STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055253	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. John of God Retirement	2468 South St Andrews Place Los Angeles, CA 90018

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) was coded accurately for one of three sampled residents (Resident 3). This deficient practice resulted in the transmission of inaccurate data to the Centers for Medicare and Medicaid Services (CMS) regarding Resident 3's health status.Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 3's diagnoses included dementia (a progressive state of decline in mental abilities) and a history of falling. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had severe cognitive impairment (difficulties with thinking, learning, memory, judgment, and problem-solving). The MDS indicated Resident 3 required partial to moderate assistance from staff for transfers in and out of bed. The MDS did not indicate Resident 3's daily use of a bed or wheelchair alarm (safety devices that sound an alert to caregivers when someone attempts to get out of bed, helping to prevent falls). During a review of Resident 3's physician order, dated 4/30/2024, the order indicated staff were to apply a wheelchair and bed alarm to alert staff when Resident 3 was trying to get up without assistance. During a review of Resident 3's Medication Administration Record (MAR), dated 12/1/2025 to 12/31/2025, the MAR indicated Resident 3 used a wheelchair and bed alarm every day during the month of December 2025. During an interview on 1/15/2026 at 3:45 p.m., with the MDS Assistant (MDSA), the MDSA stated that when coding use of alarms in the MDS, staff reviewed the previous seven days for use of alarms to determine the correct coding. The MDSA stated Resident 3 used alarms daily during the seven-day lookback period and stated her MDS dated [DATE] was not accurate. The MDSA stated the MDS should be accurate because it explained the clinical condition of the resident and the care they received or required. The MDSA stated the MDS also guided the plan of care, and stated that if the MDS indicated alarms were being used, it would prompt the interdisciplinary team to review the use of the alarms to determine if they can be discontinued. The MDSA stated that alarms were considered a restraint, and stated accurate MDS assessments helped in ensuring their use was routinely reviewed. During a review of the facility job description titled MDS Coordinator Lead, dated 8/2019, the job description indicated the MDS nurse was to ensure residents assessments presented an accurate reflection of the resident.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a care plan was developed to reflect an order for floor mats (cushioned floor pads designed to help prevent injury should a person fall) for one of three sampled residents (Resident 1), related to the resident's high risk for falls. This deficient practice placed Residents 1 at risk of not having floor mats at the bedside, and placed the resident at risk for injuries related to potential falls. Cross Reference F689.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and most recently readmitted on [DATE]. Resident 1's diagnoses included cognitive impairment (a decline in mental abilities like memory, thinking, learning, judgment, and concentration) and lack of coordination. During a review of Resident 1's History and Physical (H&P), dated 8/21/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 10/29/2025, the MDS indicated Resident 1 had severe cognitive impairment (ability to think and reason). The MDS indicated Resident 1 required substantial to maximal assistance from staff for repositioning left and right while in bed, and for transitioning from a lying to sitting position, and from a lying position to sitting at the edge of the bed. During a review of Resident 1's Change of Condition (COC) assessment, dated 8/11/2025, the COC indicated on 8/11/2025, nursing staff found Resident 1 sitting on the floor leaning on her bed following an unwitnessed fall. During a review of Resident 1's Fall Risk Evaluation, dated 8/11/2025 (after Resident 1's fall), the evaluation indicated Resident 1 was at high risk for falls. During a review of Resident 1's physician order, dated 8/11/2025 (after Resident 1's fall), the physician order indicated Resident 1 had orders for floor mats on either side of their bed. During a review of Resident 1's Rehab Post Fall Screen, dated 8/12/2025, the assessment indicated Resident 1 experienced confusion, impulsiveness, and had poor safety awareness. During a review of the Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal for a resident) Review notes, dated 8/12/2025, the IDT notes indicated placement of floor mats at Resident 1's bedside was recommended to reduce her injury risk. During a review of Resident 1's COC assessments, dated 8/18/2025 and 12/17/2025, the COC assessments indicated on 8/18/2025 and 12/17/2025, Resident 1 sustained two additional unwitnessed falls at her bedside. During an observation on 1/15/2026 at 9:10 a.m., at Resident 1's bedside, no fall mats were observed to either side of Resident 1's bed. During an interview on 1/15/2026 at 9:22 a.m., in Resident 1's room, with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 was at risk for falls due to her history of falls and frequent attempts to get out of bed unassisted. CNA 1 stated she usually removed the floor mat during the 7:00 a.m. to 3:00 p.m. (day) shift and was not sure if staff replaced the floor mat in the evening. During a telephone interview on 1/15/2025 at 11:45 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 had a history of falls and attempting to get out of bed unassisted and was at risk for additional falls. LVN 1 stated he could not recall any recent use of floor mats as a fall risk intervention for Resident 1 and was not aware if Resident 1 had orders for floor mats. LVN 1 stated floor mats should be care planned to ensure that all staff were aware of the reason they were needed. During an interview on 1/15/2026 at 12:16 p.m., with LVN 2, LVN 2 stated Resident 1 was at risk for falls and had orders for floor mats to either side of Resident 1's bed. LVN 2 stated he was responsible for ensuring that the physician orders were carried out. LVN 2 stated he did not recall checking to ensure Resident 1 had floor mats at her bedside that morning (1/15/2026). LVN 2 stated the purpose of the floor mats was to prevent slipping and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to prevent and/or minimize injuries from falls. LVN 2 stated Resident 1 did not have a care plan for her use of floor mats and stated a care plan would have ensured staff were aware that they were ordered and ensured that they were implemented as ordered. During a review of the facility's policy and procedure (P&P) titled Care Plan, dated 3/2024, the P&P indicated the care plan was to be used in developing the resident's daily care routines and was to be available to staff who were responsible for providing care or services to the resident.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure fall prevention interventions, such as the use of floor mats and bed alarms and wheelchair alarms (a safety device that sounds an alert to caregivers when someone attempts to get out of bed, helping to prevent falls), were implemented for one of three sampled residents (Residents 1 and 2), who were at risk for falls when: 1. Resident 1 did not have floor mats at the bedside, as ordered, following a fall on 8/11/2025. 2. Resident 1's physician was not notified in a timely manner of the resident's refusal of bed and wheelchair alarms. 3. A fall risk evaluation was not conducted for Resident 2 following her fall on 1/11/2026. These deficient practices placed Residents 1 and 2 at risk for falls and associated injuries.Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and most recently readmitted on [DATE]. Resident 1's diagnoses included cognitive impairment (a decline in mental abilities like memory, thinking, learning, judgment, and concentration) and lack of coordination. During a review of Resident 1's History and Physical (H&P), dated 8/21/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 10/29/2025, the MDS indicated Resident 1 had severe cognitive impairment (ability to think and reason). The MDS indicated Resident 1 required substantial to maximal assistance from staff for repositioning left and right while in bed, and for transitioning from a lying to sitting position, and from a lying position to sitting at the edge of the bed. During a review of Resident 1's Change of Condition (COC) assessment, dated 8/11/2025, the COC indicated on 8/11/2025, nursing staff found Resident 1 sitting on the floor leaning on her bed following an unwitnessed fall. During a review of Resident 1's Fall Risk Evaluation, dated 8/11/2025 (following the fall), the evaluation indicated Resident 1 was at high risk for falls. During a review of Resident 1's physician order, dated 8/11/2025 (following the fall), the physician order indicated to place floor mats to either side of the bed. During a review of Resident 1's Rehab Post Fall Screen, dated 8/12/2025, the assessment indicated Resident 1 experienced confusion, impulsiveness, and had poor safety awareness. During a review of the Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal of a resident) Review notes, dated 8/12/2025, the IDT notes indicated placement of floor mats at Resident 1's bedside was recommended to reduce her injury risk. During an observation on 1/15/2026 at 9:10 a.m., at Resident 1's bedside, no fall mats were observed to either side of Resident 1's bed. One fall mat was observed stored behind the door to Resident 1's room. During an interview on 1/15/2026 at 9:22 a.m., in Resident 1's room, with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 was at risk for falls due to history of falls and frequent attempts to get out of bed unassisted. CNA 1 stated the fall mat behind the door belonged to Resident 1, and stated only one fall mat was placed at Resident 1's bedside while she was in bed. CNA 1 stated she usually removed the floor mat during the 7:00 a.m. to 3:00 p.m. (day) shift and was not sure if staff replaced the floor mat in the evening. During a telephone interview on 1/15/2025 at 11:45 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 had a history of falls and attempting to get out of bed unassisted and was at risk for additional falls. LVN 1 stated he could not recall any recent use of floor mats as a fall risk intervention for Resident 1 and was unaware of any orders for floor mats. During an interview on 1/15/2026 at 12:16 p.m., with LVN 2, LVN 2 stated Resident 1 was at risk for falls and had orders for floor mats to either side of Resident 1's bed. LVN 2 stated he was responsible for ensuring that the physician order was carried out. LVN 2 stated he did not check to ensure (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 had floor mats at her bedside that morning (1/15/2026). LVN 2 stated the purpose of the floor mats was to prevent slipping and to prevent and/or minimize injuries from falls. During an interview on 1/15/2026 at 4:11 p.m., with the Assistant Director of Nursing (ADON), the ADON stated floor mats prevented and/or minimized injuries from falls, and stated that if ordered by the physician, the order should be followed. During a review of the facility's policy and procedure (P&P) titled Fall and Fall Risk Management, dated 3/2024, the P&P indicated staff, in conjunction with the physician, were to identify and implement relevant interventions to try to minimize serious consequences of falling. During a review of the facility's job description for Licensed Vocational Nurses (LVNs), dated 8/2019, the job description indicated LVNs were to ensure that physician orders were carried out. 2. During a review of Resident 1's COC assessment, dated 8/18/2025, the COC indicated on 8/18/2025, staff found Resident 1 on the floor following an unwitnessed fall. The COC assessment indicated Resident 1's physician recommended a wheelchair alarm as a fall precaution. The COC did not indicate Resident 1 had floor mats at her bedside at the time of the fall. During a review of Resident 1's physician order, dated 8/18/2025, the order indicated staff were to apply a bed alarm and wheelchair alarm to alert staff and promote safety awareness and prevent injury from falls when Resident 1 got up unassisted. During a review of Resident 1's care plan titled The resident uses Bed/wheelchair alarm related to (r/t) noncompliance and repeated falls, dated 8/31/2025, the care plan indicated staff were to monitor, document, and report as needed any changes regarding the effectiveness of Resident 1's bed and chair alarms. During a review of Resident 1's COC assessment, dated 12/17/2025, the COC indicated on 12/17/2025, nursing staff found Resident 1 sitting on the floor next to her bed following an unwitnessed fall. The COC did not indicate Resident 1 had floor mats or a bed alarm in place at the time of the fall. During a review of Resident 1's progress note, dated 12/17/2025, the progress note indicated Resident 1 reported mild pain near the tailbone following the fall. During a review of Resident 1's Fall Risk Evaluation, dated 12/17/2025 (after the fall), the evaluation indicated Resident 1 was at high risk for falls. During a review of Resident 1's Rehab Post Fall Screen, dated 12/18/2025, the assessment indicated Resident 1 fell in her room on 12/17/2025 at 7:45 p.m. The assessment indicated Resident 1 had poor safety awareness and forgetfulness. The assessment indicated an alarm was not in place at the time of the fall, and indicated staff should place alarms . if possible. During an observation on 1/15/2026 at 9:10 a.m., at Resident 1's bedside, observed Resident 1 did not have a bed alarm in place. During an observation on 1/15/2026 at 9:13 a.m., in the dining room, Resident 1 was observed sitting on a wheelchair. Resident 1 did not have a wheelchair alarm in place. During an interview on 1/15/2026 at 9:22 a.m., with CNA 1, CNA 1 stated she had not seen Resident 1 use a bed or wheelchair alarm. During an interview on 1/15/2026 at 11:45 a.m., with LVN 1, LVN 1 stated he had not observed the use of a bed or wheelchair alarm for Resident 1 to prevent falls. During an interview on 1/15/2026 at 11:57 a.m., with LVN 2, LVN 2 stated Resident 1 had orders for the use of a bed and wheelchair alarm due to her risk for falls. LVN 2 stated Resident 1 had a known history of removing her bed and wheelchair alarms and taking them apart. LVN 2 stated this was not a new behavior, and stated the physician was not notified until 1/15/2026. LVN 2 stated the behavior should have been documented and the physician should have been notified sooner. LVN 2 stated that absence of the wheelchair and bed alarms increased Resident 1's risk for falls and injuries. During an interview on 1/15/2026 at 4:09 p.m., with the ADON, the ADON stated the physician should be notified if the resident was refusing the alarms that were ordered for her safety. The ADON stated Resident 1 was a fall risk, and stated timely reporting of her refusal of the alarms would ensure her plan of care was reviewed and other interventions to prevent falls could be identified. During a review (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the facility's P&P titled Fall - Clinical Protocol, dated 3/2024, the P&P indicated staff were to monitor and document the resident's response to interventions intended to reduce falling or the consequences of falling. 3. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and was most recently readmitted on [DATE]. Resident 2's diagnoses included rheumatoid arthritis (a chronic disease where the immune system attacks the body's own tissues, primarily the lining of the joints). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had severe cognitive impairment. The MDS indicated Resident 2 required supervision or touch assist from staff for repositioning in bed, and transfers between surfaces (i.e., bed to chair, chair to bed). During a review of Resident 2's COC assessment, dated 1/11/2026, the COC indicated on 1/11/2026, staff found Resident 2 on the floor of the dining room following an unwitnessed fall. The COC indicated Resident 2 complained of pain to her right knee that did not require pharmacological intervention. During an interview on 1/15/2026 at 3:56 p.m., with the ADON, the ADON stated that following any kind of fall, a Fall Risk Evaluation assessment should be done immediately or within 24 hours. The ADON stated a Fall Risk Evaluation was not completed for Resident 2 following her unwitnessed fall on 1/11/2026 and stated it should have been. The ADON stated the Fall Risk Evaluation was important to promptly identify interventions to prevent further falls. During a review of the facility's P&P titled Fall - Clinical Protocol, dated 3/2024, the P&P indicated that after a fall, staff were to re-evaluate the situation and consider possible reasons for the fall and reconsider the current fall interventions.