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	05/20/2026

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 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 proper wound management and care planning for one of three sampled residents (Resident 1). These deficient practices placed Resident 1 at risk for delayed wound healing, dehiscence (the premature separation or reopening of the edges of a surgical wound), and infection.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included pneumonia (an infection/inflammation in the lungs), muscle weakness, and sepsis (infection in the blood). During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 4/27/2026, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were intact. The MDS indicated Resident 1 was independent for 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 1's History and Physical (H&P), dated 1/22/2026, the H&P indicated Resident 1 could make needs known and make medical decisions. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents) Note, dated 4/23/2026, the note indicated Resident 1 arrived to the facility from her medical appointment with an incision (a deliberate cut or wound made into the body tissues using a sharp instrument) to her left elbow mass (any abnormal lump, swelling). The SBAR did not indicate orders for wound care and daily wound monitoring were obtained. During an interview on 5/20/2026 at 8:22 a.m. with Resident 1, Resident 1 stated she had surgery on her left elbow the previous month and was worried that the surgical wound would become infected because staff had not cleaned the wound. Resident 1 stated the nursing staff only wrapped the dressing with gauze. During a concurrent observation and interview on 5/20/2026 at 10:28 a.m. with Resident 1, in Resident 1's room, Resident 1's left elbow wound dressing and wound was observed. Resident 1's wound dressing was loose, saturated with a brown substance, and had dried blood. Resident 1 had one wound incision and sutures (specialized threads or strands used by healthcare professionals to stitch together tissues following an injury or surgical procedure). During a concurrent record interview and record review on 5/20/2026 at 12:12 p.m. with Treatment Nurse (TXN) 1, Resident 1's care plan titled, At Risk For Pain, Infection Due To Status Post Left Elbow Incision, initiated 4/23/2026, was reviewed. The care plan did not indicate interventions to address the care, assessment, and follow up of the left elbow wound. TXN 1 stated the lack of a Weekly Skin interdisciplinary team (IDT, group of different disciplines working together towards a common goal of a resident) paired with the lack of care plan interventions to address Resident 1's wound placed Resident 1 at risk for complications related to the wound, like dehiscence and infection. During an interview on 5/20/2026 at 2:21 p.m. with the Director of Nursing (DON), the DON stated appropriate wound care plan interventions were important to support wound healing and prevent infection. The DON stated the lack of a care plan placed Resident 1 at risk for delayed treatment, wound healing, and infection. During a review of the facility's policy and procedure (P&P) (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled, Care Plans, Comprehensive Person-Centered, revised 2001, the P&P indicated the facility was to ensure a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The P&P indicated interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the following for one of three sampled residents (Resident 1):1. A follow^up wound^care appointment was scheduled after Resident 1's initial post^procedure visit on 4/30/2026.2. Physician orders for daily wound monitoring, assessment, and treatment were obtained and clarified.3. Wound care was performed only with a valid physician order.4. Physician wound^care orders were accurately transcribed and implemented. These deficient practices resulted in delayed wound treatment and placed Resident 1 at risk for wound dehiscence (the premature separation or reopening of the edges of a surgical wound) and infection. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included pneumonia (an infection/inflammation in the lungs), muscle weakness, and sepsis (infection in the blood). During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 4/27/2026, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were intact. The MDS indicated Resident 1 was independent for 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 1's History and Physical (H&P), dated 1/22/2026, the H&P indicated Resident 1 could make needs known and make medical decisions. During a review of Resident 1's Change of Condition Note, dated 4/23/2026, the note indicated Resident 1 arrived to the facility from her medical appointment with an incision (a deliberate cut or wound made into the body tissues using a sharp instrument) to her left elbow mass (any abnormal lump, swelling). The note did not indicate orders for wound care and daily wound monitoring, of the left elbow incision, were obtained. During a review of Resident 1's Physician Orders, dated 4/23/2026 through 5/19/2026, the orders did not indicate daily wound care or assessment for Resident 1's left elbow surgical wound. During a review of Resident 1's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 5/1/2026 through 5/19/2026, the MAR and TAR did not indicate Resident 1's left elbow wound was assessed, monitored for infection, or treated. During an interview on 5/20/2026 at 8:22 a.m. with Resident 1, Resident 1 stated she had surgery on her left elbow the previous month and was worried that it would become infected because staff had not cleaned the wound. Resident 1 stated the nursing staff only wrapped the dressing with gauze. During an observation on 5/20/2026 at 10:28 a.m. with Resident 1, in Resident 1's room, Resident 1's left elbow wound dressing and wound was observed. Resident 1's wound dressing was loose, saturated with a brown substance, and had dried blood. Resident 1 had one wound incision and sutures (specialized threads or strands used by healthcare professionals to stitch together tissues following an injury or surgical procedure). 1. During an interview on 5/20/2026 at 11:23 am. with Registered Nurse (RN) 1, RN 1 stated on 4/23/2026, Resident 1 had an incision and drainage (I&D, a minor surgical procedure used to treat localized infections). RN 1 stated Resident 1 went to a follow up appointment 4/30/2026. RN 1 stated the expectation of the licensed staff was to check any post-procedure paperwork to verify wound care orders or obtain orders from the resident's attending physician to monitor, assess, and treat the wound. RN 1 stated there were no wound care orders or assessment orders obtained for Resident 1 and no documentation to indicate the licensed nurses attempted to clarify or obtain any orders from 4/23/2026 to 5/2/2026. RN 1 stated it was important to ensure wound care and daily assessment orders were in place to ensure the wound healed appropriately and to minimize the chance of infection, especially because Resident 1 had sutures (a sterile surgical thread and needle used to hold body tissues together after an injury or surgery). RN 1 stated the licensed nurses should have verified if a wound care follow-up appointment was needed after Resident 1's initial follow-up appointment on 4/30/2026. RN 1 stated the lack of daily assessment and monitoring, wound care orders, and a timely appointment follow up (after 4/30/2026) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	delayed care and treatment for Resident 1's wound and placed her at risk for infection and poor wound healing. 2. During a concurrent interview and record review on 5/20/2026 at 2:50 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 1's Change of Condition Note, dated 4/23/2026, readmission Note, dated 5/1/2026, and Physician Order, dated 5/1/2026, was reviewed. The Change of Condition Note and the readmission Note, both authored by LVN 2, did not indicate orders for treatment, assessment, and follow up. The Physician Order indicated left elbow incision site with dressing. LVN 2 stated there were no specific orders for wound care or shift to shift monitoring for Resident 1's wound. LVN 2 stated the admitting nurse, or the treatment nurse should have obtained orders for assessment, monitoring and follow-up wound care. 3. During an interview on 5/20/2026 at 12:33 p.m. with Treatment Nurse (TXN) 2, TXN 2 stated he recalled reinforcing Resident 1's dressing with rolled gauze before he ended his shift on Friday (5/15/2026). TXN 2 stated he had knowledge Resident 1 had an incision on her left elbow but did not verify the need for wound care orders or daily monitoring and assessment. TXN 2 stated it was important to obtain orders from the physician for monitoring, assessing, and wound treatment to prevent any complications and to minimize the chance of infection. TXN 2 stated that he should not have applied the rolled gauze without a physician order because it was not the facility's standard of practice. 4. During a concurrent interview and record review on 5/20/2026 at 11:23 am. with RN 1, Resident 1's Physician Orders, dated 4/23/2026 through 5/19/2026, and Skin Evaluation Assessment, dated 5/2/2026, were reviewed. The Skin Evaluation Assessment indicated orders for the left elbow wound to be cleansed with normal saline (a solution that safely cleans and flushes injuries, surgical sites, and burns without damaging surrounding tissue), dressed with xeroform (a type of wound dressing), an abdominal pad (a thick, highly absorbent medical dressing used to manage large, heavily draining wounds), gauze and rolled gauze. RN 1 stated there were no transcribed orders for wound care after 5/2/2026. RN 1 stated orders obtained by TXN 3 should have been transcribed (on 5/2/2026) and clarified to ensure Resident 1's wound was cleaned, treated, and monitored. During a phone interview on 5/20/2026 at 2:29 p.m. with TXN 3, TXN 3 stated the facility's standard practice was to conduct a full skin assessment upon admission and ensure any wound orders were obtained, if needed. TXN 3 stated she recalled that she obtained wound care orders from the physician for Resident 1 but did not remember to transcribe the orders. TXN 3 stated that it was important that the orders were transcribed for the treatment nurses could carry out the order. TXN 3 stated the lack of wound cleansing and dressing orders placed Resident 1 at risk for the development of an infection. During a review of the facility's policy and procedure (P&P) titled, Quality of Care (undated), the P&P indicated the facility was required to maintain quality of care to meet certain quality indicators and standards set by federal and state laws which include measures related to resident care, staffing levels, health and safety, infection control, and more. During a review of the facility's P&P titled, admission Assessment and Follow Up: Role of the Nurse, revised 2001, the P&P indicated the licensed nurse would ensure to contact the attending physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings. During a review of the facility's LVN Job Description, dated 2/2024, the job description indicated the LVN was to ensure the following:Transcribe the physician's order to resident charts, cardex medication cards, treatment care plans, as required.Consult with the resident's physician in providing the resident's care, treatment, rehabilitation etc. as required.Review the resident's chart for specific treatments, medication orders, diets, etc., as necessary.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were not stored at the bedside for one of three sampled residents (Resident 1). This deficient practice had the potential to result in unauthorized medication use.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included pneumonia (an infection/inflammation in the lungs), muscle weakness, and sepsis (infection in the blood). During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 4/27/2026, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making were intact. The MDS indicated Resident 1 was independent for 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 1's History and Physical (H&P), dated 1/22/2026, the H&P indicated Resident 1 could make needs known and make medical decisions. During a review of Resident 1's Physician Orders, dated 5/1/2026, the orders indicated Artificial Tears Solution 1.4 percent (%) (Polyvinyl Alcohol), instill one drop in both eyes four times a day for dry eye, and Flonase Allergy Relief Suspension (Fluticasone Propionate), give one spray into both nostrils two times a day for allergies. During a concurrent observation and interview on 5/20/2026 at 10:28 a.m. with Resident 1, in Resident 1's room, one bottle of Artificial Tears Solution and one bottle of Flonase Allergy Relief Suspension were observed on Resident 1's bedside. Resident 1 stated the licensed nurses left the medications at her bedside. During a concurrent interview and record review on 5/20/2026 11:23 a.m. with Registered Nurse (RN) 1, Resident 1's Self-Administration of Medication Observation Form, dated 5/1/2026, was reviewed. The form indicated Resident 1 did not want to self-administer medications. RN 1 stated medications should not be left at Resident 1's bedside, especially because the form indicated she was not to self-administer medications. RN 1 stated if eye drops and a nasal spray were left at the bedside, there was potential Resident 1 could incorrectly self-administer her own medications and, or another resident could obtain possession of the medication and self-administer. During a review of the facility's policy and procedure (P&P) titled, Self Administration of Medications, revised 2001, the P&P indicated any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, revised 2001, the P&P indicated the nursing staff was responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.