 8:23 a.m., LVN 3 stated she (LVN 3) went to the room of Resident 33 and Resident 47 on 11/3/2024 at approximately 7:00 a.m. at the start of the 7:00 a.m. to 3:00 p.m. shift. LVN 3 stated Resident 33 was bleeding continuously to the mid-forehead despite the application of a pressure dressing (a bandage that applies pressure to a wound to help it heal). LVN 3 stated Resident 47 was in the room and stated, he (Resident 33) kept calling me the N-word, so I hit him with a cup. LVN 3 stated 911 was called, the paramedics arrived and took Resident 33 to the GACH 1. LVN 3 stated Resident 47 was moved to a different room from Resident 33. LVN 3 stated Resident 33 returned from GACH 1 at approximately 2:30 p.m. with sutures in his forehead. LVN 3 stated this incident is being treated as physical abuse and that a CNA is monitoring Resident 47, at all times. During an interview with Resident 47 on 11/05/2024 at 11:20 a.m., Resident 47 stated he hit Resident 33 with a coffee cup because he (Resident 33) called him the N-word. Resident 47 stated police came to the facility and stated he (Resident 47) had every right to do what he did. During an interview with the Director of Nursing (DON) on 11/07/2024 at 9:19 a.m., the DON stated the physical abuse allegation was substantiated (to show something to be true, or to support a claim with facts) because Resident 47 stated he hit Resident 33 because he became offended when Resident 33 called him the N-word. The DON stated it is important to keep residents safe from abuse to protect the residents and keep them from injury. During an interview with the Administrator (ADM) on 11/07/2024 at 1:59 p.m., the ADM stated the abuse allegation was substantiated because Resident 47 acted willfully (done intentionally, or on purpose) when he threw the cup at Resident 33. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled, Abuse Prevention and Prohibition Program, last reviewed on 10/29/2024, the P&P indicated the residents have the right to be free from mistreatment, neglect (fail to care for properly), abuse The policy and procedure indicated facility staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, misappropriation (unauthorized, improper, or unlawful use) of resident property, or deprivation of goods necessary to attain or maintain physical, mental, and psychosocial well-being.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44309 Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition, and current treatments) to meet the resident`s needs for one of five sampled residents (Resident 14) by failing to develop and implement a comprehensive person-centered care plan addressing Resident 14`s problem with communication. This deficient practice had the potential to result in Resident 14 not being able to communicate requests, needs or concerns which could lead to inadequate care of Resident 14. Findings: During a review of Resident 14's Admission Record, the Admission Record indicated the facility admitted the resident on 5/11/2023, with diagnoses including unspecified dementia (a progressive state of decline in mental abilities) , repeated falls, dysphagia (swallowing difficulties), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities of living). During a review of Resident 14's Minimum Data Set (MDS -a federally mandated resident assessment tool) dated 8/8/2024, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 14 was dependent on staff (helper does all of the effort) for oral hygiene, showering/bathing, upper and lower body dressing, toileting hygiene, and personal hygiene. The MDS indicated Resident 14`s preferred language was Armenian, and he would want or need an interpreter to communicate with a doctor or healthcare staff.  During a review of Resident 14`s physician History and Physical (H&P) dated 6/25/2024, the H&P indicated that the resident did not have the capacity to understand and make decisions. During a review of Resident 14`s Psychosocial Assessment/Social History/Discharge Planning Form dated 8/8/2024, it indicated Resident 14`s primary language is Armenian, and Resident 14 is able to speak Armenian and some English. The Psychosocial Assessment/Social History/Discharge Planning Form indicated Resident 14 needed an interpreter to communicate with a doctor or a health care staff. During a review of Resident 14's Care Plan (CP-a document that outlines how a patient's health care needs will be met) on communication problem due to dementia, initiated on 2/24/2024, the CP indicated that the resident was at risk for decline (gradually become worse) in communication skills. The care plan goal for the resident was to be able to make his basic needs known on a daily basis. The care plan interventions were to anticipate and meet the resident`s needs, monitor the effectiveness of communication strategies and assistive devices, use communication techniques which enhance (increase) interaction and to use alternative communication tools as needed such as communication book/board, writing pad, gestures (a movement of the body that expresses an attitude), signs, and pictures. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 11/4/2024 at 9:33 a.m., inside Resident 14's room, Resident 14 was not present. Certified Nursing Assistant 1 (CNA 1) who was inside Resident 14`s room stated that Resident 14 was in the activity room. CNA1 stated Resident 14 is confused and can be aggressive towards staff members, speaks Armenian. and is able to say couple of words in English. CNA1 stated that he (CNA 1) is unable to communicate with Resident 14 because Resident 14 does not seem to understand English. CNA1 stated a communication board with pictures and signs is required for residents who do not speak English. CNA1 started looking for a communication board/device at Resident 14`s bedside. However, he did not find one. During a concurrent observation and interview on 11/4/2024 at 9:55a.m. inside the activity room, Resident 14 was observed sitting on his wheelchair, drinking coffee. Resident 14 was able to answer simple questions in Armenian asked by the surveyor. Resident 14 did not have a communication board/device with him. During an observation on 11/5/2024 at 11:30 a.m., inside the activity room, Resident 14 was observed sitting on his wheelchair and an Armenian communication board/device was attached to the resident`s wheelchair.  During a concurrent interview and record review on 11/6/2024 at 1:44 p.m., with MDS Coordinator (MDSC), Resident 14`s care plans were reviewed. The MDSC stated Resident 14 is Armenian speaking and he (Resident 14) is unable to speak English fluently. The MDSC stated that she (MDSC) is in charge of developing and updating residents` care plans in the facility. The MDSC stated Resident 14`s care plan for communication was not person centered for him (Resident 14) because the care plan did not indicate the specific language that he (Resident 14) speaks. The MDSC stated there is no care plan developed for Resident 14 indicating that he (Resident 14) speaks Armenian. The MDSC stated the Armenian communication board/device was placed on Resident 14`s wheelchair after the surveyor noticed that there was no communication board available for Resident 14 at his bedside or on his wheelchair. The MDSC stated he missed developing a person-centered care plan for Resident 14 `s inability to communicate. The MDSC stated the potential outcome of not developing a person-centered care plan for residents who have communication problems and English is not their primary language is the inability to address the appropriate care and services that they need. During a review of the facility's policy and procedure (P&P) titled, Develop-Implement comprehensive Care Plans, revised on 03/2023, the P&P indicated that the facility develops a person-centered comprehensive care plans that are culturally competent and trauma-informed, developed and implemented to meet his or her preferences and goals, and address the resident`s medical, physical, mental, and psychosocial needs. Care plans must be person-centered and reflect the resident`s goals for admission and desired outcomes, interventions that reflect the resident`s cultural preferences, values, and practices.

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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. 34659 Based on observation, interview, and record review, the facility failed to provide care in accordance with professional standards by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (fatty area beneath the skin) administration sites of insulin (a hormone that lowers blood sugar) for one (Resident 30) of five sampled residents investigated for unnecessary medications. This deficient practice had the potential for adverse effects (undesired harmful effect resulting from a medication) of same site subcutaneous administration of insulin such as lipodystrophy (when fat cells accumulate under the skin from repeated injections in the same place). Findings: During a review of Resident 30's Face Sheet (admission record), the Face Sheet indicated the facility admitted the resident on 9/11/2023 with diagnoses that included diabetes mellitus (high blood sugar). During a review of Resident 's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/12/2024, the MDS indicated Resident 30 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 30 required setup help (helper sets us or cleans up; resident completes activity) with eating. The MDS indicated Resident 30 receives insulin injections. During a review of Resident 30's Care Plan (CP) for Diabetes Mellitus, the CP indicated a goal the resident will remain free from complications related to diabetes through the review date. The care plan indicated an intervention to rotate insulin injection sites. During a review of Resident 30's Physician's Orders, the documents indicated the following: - Insulin Glargine Subcutaneous Solution Pen-injector 100 units per milliliter (unit/ml, a unit of measure for insulin), inject 34 units subcutaneously at bedtime for diabetes mellitus; rotate sites, dated 7/16/2024. - Insulin Glargine Subcutaneous Solution Pen-injector 100 units/ml, inject 46 units subcutaneously one time a day for diabetes mellitus, give before breakfast, dated 7/16/2024. - Novolog FlexPen Subcutaneous Solution Pen-injector 100 unit/ml, inject as per sliding scale subcutaneously before meals and at bedtime for diabetes mellitus; rotate injection sites: -If 0 - 200 milligrams per deciliter (mg/dL, a unit of measure for blood sugar) give no units. - if BS is less than 70 mg/dL, give orange juice and call the physician - if 201 - 250 mg/dL, give 3 units. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- if 251 - 300 mg/dL, give 4 units. - if 301 - 350 mg/dL, give 6 units. - if 351 - 400 mg/dL, give 9 units. - if 401 - 450 mg/dL, give 12 units - if blood sugar is greater than 401, notify the physician, dated 2/28/2024. - Novolog FlexPen Subcutaneous Solution Pen-injector 100 unit/ml, inject as per sliding scale subcutaneously before meals and at bedtime for diabetes mellitus; rotate injection sites: - if 0 - 200 milligrams per deciliter (mg/dL, a unit of measure for blood sugar) give no units. - if BS is less than 70 mg/dL, give orange juice and call the physician - if 201 - 250 mg/dL, give 4 units. - if 251 - 300 mg/dL, give 6 units. - if 301 - 350 mg/dL, give 8 units. - if 351 - 400 mg/dL, give 10 units. - if 401 - 450 mg/dL, give 12 units - if blood sugar is greater than 401, notify the physician, dated 10/07/2024. During a review of Resident 30's Location of Administration Record, dated 10/01/2024 to 10/31/2024, the Location of Administration Record indicated insulin administered on the following dates and sites: - On 10/01/2024 at 5:48 p.m., insulin was administered on the abdomen on the left upper quadrant (left upper part of the abdomen). - On 10/01/2024 at 9:25 p.m., insulin was administered on the abdomen on the left upper quadrant. - On 10/07/2024 at 5:41 a.m., Novolog FlexPen insulin was administered on the abdomen on the left upper quadrant. - On 10/07/2024 at 5:42 a.m., Glargine insulin was administered on the abdomen on the left upper quadrant. - On 10/08/2024 at 6:31 a.m., Glargine insulin was administered on the abdomen on the right upper quadrant. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 10/08/2024 at 10:21 p.m., Glargine insulin was administered on the abdomen on the right upper quadrant. - On 10/15/2024 at 6:31 a.m., Glargine insulin was administered on the abdomen on the right upper quadrant. - On 10/15/2024 at 9:36 p.m., Glargine insulin was administered on the abdomen on the right upper quadrant. - On 10/24/2024 at 5:38 a.m., Glargine insulin was administered on the abdomen on the right lower quadrant. - On 10/24/2024 at 5:38 a.m., Novolog FlexPen insulin was administered on the abdomen on the right lower quadrant. - On 10/25/2024 at 11:50 a.m., Novolog insulin was administered on the abdomen on the left upper quadrant. - On 10/25/2024 at 5:53 p.m., Novolog insulin was administered on the abdomen on the left upper quadrant. - On 10/26/2024 at 4:25 p.m., Novolog insulin was administered on the abdomen on the right lower quadrant. - On 10/26/2024 at 9:26 p.m., Novolog insulin was administered on the abdomen on the right lower quadrant. - On 10/29/2024 at 5:32 p.m., Novolog insulin was administered on the abdomen on the right lower quadrant. - On 10/29/2024 at 9:40 p.m., Novolog insulin was administered on the abdomen on the right lower quadrant. - On 10/31/2024 at 6:16 a.m., Glargine insulin was administered on the abdomen on the right lower quadrant. - On 10/31/2024 at 6:16 a.m. Novolog insulin was administered on the abdomen on the right lower quadrant. During an observation and interview with Resident 30 on 11/04/2024 at 9:30 a.m., Resident 30 stated she receives insulin. When asked if staff rotate the insulin injection sites, she stated she gets the injections in her stomach but did not know that the injection sites need to be rotated. During an interview and observation with Licensed Vocational Nurse 2 (LVN 2) on 11/06/2024 at 1:49 p.m., observed the computer charting at a computer terminal at one of the medication carts for the MAR (also known as eMAR). LVN 2 demonstrated how to see the last three instances of where the insulin was given on a resident. The LVN 2 stated it is the practice of the facility to rotate insulin injection sites. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview with LVN 5 on 11/07/2024 at 7:25 a.m., reviewed Resident 30's 10/2024 MAR. LVN 5 stated he gave insulin without rotating sites on 10/07/2024, 10/24/2024, and 10/31/2024. LVN 5 stated Resident 30 lifts their shirt and indicates the place to administer the insulin. LVN 5 stated he has not educated Resident 30 on the importance of rotating insulin injection sites. LVN 5 stated it is important to rotate insulin injection sites to not cause a fatty lump or irritate the skin. During a concurrent interview and record review with the Director of Nursing (DON) on 11/07/2024 at 1:22 p. m., reviewed Resident 30's 10/2024 MAR. The DON confirmed that the instances in which the insulin infection sites were not rotated. The DON stated it is the policy to rotate injection sites for residents who are prescribed insulin. The DON stated this is important to avoid causing lipodystrophy. A review of the facility's policy and procedure titled, Insulin Administration, last reviewed 10/29/2024, indicated insulin injection sites should be rotated to reduce the risk of damaging the skin tissue.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 44309 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 14) was provided a communication device or board (a tool that includes pictures that help residents communicate their healthcare and every-day needs to facility staff) in his preferred language. This deficient practice had the potential to prevent the resident from communicating with the staff and receiving care in a timely manner. Cross reference F656 Findings: During a review of Resident 14's Admission Record, the Admission Record indicated the facility admitted the resident on 5/11/2023, with diagnoses including unspecified dementia (a progressive state of decline in mental abilities) , repeated falls, dysphagia (swallowing difficulties), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities of living). During a review of Resident 14's Minimum Data Set (MDS -a federally mandated resident assessment tool) dated 8/8/2024, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 14 was dependent on staff (helper does all of the effort) for oral hygiene, showering/bathing, upper and lower body dressing, toileting hygiene, and personal hygiene. The MDS indicated Resident 14`s preferred language was Armenian, and he would want or need an interpreter to communicate with a doctor or healthcare staff.  During a review of Resident 14`s physician History and Physical (H&P) dated 6/25/2024, the H&P indicated that the resident did not have the capacity to understand and make decisions. During a review of Resident 14`s Psychosocial Assessment/Social History/Discharge Planning Form dated 8/8/2024, the form indicated Resident 14`s primary language is Armenian, and Resident 14 is able to speak Armenian and some English. The Psychosocial Assessment/Social History/Discharge Planning Form indicated Resident 14 needed an interpreter to communicate with a doctor or a health care staff. (continued on next page)

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 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Care Center on Hazeltine, LLC	6835 Hazeltine Ave. Van Nuys, CA 91405

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 14's Care Plan (CP-a document that outlines how a patient's health care needs will be met) on initiated on 2/24/2024, the CP indicated that the resident had a communication problem due to dementia and was at risk for decline (gradually become worse) in communication skills. The care plan goal for the resident was to be able to make his basic needs known on a daily basis. The care plan interventions were to anticipate and meet the resident`s needs, monitor the effectiveness of communication strategies and assistive devices, use communication techniques which enhance (increase) interaction and to use alternative communication tools as needed such as communication book/board, writing pad, gestures (a movement of the body that expresses an attitude), signs, and pictures. During a concurrent observation and interview on 11/4/2024 at 9:33 a.m., inside Resident 14's room, Resident 14 was not present. Certified Nursing Assistant 1 (CNA 1) who was inside Resident 14`s room stated that Resident 14 was in the activity room. CNA1 stated Resident 14 is confused and can be aggressive towards staff members, speaks Armenian. and is able to say couple of words in English. CNA1 stated that he (CNA 1) is unable to communicate with Resident 14 because Resident 14 does not seem to understand English. CNA1 stated a communication board with pictures and signs is required for residents who do not speak English. CNA1 started looking for a communication board/device at Resident 14`s bedside. However, he did not find one. During a concurrent observation and interview on 11/4/2024 at 9:55a.m. inside the activity room, Resident 14 was observed sitting on his wheelchair, drinking coffee. Resident 14 was able to answer simple questions in Armenian asked by the surveyor. Resident 14 did not have a communication board/device with him. During an observation on 11/5/2024 at 11:30 a.m., inside the activity room, Resident 14 was observed sitting on his wheelchair and an Armenian communication board/device was attached to the resident`s wheelchair.  During a concurrent interview and record review on 11/6/2024 at 1:44 p.m., with MDS Coordinator (MDSC), Resident 14`s care plans were reviewed. The MDSC stated Resident 14 is Armenian speaking and he (Resident 14) is unable to speak English fluently. The MDSC stated that she (MDSC) is in charge of developing and updating residents` care plans in the facility. The MDSC stated Resident 14`s care plan for communication was not person centered for him (Resident 14) because the care plan did not indicate the specific language that he (Resident 14) speaks. The MDSC stated there is no care plan developed for Resident 14 indicating that he (Resident 14) speaks Armenian. The MDSC stated the Armenian communication board/device was placed on Resident 14`s wheelchair after the surveyor noticed that there was no communication board available for Resident 14 at his bedside or on his wheelchair. The MDSC stated he missed developing a person-centered care plan for Resident 14 `s inability to communicate. The MDSC stated the potential outcome of not providing a communication board/device for a non-English speaking resident is inability to understand the resident and provide care for him. During an interview on 11/7/2024 at 11:16 a.m., with the Director of Nursing (DON), the DON stated staff are required to provide a communication board or device to the residents who do not speak English in the language that they speak. The DON stated Resident 14 was not provided a communication device/board in his primary language. The DON stated the potential outcome of not providing a communication board/device to the residents who do not speak English is the inability to communicate with the resident accurately and understand his needs.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50033 Based on interview and record review, the facility failed to ensure residents who receive apixaban (a medication that treats and helps prevents blood clots in the heart and blood vessels) were accurately monitored for side effects (an often harmful and unwanted effect) for one of six sampled residents (Resident 13). This deficient practice had the potential to result in Resident 13 experiencing adverse side effects (unwanted, uncomfortable, or dangerous effects that a drug may have) from the anticoagulant including unusual bruising (a mark on the skin that occurs when small, bleeding from the gums or nose, and having blood in the stool. Findings: During a review of Resident 13's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to, epilepsy (a brain disorder that causes seizures [sudden, uncontrolled electrical disturbances in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), acute kidney failure (when the kidneys suddenly cannot filter waste products from the blood), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and dementia (a progressive state of decline in mental abilities). During a review of Resident 13's History and Physical (H&P), dated 7/7/2024, the H&P indicated Resident 13 does not have the capacity to understand and make decisions. During a review of Resident 13's Minimum Data Set Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/13/2024, the MDS indicated the resident had severely impaired cognition (thought processes) and was dependent on staff for all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 13's physician's orders, the orders indicated the following orders: 1. Apixaban 2.5 milligram (mg) tablet: give one tablet twice a day for atrial fibrillation, dated 9/8/2024. 2. Apixaban: monitor for signs and symptoms of bleeding (abnormal or unexplained bruising, petechiae, internal bleeding, nosebleeds, bleeding gums, abnormal bleeding), dated 9/8/2024. During a review of Resident 13's care plan (a document that summarizes a patient's health conditions, treatments, and care needs), titled The resident has high risk for bleeding, bruising, and/or skin discoloration related to anticoagulant therapy apixaban ., revised on 9/8/2024, the care plan indicated to monitor, document, and report to the doctor signs and symptoms of anti-coagulant complications including bruising. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 11/6/2024 at 3:39 p.m. with Licensed Vocational Nurse (LVN) 4, Resident 13's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 10/16/2024 and Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 10/1/2024-10/31/2024 were reviewed. The SBAR indicated Resident 13 had bruising to the right knee and right toes. The 10/2024 MAR did not indicate Resident 13 experienced any bruising in October 2024. LVN 4 stated bruising should be documented each shift in the MAR under the order to monitor for signs and symptoms of bleeding and bruising and she could not explain why there is bruising noted in Resident 13's SBAR but not in the MAR. LVN 4 stated if bruising is present but not properly documented it could affect the resident because apixaban can cause bruising as a side effect and they might need to notify the doctor and possibly hold the medication. During an interview on 11/6/2024 at 4:26 p.m. with the Director of Nursing (DON), the DON stated Resident 13's bruising should have been documented in the MAR. The DON stated they may not be able to accurately inform the physician of all side effects of the medication if the side effects are not all documented. During a concurrent interview and record review on 11/7/2024 at 3:01 p.m. with the DON, the manufacturer's guidelines for apixaban provided by the facility, dated December 2012, was reviewed. The DON stated they do not have a facility policy regarding anticoagulant side effect monitoring, but they do follow the manufacturer's guidelines. The manufacturer's guidelines indicated apixaban can cause bleeding and bruising and any unusual bleeding should be evaluated and reported to a physician.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview and record review, the facility failed to ensure a resident was free from unnecessary psychotropic drugs (any drug that affects behavior, mood, thoughts, or perception in excessive dose, excessive duration, without adequate monitoring) for one of six sampled residents (Residents 10) by failing to ensure Resident 10 received the correct dose of duloxetine (medication that is used to treat depression [a persistent feeling of sadness or a lack of interest in outside stimuli]) as ordered by the physician. This deficient practice resulted in an administration of excessive dose of duloxetine to Resident 10 and had the potential to place the resident at risk for significant adverse consequence (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic drug, which could result to impairment (being weakened) or decline (gradually become less) in the resident's mental, physical condition, functional, and psychosocial status. Findings: During a review of Resident 10's Admission Record, the Admission Record indicated the facility originally admitted the resident on 6/1/2020, and readmitted on [DATE], with diagnoses including major depressive disorder (characterized by a persistent feeling of sadness or a lack of interest in outside stimuli), difficulty in walking, and type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control). During a review of Resident 10's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 8/20/2024, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 10 was feeling down, tired, was depressed, and experiencing low levels of energy. The MDS further indicated that Resident 10 was taking antidepressant medication (medication used to treat depression). During a review of Resident 10`s physician History and Physical (H&P) dated 2/5/2024, the H&P indicated that the resident had the capacity to understand and make decisions.  During a review of Resident 10`s Physician Order dated 4/18/2024, the order indicated to administer duloxetine oral capsule 30 milligrams (mg-a unit of measure of mass) by mouth once a day for depression manifested by crying episodes. Further review of Resident 10`s physician orders indicated that the order for duloxetine 30 mg once a day was discontinued on 5/15/2024 and was changed to duloxetine 20 mg once a day with a start date of 5/16/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 10`s Note to Attending Physician/Prescriber Form dated 5/15/2024, the note indicated that the facility`s consultant pharmacist (a healthcare specialist who provides expert advice on medications and pharmaceutical services, including patient safety) recommended a Gradual Dose Reduction (GDR- the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) for duloxetine 30 mg. The note further indicated that Resident 10`s Nurse Practitioner (NP- a nurse who has advanced clinical education and training in administering patient care) agreed with the GDR and then ordered duloxetine 20 mg to be administered by mouth once a day.  During a review of Resident 10`s care plan, initiated on 4/18/2024, the care plan indicated that the resident is taking duloxetine 30 mg manifested by crying episodes. The care plan indicated that Resident 10 was at risk for adverse reactions of the medication. The care plan further indicated that a GDR was done, and Resident 10 is currently taking duloxetine 20 mg by mouth daily. The care plan goal for the resident was to not experience adverse side effect of this medication. The care plan interventions were to administer the medication as ordered by the physician, encourage verbalization of needs, fears, and concerns, encourage to join activities of interest to divert the attention (to turn the attention away) positively, and to monitor side effects of anti-depressant during every shift such as headache, dizziness, tremors (shaking in part of body), and dry mouth. During a review of Resident 10`s Medication Administration Record (MAR - a record of mediations administered to residents) for November 2024, indicated that the resident received duloxetine 20 mg from 11/1/2024 to 11/4/2024. During an observation of the medication administration for Resident 10 on 11/5/2024 at 9:06 a.m., Licensed Vocational Nurse 2 (LVN 2) checked duloxetine medication bubble pack (a card that packages doses of medication within small, clear, or light-resistant, plastic bubbles that is punched out to administer to a resident) against Resident 10`s MAR. LVN 2 stated, Resident 10 is required to receive duloxetine 20 mg per her physician`s order, however, the existing bubble pack for duloxetine was for 30 mg. LVN 2 stated that based on the available count of duloxetine in the bubble pack, it appears that Resident 10 was administered 30 mg of duloxetine instead of 20 mg as ordered by the physician. LVN 2 stated Resident 10 was medicated with a greater dose than ordered by her physician. LVN 2 stated she is not going to administer 30 mg of duloxetine and will contact the pharmacy to instead receive the 20 mg of duloxetine which is the correct dose. During a concurrent interview and record review on 11/5/2025 at 9:15 a.m., with the Director of Nursing (DON), Resident 10`s physician orders, MAR, facility`s pharmacy proof of delivery form for October 2024, and bubble pack for duloxetine were reviewed. The DON stated Resident 10`s duloxetine order was changed from 30 mg to 20 mg on 5/15/2024, because the facility`s pharmacy consultant recommended GDR. The DON stated Resident 10 has been receiving duloxetine 20 mg since 5/16/2024. The DON stated the pharmacy delivered duloxetine 30 mg for Resident 10 instead of the of 20 mg on 10/11/2024. The licensed nurses have been administering duloxetine 30 mg to Resident 10 instead of 20 mg for 21 days based on the count on the bubble pack. The DON stated licensed staff are required to check the dosage of medication against physician order to ensure the correct dose of medication is being administered. The DON stated the potential outcome of administering the incorrect dose of duloxetine is over medicating and exposing the resident to possible adverse reactions of the medication such as drowsiness (feeling of being sleepy), and dry mouth. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility`s policy and procedure (P&P) titled Medication Administration-General Guidelines, reviewed on 10/29/2024, the P&P indicated that five rights-right resident, right drug, right dose, right route, and right time, are applied for each medication being administered. A triple check of these five rights is recommended at three steps in the process of preparation of a medication for administration, when the medication is selected, when the dose is removed from the container and finally just after the dose id prepared and the medication put away. Prior to administration, the medication and dosage schedule on the resident`s MAR and compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician`s orders are checked for the correct dosage schedule. During a review of the facility`s policy and procedure titled Medication Errors, revised March 2024, the P&P indicated that the facility ensures that its residents are free from any significant medication errors, and that its medication error rates are not five percent or greater.

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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 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** 44309 Based on observation, interview, and record review the facility failed to ensure a resident was free from significant medication error by failing to administer the correct dose of duloxetine (medication used to treat depression [a persistent feeling of sadness or a lack of interest in outside stimuli]) as ordered by the physician for one of three sample residents (Resident 10). This deficient practice resulted in an administration of excessive dose of duloxetine to Resident 10 and had the potential to place the resident at risk for significant adverse consequence (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic drug, which could result to impairment (being weakened) or decline (gradually become less) in the resident's mental, physical condition, functional, and psychosocial status. Cross reference F758 Findings: During a review of Resident 10's Admission Record, the Admission Record indicated the facility originally admitted the resident on 6/1/2020, and readmitted on [DATE], with diagnoses including major depressive disorder (characterized by a persistent feeling of sadness or a lack of interest in outside stimuli), difficulty in walking, and type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control). During a review of Resident 10's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/20/2024, the MDS indicated the resident\`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 10 was feeling down, tired, was depressed, and experiencing low levels of energy. The MDS further indicated that Resident 10 was taking antidepressant medication (medication used to treat depression). During a review of Resident 10\`s physician History and Physical (H&P) dated 2/5/2024, the H&P indicated that the resident had the capacity to understand and make decisions.  During a review of Resident 10\`s Physician Order dated 4/18/2024, the order indicated to administer duloxetine oral capsule 30 milligrams (mg-a unit of measure of mass) by mouth once a day for depression manifested by crying episodes. Further review of Resident 10\`s physician orders indicated that the order for duloxetine 30 mg once a day was discontinued on 5/15/2024 and was changed to duloxetine 20 mg once a day with a start date of 5/16/2024. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 10`s Note to Attending Physician/Prescriber Form dated 5/15/2024, the note indicated that the facility`s consultant pharmacist (a healthcare specialist who provides expert advice on medications and pharmaceutical services, including patient safety) recommended a Gradual Dose Reduction (GDR- the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) for duloxetine 30 mg. The note further indicated that Resident 10`s Nurse Practitioner (NP- a nurse who has advanced clinical education and training in administering patient care) agreed with the GDR and then ordered duloxetine 20 mg to be administered by mouth once a day.  During a review of Resident 10`s care plan initiated on 4/18/2024, indicated that the resident is taking duloxetine 30 mg manifested by crying episodes. The care plan indicated that Resident 10 was at risk for adverse reactions of the medication. The care plan further indicated that a GDR was done, and Resident 10 is currently taking duloxetine 20 mg by mouth daily. The care plan goal for the resident was to not experience adverse side effect of this medication. The care plan interventions were to administer the medication as ordered by the physician, encourage verbalization of needs, fears, and concerns, encourage to join activities of interest to divert the attention (to turn the attention away) positively, and to monitor side effects of anti-depressant during every shift such as headache, dizziness, tremors (shaking in part of body), and dry mouth. During a review of Resident 10`s Medication Administration Record (MAR - a record of mediations administered to residents) for November 2024, indicated that the resident received duloxetine 20 mg from 11/1/2024 to 11/4/2024. During an observation of the medication administration for Resident 10 on 11/5/2024 at 9:06 a.m., Licensed Vocational Nurse 2 (LVN 2) checked duloxetine medication bubble pack (a card that packages doses of medication within small, clear, or light-resistant, plastic bubbles that is punched out to administer to a resident) against Resident 10`s MAR. LVN 2 stated, Resident 10 is required to receive duloxetine 20 mg per her physician`s order, however, the existing bubble pack for duloxetine was for 30 mg. LVN 2 stated that based on the available count of duloxetine in the bubble pack, it appears that Resident 10 was administered 30 mg of duloxetine instead of 20 mg as ordered by the physician. LVN 2 stated Resident 10 was medicated with a greater dose than ordered by her physician. LVN 2 stated she is not going to administer 30 mg of duloxetine and will contact the pharmacy to instead receive the 20 mg of duloxetine which is the correct dose. During a concurrent interview and record review on 11/5/2025 at 9:15 a.m., with the Director of Nursing (DON), Resident 10`s physician orders, MAR, facility`s pharmacy proof of delivery form for October 2024, and bubble pack for duloxetine were reviewed. The DON stated Resident 10`s duloxetine order was changed from 30 mg to 20 mg on 5/15/2024, because the facility`s pharmacy consultant recommended GDR. The DON stated Resident 10 has been receiving duloxetine 20 mg since 5/16/2024. The DON stated the pharmacy delivered duloxetine 30 mg for Resident 10 instead of the of 20 mg on 10/11/2024. The licensed nurses have been administering duloxetine 30 mg to Resident 10 instead of 20 mg for 21 days based on the count on the bubble pack. The DON stated licensed staff are required to check the dosage of medication against physician order to ensure the correct dose of medication is being administered. The DON stated if a licensed nurse administers the incorrect dose of a medication, it is considered medication error. The DON stated medication error occurred when licensed nurses administered Resident 10 doluxetine 30 mg instead of duloxetine 20 mg. The DON stated the potential outcome of administering the incorrect dose of duloxetine is over medicating and exposing the resident to possible adverse reactions of the medication such as drowsiness (feeling of being sleepy), and dry mouth. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility`s policy and procedure titled Medication Errors, revised March 2024, indicated that the facility ensures that its residents are free from any significant medication errors, and that its medication error rates are not five percent or greater.  During a review of the facility`s policy and procedure (P&P) titled Medication Administration-General Guidelines, reviewed on 10/29/2024, the P&P indicated that five rights-right resident, right drug, right dose, right route, and right time, are applied for each medication being administered. A triple check of these five rights is recommended at three steps in the process of preparation of a medication for administration, when the medication is selected, when the dose is removed from the container and finally just after the dose id prepared and the medication put away. Prior to administration, the medication and dosage schedule on the resident`s MAR and compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician`s orders are checked for the correct dosage schedule.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50033 Based on observation, interview, and record review, the facility failed to discard a medicated ointment belonging to Resident 8 from one of one inspected treatment carts after the resident had been discharged . This deficient practice resulted in the facility staff still being able to access a discharged resident's medication. Findings: During a review of Resident 8's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and dementia (a progressive state of decline in mental abilities). The Admission Record indicated Resident 8 was discharged on [DATE]. During a review of Resident 8's History and Physical (H&P), dated 7/30/2024, the H&P indicated Resident 8 does not have the capacity to understand and make decisions. During a review of Resident 8's physician's orders, a discontinued order dated 6/27/2024 indicated to insert one application of Preparation H ointment rectally as needed up to four times a day for hemorrhoids. During an observation on 11/5/2024 at 11:06 a.m. with Treatment Nurse (TN) 1, Resident 8's Preparation H ointment was inside the treatment cart. During a concurrent observation and interview on 11/5/2024 at 2:20 p.m. with the Director of Nursing (DON), Resident 8's Preparation H ointment was in the discarded medications area. The DON stated when a resident is discharged a nurse should remove the medications from the medication and treatment carts and she will put them aside and discard them. During a concurrent interview and record review on 11/6/2024 at 4:26 p.m. with the Director of Nursing (DON), the DON stated Resident 8 was discharged so the Preparation H ointment should be discarded and not on the treatment cart. During a review of the facility's policy and procedure (P&P) titled, Disposal of Medications and Medication-Related Supplies, last reviewed on 10/29/2024, the P&P indicated unused, unwanted, and non-returnable medications should be removed from their storage area and secured until destroyed. The P&P also indicated medications left in the facility after a resident's discharge should be destroyed.

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 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Care Center on Hazeltine, LLC	6835 Hazeltine Ave. Van Nuys, CA 91405

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on observation, interview, and record review, the facility failed to meet the nutritional needs for one of three sampled residents (Resident 12) by failing to provide a fortified diet (a food that has extra nutrients [important substances you get from food that help your body survive and grow] added to it) as ordered by the physician. This deficient practice had the potential to result in Resident 12's decreased nutritional intake and weight loss. Findings: During a review of Resident 12's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 8/25/2014, and readmitted on [DATE], with diagnoses including dysphasia (swallowing difficulties), anorexia (an eating disorder that causes people to weigh less than is considered healthy for their age and height), unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) . During a review of Resident 12's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/25/2024, the MDS indicated the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 12 was dependent to staff (helper does all of the effort) for eating, oral hygiene, showering/bathing, toileting hygiene, and personal hygiene. The MDS indicated Resident 12 did not have a weight loss of 5% or more within the last month nor did it indicate Resident 12 had a weight loss of 10% or more in the last six months. During a review of Resident 12's Physician Order dated 9/14/2024, the order indicated that the resident should be provided with a diet which includes a regular pureed textured (a smooth texture with no lumps), fortified, and large portioned meals with a moderately thick consistency fluid (fluids that are thicken than regular, still pourable but flows more slowly like honey). During a review of Resident 12`s Nutritional assessment dated [DATE], the assessment indicated that the resident`s current weight was normal within his Ideal Body Weight Range (IBWR-a target weight based on your height and gender). However, the assessment indicated that Resident 12 had a gradual weight loss of nine pounds (lbs.- a unit of weight) within the last year. The assessment further indicated that Resident 12 had a good appetite, and his food intake was 75% and higher. During a review of Resident12's Care Plan (written guide that organizes information about the resident's care) initiated on 9/14/2024, the care plan indicated that the resident had a regular diet, pureed texture, moderately thick consistency, fortified and large portion diet. The care plan goal was to adhere (follow) to the diet as ordered by the physician. The care plan interventions were to monitor the resident`s meal intake, provide a diet as ordered, and to provide the resident with his food preference so long as it does not conflict with his treatment plan. (continued on next page)

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 11/07/2024
NAME OF PROVIDER OR SUPPLIER The Care Center on Hazeltine, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6835 Hazeltine Ave. Van Nuys, CA 91405	

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 11/5/2024 at 12:24 p.m., at Resident 12`s bedside with the Dietary Supervisor (DS), Resident 12 was observed lying on his bed. Resident 12's lunch food tray was observed placed on the resident`s side table. Resident 12`s lunch menu ticket indicated a pureed, fortified, and large portioned diet. Resident 12`s lunch tray included pureed vegetables, pureed cheese ravioli, and pureed bread. The DS stated that Resident 12`s lunch tray was not a fortified diet as ordered by the physician. The DS stated that residents who are ordered to have a fortified diet should have received mashed potatoes with gravy in addition to their regular diet today. The DS stated that Resident 12 did not receive mashed potatoes with gravy on his tray. The DS returned the lunch tray to the kitchen. During a concurrent observation and interview on 11/5/2024 at 12:29 p.m. in the kitchen, [NAME] 1 observed Resident 12`s lunch tray and lunch menu ticket. [NAME] 1 stated Resident 12's tray does not include mashed potatoes with gravy. [NAME] 1 stated that Resident 12 was required to receive fortified large portion pureed food. [NAME] 1 stated that a fortified diet was not provided to Resident 12. During an interview on 11/5/2024 at 12:33 p.m., with Registered Nurse 1 (RN 1), RN 1 stated that she checked the residents` food trays today against their physician orders prior to distributing them. RN1 stated Resident 12 has already received his fortified diet for lunch and consumed it (fortified diet lunch). RN 1 then walked inside Resident 12`s room with the DS and observed that there was no food tray at Resident 12`s bedside. The DS informed RN 1 that he returned Resident 12`s lunch tray to the kitchen because the meal was not fortified. RN1 stated she checked Resident 12`s lunch tray before distribution. However, she did not confirm that if it was a fortified meal. RN1 stated the physician ordered a fortified diet for Resident 12 because he is at risk for weight loss. RN 1 stated the potential outcome of not providing the ordered fortified diet is weight loss. During a concurrent interview and record review on 11/5/2024 at 2:10 p.m., with the facility`s Registered Dietician (RD-a health professional who has special training in diet and nutrition), Resident 12`s Nutritional Assessments, weights, and Physician Orders were reviewed. RD stated that Resident 12`s diet order is fortified large portion meals. The RD stated that the potential outcome of not providing fortified meals to a resident who is recovering from a weight loss is not following the physician`s order and possible additional weight loss. During an interview on 11/7/2024 at 1:30 p.m., with the Director of Nursing (DON), the DON stated that the facility is required to serve meals based on the residents` physician orders. The DON stated Resident 12 was not provided with a fortified diet as ordered by his physician. The DON further stated the potential outcome of not serving fortified diet to a resident as ordered by the physician is inability to meet the resident`s nutritional needs which could lead to weight loss. During a review of the facility's policy and procedure (P&P), titled Food and Nutritional Services, revised March 2023, the P&P indicated the facility provides each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. The facility has an ongoing communication and coordination among and between staff within all departments to ensure the resident assessment, care plan and food and nutrition services meet each resident`s daily nutritional and dietary needs and choices. (continued on next page)

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	555519	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled Assisted Nutrition and Hydration, revised March 2023, the P&P indicated the purpose of this policy is to provide nutritional and hydration care and services to each resident, consistent with the resident`s comprehensive assessment. Provide a therapeutic diet that takes in to account the resident`s clinical condition, and preferences, when there is a nutritional indication. Therapeutic diet is ordered by the physician or other delegated provider that is part of treatment for a disease or clinical condition to eliminate, decrease or increase certain substances in the diet, or to provide mechanically altered food when indicated.

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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.

44309

Based on observation, interview, and record review the facility failed to ensure a safe and sanitary environment and food storage practices in the kitchen when:

1. A single sausage patty was observed exposed and unwrapped on top of an open box containing an unsealed bag of the same sausage patties in Freezer 1.

2. An undated bottle of Gatorade belonging to a staff member was stored in Refrigerator 2.

3. Shelves intended to hold clean trays were observed stained, with crumbs and dust.

4. Two plastic bins holding clean utensils were observed with reddish food residue and crumbs and placed on dusty shelves.

These deficient practices had the potential to place the facility residents at risk for foodborne illness (illness caused by food contaminated with bacteria, viruses, and other toxins) and to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another).

Findings:

During an initial kitchen tour on 11/4/2024 at 7:45 a.m., with [NAME] 1, observed an unwrapped sausage patty on top of an open box containing an unsealed bag of the same sausage patties in the Freezer 1. [NAME] 1 immediately discarded the exposed sausage patty and stated that the bag inside the box was not sealed, and all the sausages were exposed in Freezer 1. [NAME] 1 stated food stored in the freezer must be properly wrapped and sealed to prevent freezer burn (a condition of discoloration or other damage caused to frozen food by evaporation [liquid turns into a gas], typically due to inadequate packaging or storage conditions in the freezer]). [NAME] 1 removed the sausage patty box and disposed of it.

During a concurrent observation and interview on 11/4/2024 at 7:45 a.m., in the facility`s kitchen with [NAME] 1, an undated bottle of Gatorade was observed in Refrigerator 2. [NAME] 1 stated the bottle that was left in the refrigerator belongs to one of the staff. [NAME] 1 stated that personal food or drinks are not allowed in the kitchen refrigerator. Observed [NAME] 1 discard the Gatorade bottle.

During a concurrent observation and interview on 11/4/2024 at 8:00 a.m. with [NAME] 1, shelves intended to hold clean trays were observed stained, with crumbs and dust. Two plastic bins holding clean utensils were observed with reddish food residue and crumbs and placed on dusty shelves. [NAME] 1 stated the shelves and utensil bins are dirty and dusty. [NAME] 1 stated the potential outcome of dirty kitchen shelves and utensil bin is cross-contamination.

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NAME OF PROVIDER OR SUPPLIER The Care Center on Hazeltine, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6835 Hazeltine Ave. Van Nuys, CA 91405	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/4/2024 at 12:45 p.m., with Dietary Supervisor (DS), the DS stated food in the freezer must be properly wrapped and sealed to prevent freezer burn. The DS stated personal food or drinks are not permitted to be stored in the kitchen refrigerator or freezer. The DS stated the kitchen staff do not clean the kitchen over the weekend and he (DS) is the one cleaning the kitchen when he arrives to the facility on Mondays. The DS stated the potential outcome of an unclean and unsanitary kitchen environment is cross contamination and infection. During a review of the facility`s policy and procedure (P&P) titled Food Storage, revised on 9/1/2021, the P&P indicated that food items will be stored, thawed, and prepared in accordance with good sanitary practice. Foods to be frozen should be stored in their original containers if designed for freezing. Foods to be frozen should be store in airtight containers or wrapped in heavy-duty aluminum foil, special laminated papers, or plastics. During a review of the facility`s policy and procedure titled Cleaning Schedule, revised on 7/1/2016, the P&P indicated that the dietary staff would maintain a sanitary environment in the dietary department by complying with the routine cleaning schedule developed by Dietary Manager. The Dietary Manager will develop a cleaning schedule that includes the frequency of which equipment, and areas are to be cleaned. The Dietary Manager monitors the cleaning schedule to ensure compliance.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50033 Based on observation, interview, and record review, the facility failed to maintain infection control practices when Licensed Vocational Nurse 1 (LVN 1) did not wash hands between administering medications via gastrostomy tube (also known as a G-Tube, is a flexible that is inserted through the abdominal wall and into the stomach to provide nutrition and fluids) and giving an insulin (a hormone that lowers the level of sugar in the body) injection to Resident 32. This deficient practice had the potential to cause Resident 32 to develop an infection. Findings: During a review of Resident 32's Admission Record, the Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to, anemia (a condition where the body does not have enough healthy red blood cells), colon cancer, and vascular dementia (a progressive state of decline in mental abilities that occurs when the blood supply to the brain is disrupted). During a review of Resident 32's History and Physical (H&P), dated 10/5/2024, the H&P indicated Resident 32 does not have the capacity to understand and make decisions. During a concurrent observation and interview on 11/6/2024 at 9:54 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 did not wash his hands after giving Resident 32 medications via G-tube and before donning gloves to prepare to give Resident 32 an injection. LVN 1 went to give Resident 32 the insulin injection when the surveyor stopped him and inquired about hand hygiene practices. LVN 1 stated he should have washed his hands after giving the medications via the gastrostomy tube and before donning gloves to give the injection. LVN 1 stated he should wash his hands to maintain infection control. During a concurrent interview and record review on 11/6/2024 at 4:26 p.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Medication Administration-General Guidelines, last reviewed on 10/29/2024, indicated the person administering medications adheres to good hand hygiene, which includes washing hands thoroughly before and after coming into direct contact with a resident and administration of medications given via enteral tubes. The DON stated hands should be washed after giving medications via a gastrostomy tube for infection control purposes.