STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055704	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Angels Nursing Health Center	415 S Union Avenue Los Angeles, CA 90017

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** c.During a review of Resident 28's admission Record, the admission Record indicated the facility readmitted the resident on 1/8/2025 with diagnoses that included quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), and dementia (a progressive state of decline in mental abilities). During a review of Resident 28's History and Physical (H&P) dated 1/9/2025, the H&P indicated the resident did not have the capacity to make decisions. During a review of Resident 28's ADA dated 1/17/2025, the ADA indicated section 2 was not completed. During a review of Resident 28's MDS dated [DATE], the MDS indicated Resident 28 had the ability to understand others however missed some part/intent of the message but comprehended most of the conversation. During an interview on 5/20/2025 at 12:52 PM with Registered Nurse (RN) 1, RN 1 stated the social worker was supposed to follow up on the advance directives and that sometimes the licensed staff (in general) also would follow up. RN 1 stated the resident would need an advance directive upon admission and a new advance directive if readmitted . RN 1 stated the ADA form was not official if not signed by the resident or their representative. During an interview on 5/20/2025 at 12:53 PM with the SSD, the SSD stated that upon admission the advance directive must be signed, including upon readmission. The SSD stated Resident 28's advance directive was incomplete. During a concurrent interview and record review on 5/20/2025 at 12:55 PM with the SSD, the facility's policy and procedures (P&P) titled, Advance Directives dated 2/9/2024 was reviewed. The SSD stated the P&P indicated the admission staff or designee would obtain a [NAME] of a resident's advance directive.The SSD stated the P&P indicated a copy of the resident's advance directive would be included in the resident's medical record. The P&P indicated upon admission, the admissions staff or designee will provide written information to the residents concerning his or her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. The SSD stated that the policy indicated the advance directive for Resident 28 should be done on admission and readmission. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/2025 at 1 PM with the ADM, the ADM stated that if the ADA form was incomplete, the facility would not know what the resident's wishes were. b.During a review of Resident 26's admission Record indicated the facility admitted the resident on 3/11/2021 with diagnoses that included vascular dementia (reduced blood flow to the brain leading to damage and death of brain cells) and metabolic encephalopathy (a dysfunction that disrupts the body's chemical processes and affect brain function). During a review of Resident 26's History and Physical dated 7/15/2024, the History and Physical indicated Resident 26 could make needs known but could not make medical decisions. During a review of Resident 26's Minimum Data Set (MDS, a resident assessment tool) dated 3/22/2025, the MDS indicated the resident was not oriented to year, month, or day and had poor recall. During an interview on 5/20/2025 at 11:19 AM with the Social Services Director (SSD), the SSD stated Resident 26 did not have an advance directive. The SSD stated Resident 26 did not have family or friends to be a representative. The SSD stated the Interdisciplinary Team (IDT, group of diverse health care professionals from different fields) could make decisions for Resident 26 per their policy. The SSD stated she (SSD) applied for a conservator for Resident 26 dated 5/2/2025. The SSD stated she (SSD) went back and forth with the public guardian department to determine if Resident 26 would be assigned a conservator. The SSD stated she (SSD) applied to the conservatorship due to the IDT team being Resident 26's only decision maker. During an interview on 5/21/2025 at 9:58 with the SSD, the SSD stated if a resident (in general) did not have the capacity to make decisions, the Bioethics Committee, which was made up of the members of the IDT team, could meet and determine Resident 26 was a full treatment and resuscitation. During an interview on 5/21/2025 at 10:28 AM with the Director of Nursing (DON), the DON stated if Resident 26 did not have an advance directive, then the resident would be considered a full code (a patient who chooses to be resuscitated if he or she stops breathing of if the heart stops beating). The DON stated it was difficult for the facility to determine what to do for the resident. The DON stated without an advance directive the facility did not know the wishes of Resident 26. During a review of the facility's policy and procedures (P&P) titled, Advance Directives dated 2/9/2024, the P&P indicated the admission staff or designee will obtain a copy of a resident's advance directive. A copy of the resident's advance directive will be included in the resident's medical record. Upon admission, the admissions staff or designee will provide written information to the residents concerning his or her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. Based on interview and record review the facility failed to ensure three of nine sampled residents (Resident 18, Resident 26, and Resident 28) had a documented advance directive (written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor). This failure had the potential for the facility not to know the wishes of Resident 18, Resident 26, and Resident 28. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings: a. During a review of Resident 18's admission Record, the admission Record indicated the facility originally admitted the resident on 4/13/2018 and readmitted him on 7/13/2023 with diagnoses that included metabolic encephalopathy (change in how your brain works due to an underlying condition), dementia (a progressive state of decline in mental abilities) and a history of mental and behavioral disorders (conditions that affect how a person thinks, feels, and behaves). The admission Record indicated Resident 18 had a responsible party (a person who is named in as someone who the facility could reach for questions and to help make decisions for the resident) identified as Family Member 1 (FAM1). During a review of Resident 18's social worker progress note dated 11/9/2023, the social worker progress note indicated Resident 18's FAM1 was the resident's responsible party. During a review of Resident 18's History and Physical (H&P) dated 12/11/2024, the H&P indicated Resident 18 did not have the capacity to understand (ability to understand the meaning of something) and make decisions. During a review of resident 18's Advance Directive Acknowledgement (ADA, a form given to a resident that indicates the resident understands their options for an advanced directive [a legal document indicating resident preference on end-of-life treatment decisions]) dated 12/11/2024, indicated the resident, or their representative did not sign the form. The ADA indicated only the physician signed the form. The ADA indicated the initials on the following sections were blank: -The resident/representative had been given materials about their right to accept or refuse medical treatments. -The resident/representative had been informed of their rights to formulate (create) an advanced directive. -The resident/representative understood they were not required to have an advanced directive in order to receive medical treatment at the facility. -The resident/representative understood the terms of any advanced directive that they have executed (put into place) will be followed by the health care facility and the resident's caregivers to the extent permitted by law. During a review of Resident 18's Minimum Data Set (MDS, a resident assessment tool) dated 2/9/2025, the MDS indicated Resident 18's temporal orientation (ability to tell the year, month, and week) was impaired. The MDS indicated Resident 18 could not answer what day, month or year it was. The MDS indicated Resident 18 could not recall (remember) the words sock, blue, and bed when asked to repeat those words. The MDS indicated Resident 18's memory, orientation, and judgment were severely impaired. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/20/2025 at 12:52 PM with Registered Nurse 1 (RN 1), Resident 18's ADA dated 12/11/2025 was reviewed. RN 1 stated the facility's social worker was supposed to follow up with the resident/resident representative for advanced directives. RN 1 stated the ADA was not signed by the resident or their representative. RN 1 stated the ADA form was not official if it was not signed by the resident or their representative. During a concurrent interview and record review on 5/20/2025 at 12:55 PM with the Social Services Director (SSD) the facility's policy and procedure (P&P) titled Advanced Directives, dated 2/9/2024 and the ADA dated 12/11/2024 was reviewed. The SSD stated the P&P indicated the facility would obtain (get) a copy of a resident's advanced directive upon admission and place it into the resident's medical record. The SSD stated the P&P indicated if a resident did not have an advanced directive, the facility would provide the resident and/or next of kin (is the closest living relative to someone who would step in if the person is unable to make decisions for themselves) with information about advanced directive upon admission. The SSD stated the ADA is not complete. The SSD stated the facility should have fille out Resident 18 ' s ADA when he was readmitted per the facility's policy. During an interview on 5/20/2025 at 1pm with the facility's Administrator (ADM), the ADM stated if Resident 18 ' s advanced directive was not completed the facility would not know what his end-of-life wishes were.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** b. During a review of Resident 28's admission Record, the admission Record indicated the facility readmitted the resident on 1/8/2025 with diagnoses that included contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) on both knees, both ankles, both hands and right elbow, type 2 diabetes mellitus, quadriplegia and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 28's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 1/9/2025, for the resident to have a LALM for wound care and management. The order indicated for staff to check the LALM placement and function every shift. During a review of Resident 28's care plan titled, The resident has pressure relieving device: LAL mattress, dated 1/21/2025, the care plan indicated to Set device to appropriate setting related to resident ' s weight. During a review of Resident 28's MDS dated [DATE], the MDS indicated Resident 28 had the ability to understand others however Resident 28 missed some part/intent of the message but comprehends most of the conversation. The MDS indicated Resident 28 was dependent on others for going from sitting to lying position, lying to sitting on the side of the bed, and transferring from chair/bed to chair, toilet, and tub/shower. During a review of the facility's vitals for Resident 28 dated 5/2/2025, the vitals indicated Resident 28 weighed 153 lbs. During an observation on 5/19/2025 at 9:30 AM in Resident 28's room, Resident 28's LALM pump located at the food of her bed was observed to be set to 230 lbs. A sticker to the left of the pump indicated the LALM should be set to 150-180 lbs. During an interview on 5/19/2025 at 9:35 AM with the Certified Nurse Assistant (CNA) 1, CNA 1 stated they (CNAs in general) were not allowed to touch the buttons on the LALM pump. During an interview on 5/19/2025 at 9:37 AM with the Infection Control Nurse(IP, nurse who helps prevent and identify the spread of infectious agents like bacteria and viruses in a healthcare environment), the IP stated the LALM must have been disconnected by the maintenance personnel (unidentified) while on break because before going on break, the bed was at the correct setting. During an interview on 5/19/2025 at 9:41 AM with the IP, the IP stated the LALM was used to prevent sores on the buttocks, elbows, and other body parts with bony prominences. The IP stated if the LALM was not within the proper range, it could not achieve their goal. The IP stated the LALM was set to 230 lbs., and it should have been lower since Resident 28 weighed 153 lbs. The IP stated the bed could be too hard for Resident 28, which could cause pressure sores. During an interview on 5/19/2025 at 9:45 AM with the Maintenance Director (MD), the MD stated the LALM was never unplugged because he (MD) was working on finding a solution for the feeding machines cords to reach the outlet. (continued on next page)

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	055704	A. Building B. Wing	05/22/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/2025 at 8:59 AM with the TX, the TX stated the LALM should be set based on the resident's weight. The TX stated the LALM settings were evaluated daily to ensure it was functioning properly and to ensure the LALM had the correct setting. During an interview on 5/20/2025 at 9:08 AM with the TX, the TX stated she (TX) was not sure what the facility's LALM policy and stated the licensed nurses (in general) set the pump setting based on the resident ' s weight and make sure that it was working properly. The TX stated if there were any issues with the LALM the facility would call the manufacturer. During an interview on 5/20/2025 at 9:25 AM with the Director of Nursing (DON), the DON stated that if the LALM is too hard, it could cause a wound ulcer, slow wound healing or make a wound ulcer worse. During a review of the LALM manufacturer guidelines titled, Proactive medical products Operation Manual for Proteckt® Aire 6000, dated 10/25/2023, the manufacturer guidelines indicated the LALM was selected by patients weight guide listed on the panel providing pressure change options. The manufacturer guideline indicted users can adjust the air mattress to a desired firmness according to the patient ' s weight and comfort. Based on observation, interview, and record review, the facility failed to maintain the appropriate Low Air Loss Mattress (LALM, a pressure-relieving mattress used to prevent and treat pressure injuries [localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device]) settings for two of six sampled residents (Resident 6 and Resident 28). This failure had the potential to place Resident 6 and Resident 28 at risk for discomfort and worsening of wounds and pressure ulcers/injuries Findings: a. During a review of Resident 6's admission Record, the admission Record indicated the facility readmitted the resident on 2/28/2025 with diagnoses that included right buttock (butt) pressure ulcer stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), left hip pressure ulcer stage 3 (a deep wound that has broken through all layers of the skin and into the fat tissue underneath, but not yet to the muscle, bone, or tendon), type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). During a review of Resident 6's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 2/28/2025, for the resident to have a LALM for skin management. The Order Summary Report indicated for staff to check the LALM placement and function every shift. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool) dated 3/5/2025, the MDS indicated Resident 6 had the ability to understand others and had the ability to make herself understood. The MDS indicated Resident 6 was dependent on others for toileting (going to the bathroom), dressing, putting on/taking off footwear, showering, rolling left and right, going from sitting to lying position, and transferring from chair to chair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an review of the facility's SBAR (a simple communication tool, often used in healthcare, that breaks down a message into four key parts: Situation, Background, Assessment, and Recommendation) Communication dated 3/19/2025, the SBAR Communication indicated Resident 6's right ischium (one of the three bones that make up each hip bone, forming the lower and back part) stage 4 pressure ulcer depth had increased in size. Previous measurements: 1.5 x 1.4 x 3.9 (the length, width, and depth of a wound/ulcer measured in inches). Most recent measurements: 1.4 x 1.2 x 6.9). During a review of Resident 6's care plan titled, the resident has pressure relieving device: LAL mattress, dated 3/28/2025, the care plan indicated to set device to appropriate setting related to residents' weight. During a review of the facility's vitals (group of measurements) record for Resident 6 dated 5/2/2025, the vitals record indicated Resident 6 weighed 135 pounds (lbs.). During an observation on 5/20/2025 at 8:35 AM in Resident 6's room, Resident 6's LALM pump located at the foot of her bed was observed to be set to 230 lbs. A sticker to the left of the pump indicated the LALM should be set to 130 lbs. During an interview on 5/20/2025 at 8:59 AM with the treatment nurse (TX), the TX stated Resident 6's LALM should be set based on Resident 6's weight. TX stated she (TX) evaluated Resident 6's LALM settings daily to ensure it was functioning properly and to ensure the LALM had the correct setting. The TX nurse stated she (TX) did not know what Resident 6's LALM was set to and would need to go to Resident 6's room to check. During an interview on 5/20/2025 at 9:06 AM with the TX, the TX stated Resident 6's LALM was set to 180 and stated Resident 6 weight 135 lbs. The TX stated Resident 6's LALM should have been set to 130. The TX stated she (TX) was not sure what the facility's LALM policy stated and stated the licensed nurses (in general) were responsible to check the LALM function and settings. The TX stated if there were any issues with the LALM the facility would call the manufacturer.

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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. Based on observation, interview, and record review, the facility failed to inform two of three sampled residents (Resident 24 and Resident 250) of the medications that were administered to them during medication pass, as per facility's policy and procedure (P&P), titled Medication Administration - General Guidelines, dated 10/2017 and nurses' education document, titled Principles of Medication Administration, dated 2/5/2025. This deficient practice failed to provide information about medications to Resident 24 and Resident 250 before administering them. Findings: a. During a review of Resident 24's admission Record (a document containing demographic and diagnostic information), dated 5/21/2025, the admission Record indicated the facility originally admitted Resident on 2/26/2021 and readmitted the resident on 3/2/2021 with diagnoses including, but not limited to, hypertensive (high blood pressure) heart disease without heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), other iron deficiency (low level of iron) anemias, hyperlipidemia (a medical condition with high level of lipids [fatty compounds] in the blood), Type 2 Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood glucose level), paranoid Schizophrenia (a mental illness that is characterized by disturbances in thought), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), bipolar (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs type) and anxiety disorder. During a review of Resident 24's Minimum Data Set (MDS, a resident assessment tool) dated 3/9/2025, the MDS indicated Resident 24 had severely impaired cognition (mental action or process of acquiring knowledge and understanding through thought and senses). The MDS indicated Resident 24 needed setup or clean-up assistance from the facility staff for performing activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, toileting and upper body dressing, and supervision level assistance for showering, lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent observation and interview on 5/20/2025 at 8:55 AM with Licensed Vocational Nurse1 (LVN 1) in Resident 24's room, LVN 1 checked Resident 24's blood pressure. LVN 1 stated Resident 24's blood pressure reading was systolic blood pressure (SBP, the pressure caused by heart while contracting) of 122 millimeters of mercury (mmHg, a measurement of pressure) and diastolic blood pressure (DBP the pressure in the arteries when the heart rests between beats) of 70 mmHg, and heart rate was 74 beats per minute. During a concurrent observation and interview on 5/20/2025 at 8:55 AM, LVN 1 did not identify medications by their name and/or explain their purpose and indications to Resident 24 before he (Resident 24) took his medications. LVN 1 prepared and administered the following nine medications to Resident 24: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. One tablet of benztropine (a medication used to treat extrapyramidal symptoms [movement disorders caused by use of antipsychotics]) 2 milligrams (mg, a unit of measurement for mass). 2. One tablet of docusate sodium (a medication used to treat constipation) 100 mg. 3. One capsule of fish oil (a medication used to treat high level of lipids) 1000 mg. 4. One capsule of hydrochlorothiazide (a medication used to treat high blood pressure) 12.5 mg. 5. One-half tablet of metoprolol succinate (a medication used to treat high blood pressure) extended release (ER) 25 mg (dose of 12.5 mg). 6. One tablet of multivitamin. 7. One tablet of risperidone (a medication used to treat schizoaffective disorder) 3 mg. 8. One tablet of vitamin C (a vitamin used to treat low level of vitamin C) 500 mg. 9. One tablet of vitamin D3 (a vitamin used to treat low level of vitamin D) 25 micrograms (mcg - a unit of measurement for mass). During a medication reconciliation (a process of comparing medications) review on 5/20/2025 at 11:13 AM, Resident 24's Order Summary Report (a document containing a summary of all active physician orders), dated 5/21/2025 was reviewed. The Order Summary Report indicated but not limited to the following physician orders: 1. Benztropine mesylate tablet 2 mg give one tablet by mouth two times a day for extrapyramidal and movement disorder, order date 2/26/2021, start date 02/26/2021. 2. Docusate sodium oral tablet 100 mg, give one tablet by mouth one time a day for bowel management, hold for loose stools, order date 1/6/2024, start date 1/7/2024 3. Fish oil 1000 mg soft gel, give 1000 mg by mouth one time a day for supplement, order date 5/19/2025, start date 5/20/2025 4. Hydrochlorothiazide capsule 12.5 mg, give one capsule by mouth one time a day related to hypertensive heart disease without heart failure, hold if SBP is less than 110 or pulse rate less than 60, order date 9/1/2022, start date 9/2/2022. 5. Metoprolol succinate ER oral tablet, give 12.5 mg by mouth one time a day related to hypertensive heart disease without heart failure, hold if SBP <110 or pulse rate <55, order date 1/10/2024, start date 1/11/2024. 6. Multivitamins tablet, give 1 tablet by mouth one time a day for supplement, order date 2/26/2021, start date 2/27/2021. 7. Risperidone tablet 3 mg, give one tablet by mouth two times a day for paranoia that people are out to hurt him related to paranoid schizophrenia, order date 2/26/2021, start date 2/26/2021. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Vitamin C tablet 500 mg, give one tablet by mouth two times a day for supplement, order date 2/26/2021, start date 2/26/2021. 9. Vitamin D3 tablet 25 mcg, give 1 tablet by mouth one time a day for supplement, order date 2/26/2021, start date 2/27/2021. b. During a review of Resident 250's admission Record, the admission Record indicated the facility admitted Resident 250 on 5/1/2025 with diagnoses including unilateral primary osteoarthritis (inflammation and pain in joints) right knee, polyneuropathy (nerve pain), essential primary hypertension and other abnormalities of gait and mobility. During a review of Resident 250's History and Physical, dated 5/3/2025, the History and Physical indicated Resident 250 had the capacity to understand and make decisions. During a concurrent observation and interview on 5/20/2025 at 9:38 AM with LVN 1 in Resident 250's room, LVN 1 checked Resident 250's blood pressure. LVN 1 stated Resident 250's blood pressure reading was SBP of 138 mmHg and DBP of 76 mmHg, and heart rate was 82 beats per minute. During a concurrent observation on 5/20/2025 at 9:38 AM LVN 1 did not identify medications by their name and/or explain their purpose and indications to Resident 250 before he took his medications. LVN 1 prepared and administered the following 13 medications to Resident 250: 1. One tablet of amlodipine (a medication used to treat high blood pressure) 10 mg. 2. One capsule of celecoxib (a medication used to manage osteoarthritis) 200 mg. 3. One capsule of docusate sodium 100 mg. 4. One tablet of ferrous sulfate (a medication used to treat low level of iron) 325 mg. 5. One capsule of fish oil 1000 mg. 6. One tablet of folic acid (a vitamin used to treat low level of B vitamin) 1 mg. 7. One tablet of metoprolol tartrate 100 mg. 8. One tablet of multivitamin with minerals. 9. One capsule of tamsulosin (a medication used to treat benign prostatic hyperplasia ([BPH] a medical condition for prostate) 0.4 mg. 10. One tablet of lisinopril (a medication used to treat high blood pressure) 40 mg. 11. One tablet of vitamin C 500 mg. 12. One tablet of vitamin D3 125 mcg (5000 international units ([IU] a measurement for dose). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055704	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Angels Nursing Health Center	415 S Union Avenue Los Angeles, CA 90017

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	13. 30 mg of enoxaparin (a medication used to prevent blood clots) sodium injection 30 mg per 0.3 milliliters ([mL] a unit of measurement for volume) injected subcutaneously (under the skin). During a medication reconciliation review on 5/20/2025 at 11:13 AM, Resident 250's order summary report, dated 5/21/2025 was reviewed. The Order Summary Report indicated the following physician orders: 1. Amlodipine besylate oral tablet 10 mg, give 1 tablet by mouth one time a day for HTN hold for SBP <110, order date 5/1/2025, start date 5/2/2025. 2. Celecoxib oral capsule 200 mg, give 1 capsule by mouth two times a day for swelling/pain for right knee arthroplasty, order date 5/1/2025, start date 5/1/2025. 3. Docusate sodium soft gel, give 100 mg by mouth two times a day for bowel management prophylaxis, order date 05/19/2025, start date 5/19/2025. 4. Enoxaparin sodium injection solution prefilled syringe 30 mg/0.3 mL, inject 30 mg subcutaneously two times a day for deep venous thrombosis (DVT, a medical condition with blood clot in extremities like legs, which can lead to stroke [loss of blood flow to a part of the brain]) alternate site, order date 5/1/2025, start date 5/1/2025. 5. Ferrous sulfate tablet 325 (65 Fe [iron]), give 1 tablet by mouth two times a day for supplement, order date 05/09/2025, start date 5/10/2025. 6. Fish oil 1000 mg soft gel, give 1000 mg by mouth one time a day for supplement, order date 5/19/2025, start date 5/20/2025. 7. Folic acid 1 mg, give 1 tablet by mouth one time a day for supplement, order date 5/5/2025, start date 5/6/2025. 8. Lisinopril oral tablet 40 mg, give 1 tablet by mouth one time a day for HTN hold for SBP<110, order date 5/1/2025, start date 5/2/2025. 9. Metoprolol tartrate oral tablet, give 1 tablet by mouth two times a day for HTN hold for SBP <110 and HR <60, order date 5/1/2025, start date 5/2/2025. 10. Multivitamin-minerals oral tablet, give 1 tablet by mouth one time a day for supplement, order date 05/15/2025, start date 5/16/2025. 11. Tamsulosin hydrochloride (HCl) oral capsule 0.4 mg, give 1 capsule by mouth one time a day for BPH, order date 05/01/2025, start date 5/2/2025. 12. Vitamin C oral tablet 500 mg, give 1 tablet by mouth one time a day for supplement, order date 05/15/2025, start date 5/16/2025. 13. Vitamin D3 tablet 125 mcg (5000 IU), give 1 tablet by mouth one time a day for supplement, order date 5/5/2025, start date 5/6/2025. (continued on next page)

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	055704	A. Building B. Wing	05/22/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/2025 at 12:49 PM with LVN 1, LVN 1 stated while administering medications to Resident 24 and Resident 250, she (LVN1) would explain to the residents if they were receiving blood pressure medications. LVN 1 stated the facility's policy usually stated to explain if residents were getting new medications. LVN 1 stated since she had been giving medications for a long time and residents were familiar with the medications it was not necessary to explain those medications. During an interview on 05/21/2025 at 12:22 PM with the Director of Nursing (DON), the DON stated the facility nurses (in general) should have identified the name of medications, their indication and possible side effects to the residents during medication administration. The DON stated the nurse should have explained the medications (for example, risperidone), to the residents who were alert and oriented. The DON stated it was important to receive consent from residents before administering medications. The DON stated the facility staff were instructed to explain medications to residents during a recent in-service (education) conducted at the facility. The DON stated it would be a part of ensuring resident rights policy that all residents Especially who are alert and oriented were informed of the medications being administered to them. During a review of the facility's nurses' education document titled, Principles of Medication Administration, dated 2/5/2025, the document indicated, Administration Phase: involves diligent clinical judgement, decision making and full understanding of medication(s) and their side effects. Explain each procedure to the resident before performing them. During a review of the facility's P&P titled, Medication Administration - General Guidelines, dated 10/2017, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 02/09/2024, the P&P indicated, All residents have a right to a dignified existence and communication with and access to persons and services inside and outside the facility including those specified in this policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055704	A. Building B. Wing	05/22/2025

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Angels Nursing Health Center	415 S Union Avenue Los Angeles, CA 90017

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to ensure the standardized recipes for lunch menu were followed on 5/20/2025 when: 1.Fortified Diets (Diet enriched to increase caloric content of the foods commonly consumed by the resident. The amount of calorie increase should be 300-400 per day) were not prepared and were not served to seven residents who were on a fortified diet. 2.The facility failed to ensure cooks followed the spreadsheet (food portions and serving guide) 14 residents on regular diet did not receive the seasoned peas (vegetable dish) on their plate per menu and residents who were on the renal diet (a diet intended for residents with decreased kidney function. This diet regulates the dietary intake of sodium, potassium, and protein to lighten the work of the diseased kidney.) received the three-bean salad instead of wheat roll with margarine per menu. These failures had the potential to result in meal dissatisfaction, decreased nutritional intake, and weight loss. Findings: During the tray line observation on 5/20/2025 at 11:45AM, residents who were on a fortified diet, Dietary Aide (DA1) did not communicate the fortified diet orders written on the meal tickets during tray line service for lunch. A review of resident's tray or meal tickets that were placed on the carts indicated the orders for fortified diets. DA1 did not read out loud the fortified diet and Cook1 who was serving the food did not add any additional food items per fortified menu. During a concurrent observation and interview with Cook1 and DA1 on 5/20/2025 at 12:45PM regarding diet fortification process, Cook1 stated when there was a fortified diet, melted butter or margarine was added to the vegetables. [NAME] 1 stated he did not hear any fortified diet and did fortify the meal. DA1 stated he forgot to read the fortified diet orders, forgot to read resident food likes and dislikes and the different diets such as renal or carbohydrate control (diet for residents with high blood sugar). DA1 stated this resulted in some residents being served food they (residents) did not like and not serving the ordered additional calories for the residents who were on a fortified diet. DA1 stated this could result in residents being unhappy with the food and weight loss. 2.According to the facility lunch menu for the regular diet on 5/20/2025, the following items would be served on the regular diet: Roast turkey 3 ounces (oz.-unit of measure); cranberry ginger citrus sauce; bread dressing 1/3 cup; seasoned peas ½ cup; three bean salad ½ cup; vanilla mousse chocolate chip garnish 1/3 cup; milk. Renal Diet: Roast Turkey with cranberry ginger citrus sauce; bread dressing 1/3 cup; seasoned peas ½ cup; Wheat Roll and margarine; applesauce for dessert ½ cup; beverage. During an observation of tray line service for lunch on 5/20/2025 at 11:45AM, residents who were on regular diet did not receive the seasoned peas and the residents who were on renal diet received the three-bean salad instead of the wheat roll and margarine. (continued on next page)

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	055704	A. Building B. Wing	05/22/2025

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/20/2025 at 11:45AM with cook 1 and DA1, Cook1 stated the menu for 5/20/2025 was roast turkey with bread dressing. Residents on mechanical soft (food is chopped into smaller pieces and served soft) receive seasoned peas and the resident on a regular diet received the three-bean salad instead of the peas. During the same interview on 5/20/2025 at 11:45AM with DA1, DA1 stated he was not familiar with the menu and did not know if residents on regular diet should receive the seasoned peas along with the three-bean salad. DA1 stated every tray received the three-bean salad including the residents on renal diet. During a concurrent review of the spreadsheet and interview with Cook1 on 5/20/2025 at 12:45PM, Cook1 stated the residents on regular diet should receive the seasoned peas for their vegetable choice and they did not. Cook1 stated the residents on renal diet should have received the whole wheat roll with margarine and not the three bean salad. [NAME] 1 stated he did not review the spreadsheet and made mistakes during serving lunch. Cook1 stated residents on a regular diet received less food. During an interview on 5/202/2025 at 12:45PM with the DS and District manager (DM), the DS stated there were multiple mistakes during lunch service. The DS stated the residents on renal diet should have received the whole wheat bread with margarine instead of three bean salad. The DS stated the Renal diet should not have beans. The DS stated the plate looked empty for the resident (unidentified) on the regular diet who did not receive vegetables. During the same interview on 5/202/2025 at 12:45PM with the DM, the DM stated cooks (in general) should always review and follow the menu. The DM stated the staff (in general) should read all the notes and orders that were on the resident's meal ticket. During a dining observation in the residents dining room adjacent to the kitchen on 5/20/2025 at 1:15PM residents on a regular diet, their plate consisted of two items the roast turkey and bread dressing no vegetables. During a review of the facility's policy titled Menu (revised 10/2022) the policy indicated, Menus will be served as written, unless a substation is provided in response to preference, unavailability of an item. .

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	055704	A. Building B. Wing	05/22/2025

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Angels Nursing Health Center	415 S Union Avenue Los Angeles, CA 90017

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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. Based on observation, interview and record review, the facility failed to ensure safe and sanitary food and preparation practices in the kitchen by failing to: 1. Ensure Dietary Staff Dietary Aide1 (DA1) washed his hands after changing gloves and when removing the clean and sanitized dishes from the dish machine when working in the kitchen. 2. Ensure to maintain a clean kitchen when the floor and shelving in the dry storage area were dirty, one package of dried pasta was open. The Coffee machine glass gauge pipe was stained with dark brown color residue. Resident dishes were not clean and had dried white and yellow stains on them. These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 35 out of 36 residents who received food from the facility. Findings: 1.During an observation in the dishwashing area on 5/20/2025 at 9:45AM, DA1 was rinsing soiled dishes and loading the dirty dishes in the dish machine. DA1 had gloves on, and after the dish machine stopped DA1 removed soiled gloves and proceeded to remove the clean and sanitized dishes from the dish machine without washing hands. During a concurrent observation and interview with DA1 on 5/20/2025 at 9:55AM, DA1 stated he (DA1)did not wash his hands after removing gloves and before touching the clean dishes. DA1 stated he (DA1) needed to go to the handwashing sink to wash then return to pick up the clean dishes. DA1 stated that not washing hands could contaminate clean dishes. During a concurrent interview on 5/20/2025 at 9:55AM, with dietary supervisor (DS), the DS stated two staff members (unidentified) worked in the dishwashing area. The DS stated one staff member was responsible for dirty dishes and the other would remove the clean and sanitized dishes to avoid cross contamination. The DS stated the second staff was late assisting the dishwasher in removing the clean dishes. During a review of the facility's policy titled, Food: Preparation (Revised 2/2023), the policy indicated, All staff will practice proper hand washing techniques and glove use. During a review of the facility's policy titled, Ware washing (revised 2/2023), the policy indicated, All dishware, service ware, and utensils will be cleaned and sanitized after each use, all dishes will be air dried and properly stored. During a review of the 2022 U.S. Food and Drug Administration Food Code, Code 2-301.14 titled When to wash. The Code indicated, Food employees shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and E) After handling soiled equipment or utensils. (continued on next page)

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	055704	A. Building B. Wing	05/22/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation in the kitchen on 5/20/2025 at 10 AM, observed the coffee maker machine had glass gauge pipe in front of the machine. The pipes were half filled with coffee and there were dark brown stains inside the pipe. During a concurrent interview on 5/20/2025 at 10 AM with the DS, the DS stated the coffee machine was cleaned every week and the glass gauge/pipes should be cleaned with a special thin pipe brush. The DS looked at the coffee machine and stated the glass pipe was dirty. The DS did not find the special thin brush that was used to clean the glass pipe. The DS stated the stained and dirty coffee maker could contaminate the coffee and change the quality of the coffee. During an interview on 5/20/2025 at 10:05AM with Cook2 (Cook2), Cook2 stated he had never seen the brush and he had not tried to clean the coffee machine glass gauge/pipes. Cook2 stated he did not know how to access the inside of the coffee machine glass gauge for cleaning. During a review of the facility's policy titled, Equipment (revised 9/2017) the policy indicated, All equipment will be routinely cleaned and maintained in accordance with manufacture's direction and training materials. All staff members will be properly trained in the cleaning and maintenance of all equipment. During a review of facility's daily cleaning schedule log, the schedule indicated cleaning the coffee container, coffee pots and machine once a week and did not indicate cleaning the gauge and pipe. During an observation in the dry storage area on 5/20/2025 at 10:10AM, the floor behind the shelf was dirty with food particles, there was one bag of pasta with a date of 5/16/2025 stored on the shelf and the bag was open not sealed. During a concurrent observation and interview 5/20/2025 at 10:10AM, with the DS, the DS stated the dry storage room is cleaned and the floors are swept every day. The DS stated all items in the dry storage area should be labeled and packages sealed to prevent contaminants from going inside the food. The DS stated the pasta in the open bag would be discarded because it had been open and exposed to the environment. The DS looked under the shelf and stated there were food debris on the floor.The DS stated the floor behind the shelves had not been swept. The DS stated it was important to keep the floors and the food area clean to prevent attracting pests and harborage of pests. During a review of facility's policy titled Food Storage: Dry Goods (revised 2/2023) the policy indicated, All packaged and canned food items will be kept clean, dry and properly sealed. Storage areas will be neat, arranged for easy identification, and date marked as appropriate. During an observation of the tray line service for lunch (a system of food preparation, in which trays move along an assembly line) on 5/20/2025, at 11:30AM, observed three serving plates were dirty with dried white and yellow food stains on them. During a concurrent interview on 5/20/2025, at 11:30AM, with Cook1, Cook1 stated he did not notice the dirt on the plates while waiting for service. Cook1 stated food should not be served on dirty plates. Plates were expected to be cleaned and sanitized. (continued on next page)

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	055704	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Angels Nursing Health Center	415 S Union Avenue Los Angeles, CA 90017

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/20/2025 at 11:35AM with the DS, the DS stated the plates were not clean and there was dried food debris stuck on them. The DS stated dishes should be scrubbed, rinsed and then loaded in the dish machine. The DS removed the dishes and instructed DA1 to rewash and scrub before loading in the dishwashing machine. The DS stated dirty dishes could contaminate food served on the plates. During a review of the 2002 U.S. Food and Drug Administration Food Code, code 3-304.11 titled Food Contact with Equipment and Utensils code indicated, Food shall only contact surfaces of: (A) Equipment and utensils that are cleaned and sanitized .Pathogens can be transferred to food from utensils that have been stored on surfaces which have not been cleaned and sanitized.

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	055704	A. Building B. Wing	05/22/2025

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure the trash stored in the dumpster area was maintained in a sanitary manner. On 5/20/2025 at 10:30AM one of the two garbage dumpsters was overfilled with trash bags and uncovered. This failure had the potential for harborage and feeding of pests. Findings: During a concurrent observation and interview with the Dietary Supervisor (DS) and the Maintenance Supervisor (MS) on 5/20/2025 at 10:30AM, one large dumpster outside of the kitchen back door was not covered. The dumpster was overfilled with trash bags and not covered.There was another large trash dumpster that was behind gates and not accessible to staff. During a concurrent interview on 5/20/2025 at 10:30AM with the DS and the MS, the DS stated trash should be covered so flies did not accumulate around the trash areas. During the same interview on 5/20/2025 at 10:30AM with the MS, The MS stated trash was picked up three times a week. The MS stated the large dumpster that was behind the gate was empty and it should be accessible to staff to throw away trash instead of overfilling one dumpster with lid open. The MS stated all trash lids should be covered to prevent from attracting flies and pests in the facility. During a review of the facility's policy titled, Garbage and Trash (dated 2023) the policy indicated, Garbage and trashcans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed. A review of Food and Drug Administration (FDA) Food Code 2022, code number 5-501.113 titled Covering receptacles, indicated: receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered with tight-fitting lids or doors if kept outside the establishment. The Food Code also indicated under code number 5-501.110 titled Storing Refuse, Recyclables, and Returnable indicated refuse, recyclables, and returnable shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents.