STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055697	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Costa Del Sol Healthcare	1016 S. Record St. Los Angeles, CA 90023

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure four of six sampled residents (Residents 1, 2, 5, and 6), had indwelling catheters (catheter drains urine from bladder into a bag outside the body) free of sediments (mineral deposits and bacterial biofilm, leading to potential complications such as blockage and urinary tract infections) and cloudiness (when particles or substances in the urine made it appear milky, hazy, or opaque) in the urine. This failure placed the residents at risk for delayed assessments, physician notification and implementation of necessary interventions. This failure had the potential that Residents 1, 2, 5, and 6 had developed urinary tract infection (UTI).Findings: a.) During an observation on 4/16/2026 at 11:29 a.m., in Resident 1's room, Resident 1 was observed in bed and was unable to answer questions. Resident 1 had a suprapubic catheter ([SC] a hollow, flexible tube inserted through the lower abdominal wall into the bladder to drain urine when normal urination is not possible, when urethral catheterization is unsafe, such as in cases of urethral injury, strictures, enlarged prostate, pelvic trauma, or long-term urinary retention) connected to a drainage bag. The catheter tubing had visible white sediments observed. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included presence of urogenital implants (artificial, mechanical, or prosthetic devices in the urinary or reproductive system) and neuromuscular dysfunction of bladder unspecified (a condition where nerve damage from diseases or injuries disrupts normal bladder control, leading to urinary incontinence, retention, frequency, or urgency). During a review of Resident 1's History and Physical (H&P) dated 3/11/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool) dated 3/24/2026, the MDS indicated Resident 1 had moderate cognitive impairment. The MDS indicated Resident 1 was dependent on staff with the ADLs such as dressing, toilet use, transfer and mobility. Resident 1 was dependent on oral hygiene, toileting hygiene, shower/ bathing self, upper and lower body dressing and putting on footwear. During a review of Resident 1's Physicians Orders dated 4/20/2026, the order indicated to monitor changes in urine character, document cloudiness, sediments, foul smell, blood in urine, or concentrated urine output and notify the doctor for potential UTI, every shift. During review of Resident 1's care plan titled, Bladder: at risk for complications with urinary system related to neurogenic bladder (bladder dysfunction) and SC, dated 12/19/2025, the goals indicated Resident 1's signs and symptoms of UTI will be managed and treated. The interventions indicated to notify the physician for signs and symptoms of UTI such as foul smell urine, color changes in urine, hematuria (blood in urine) and sediments. b.) During an observation on 4/16/2026 at 11:40 a.m., in Resident 2's room, Resident 2 was observed laying on bed and was unable to answer questions. Resident 2 had a Foley Catheter ([FC] a thin, flexible tube inserted into the bladder to drain urine) with visible white sediments noted in the catheter tubing. During a concurrent observation and interview on 4/16/2026 at 12:04 p.m., with the Licensed Vocational Nurse (LVN) 1, LVN 1 observed Resident 2 who had a FC, had sediments in the catheter tubing. The urine appeared (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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	amber (honey yellow) in color and had sediments. LVN 1 stated that when sediments builds up in the urine or tubing, nurses must notify the physician. LVN 1 stated the FC should be assessed daily for sediments to help prevent the development of a UTI. LVN 1 stated the catheter was not assessed this morning for sediments while wound care was performed. LVN 1 stated it was important to monitor the catheter bag and tubing for sediments and inform the physician when present, and obtain an order, if needed, to flush the FC. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 2's diagnoses included quadriplegia unspecified (refers to the partial or complete paralysis of all four limbs (arms and legs) and the torso), genitourinary prosthetic device implants and grafts (medical devices used to support or replace the function of the urinary and reproductive systems, enhancing patient quality of life) and anoxic brain damage (a type of acquired brain injury caused by a total lack of oxygen reaching the brain). During a review of Resident 2's H&P dated 10/14/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Residents 2's MDS dated [DATE], the MDS indicated Resident 2 had severe cognitive impairment. The MDS indicated Resident 2 was dependent on staff with the ADLs. During a review of Resident 2's Physician Orders dated 1/21/2026, the order indicated to monitor changes in urine character, document for cloudiness, sediments, foul smell, blood in urine, or concentrated urine output and notify the doctor for potential UTI, every shift. During review of Resident 2's care plan titled, Bladder: at risk for complications with urinary system related to neurogenic bladder and indwelling catheter, dated 8/31/2025, the goals indicated Resident 2's signs and symptoms of UTI will be managed and treated. The interventions indicated to notify the physician for signs and symptoms of UTI such as foul smell urine, color changes in urine, hematuria, and sediments. c.) During a concurrent observation and interview on 4/17/2026 at 9:25 a.m., in Resident 5's room, Resident 5 was observed in bed covered with blankets and refused to answer questions. LVN 3 observed Resident 5's SC drainage bag and tubing and stated, I see cloudiness in the urine. LVN 3 stated that SC should be assessed daily for signs and symptoms of infections like presence of blood, cloudiness, sediments. LVN 3 stated presence of sediments in the tubing or allow the urine to remain cloudy is not acceptable as this can cause bacteria to grow and travel to the bladder, resulting in infection. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5's diagnoses included paraplegia, neuromuscular dysfunction of bladder unspecified and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 5's H&P dated 1/21/2026, the H&P indicated Resident 5 did not have the capacity to understand and make decisions. During a review of Residents 5's MDS dated [DATE], the MDS indicated Resident 5 was dependent on staff with the ADLs. During a review of Resident 5's Physician Orders dated 2/27/2026, the orders indicated to monitor for changes in urine character, document for cloudiness, sediments, foul smell, blood in urine, or concentrated urine output and notify the doctor for potential UTI, every shift. During review of Resident 5's care plan titled, Indwelling FC: Neurogenic Bladder, dated 2/27/2026, the goals indicated Resident 5 will show no signs or symptoms of UTI. The interventions indicated to notify the physician for signs and symptoms of UTI such as foul smell urine, color changes in urine, hematuria and sediments. d.) During a concurrent observation and interview on 4/17/2026 at 9:32 a.m., in Resident 6's room, Resident 6 was observed in bed and was unable to answer questions. LVN 3 observed Resident 6's FC drainage bag and tubing with the presence of sediments. LVN 3 stated, I usually assess FC before starting the shift and then again when I pass medications. LVN 3 stated, I did not see the sediments in the tubing, but I did not pick up the drainage bag or tubing to assess properly. LVN 3 stated, I should have picked up the drainage bag and checked it. LVN 3 stated, I will report it to the doctor and get an order for a urinalysis (a test to analyze urine's physical, chemical, and microscopic properties to detect conditions such as UTI). During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was originally admitted to the facility (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on [DATE] and readmitted on [DATE]. Resident 6's diagnoses included benign prostatic hyperplasia (a non-cancerous enlargement of the prostate gland), neuromuscular dysfunction of bladder unspecified and unspecified dementia. During a review of Resident 6's H&P dated 2/26/2026, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Residents 6's MDS dated [DATE], it indicated Resident 6 had severe cognitive impairment. The MDS indicated Resident 6 was dependent on staff with the ADLs. During a review of Resident 6's Physician Orders dated 1/21/2026, the orders indicated to monitor changes in urine character, document for cloudiness, sediments, foul smell, blood in urine, or concentrated urine output and notify the doctor for potential UTI, every shift. During review of Resident 6's care plan titled, Indwelling FC: Neurogenic Bladder, dated 5/7/2025, the interventions indicated to notify the physician for signs and symptoms of UTI such as foul smell urine, color changes in urine, hematuria and sediments. During an interview on 4/17/2026 at 1:10 p.m. with LVN 3, LVN 3 stated it was important to properly assess the catheter every morning for any changes in the urine, such as no urine output, sediments, cloudiness, or leaking. LVN 3 stated nurses need to inform the doctor and document a change of condition (COC) if there were any changes in the resident. During an interview on 4/17/2026 at 3:00 p.m., with the Director of Nursing (DON), the DON stated that it was the nurse's responsibility to assess the catheter every shift for its appearance of the urine, including sediments, hematuria, or any characteristics that may indicate abnormalities. The DON stated nurses are required to call the doctor and follow physician's orders. The DON stated nurses must continue monitoring residents' FC to prevent residents from developing infections. During a review of the facility's policy and procedures (P&P) titled, Catheter Care, Urinary, dated 5/2024, the P&P indicated the residents should be observed for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately if the urine had an unusual appearance (color, blood, etc.) and if signs and symptoms of urinary tract infection or urinary retention occur.