

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/17/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Olympia Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S. Alvarado St Los Angeles, CA 90006	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their infection control policy and procedure (P&P) for two of three sampled residents (Resident 1 and 2), by failing to report the positive COVID cases to the State Agency (SA). This deficient practice had the potential to spread infection to the residents, visitors, and the community. Findings:During a review of Resident 1's admission Record dated 8/29/25 indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN- high blood pressure), hyperlipidemia (HLD - a condition characterized by elevated levels of lipids (fats) in the bloodstream) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1's MDS, dated [DATE], indicated Resident 1 had severe cognitive (thinking, reasoning, learning, judgment) impairment and required partial to substantial assistance from staff for toileting, bathing, dressing and personal hygiene. During a review of Resident 2's admission Record dated 8/29/25 indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including abnormalities of gait and mobility, HTN, HLD, and anemia (a condition where the body does not have enough healthy red blood cells).During a review of Resident 2's MDS, dated [DATE], indicated Resident 2 had moderate cognitive (thinking, reasoning, learning, judgment) impairment and required substantial assistant to dependance on staff for toileting, bathing, dressing and personal hygiene. During an interview with concurrent record review on 8/28/25 at 4:10 pm with Director of Nursing (DON) the Resident 2's nurses notes dated 8/2/25 were reviewed. The DON verified the resident had had a change of condition, was tested for COVID on that day and was found to be positive. During an interview with concurrent record review on 8/28/25 at 4:01 pm with DON Resident 1's nurses note for 8/4/25 were reviewed. The note indicated the resident had a change of condition with a fever and had a COVID test at the facility before she was transferred to the hospital which was negative. Further review of nurses noted dated 8/8/25 indicated the resident was readmitted on that date and tested COVID upon admission. The DON stated the cases were within seven days of each other and should have been reported to the SA. During a review of the facility's policy and procedures titled Infection Prevention and Control Program , reviewed 1/24/25, Duties and Responsibilities. Notify appropriate government agencies of reportable contagious or infectious diseases.		

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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