STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056078	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta View Post Acute	831 S Lake Street Los Angeles, CA 90057

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain the clinical records as indicated in the facility's Charting and Documentation policy and procedure for one of three sampled residents (Resident 1) by failing to ensure to document: -A significant care event on 3/6/2026, including Resident 1's refusal of shower care, aggressive behavior, staff interventions, and outcome. -The transfer of care from Certified Nursing Assistant 1 (CNA 1) to CNA 2 during the shower refusal on 3/6/2026. These failures resulted in an incomplete medical record of Resident 1 and had potential to affect Resident 1's care.Findings: During a review of Resident 1's admission Record, the admission Recorded indicated the facility admitted Resident 1 on 2/27/2024, and readmitted the resident on 8/11/2025, with diagnoses including but not limited to schizophrenia (a chronic brain disorder that disrupts how a person thinks, feels, and acts, making it difficult to distinguish reality from imagination), bipolar disorder (a chronic mental health condition characterized by intense, extreme mood swings that interfere with daily life), and essential hypertension (high blood pressure, developing gradually over many years without a direct, identifiable, or secondary cause. During a review of Resident 1's History and Physical (H&P) dated 8/15/2025, the H&P indicated Resident 1 was competent to understand her medical condition. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 2/13/2026, the MDS indicated Resident 1 made herself understood and understood others. The MDS indicated Resident 1's cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks) was intact. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) for showers and hygiene. During a review of facility's shower schedule dated 3/6/2026, the shower schedule indicated Resident 1 was listed as scheduled for a shower. The shower schedule indicated that CNA 1 was assigned to provide care to Resident 1. During an interview on 4/8/2026 at 1:47 PM, with CNA 2, CNA 2 stated that on 3/6/2026, CNA 1 reported to her (CNA2) at the office that Resident 1 refused to take a shower from CNA 1. CNA 2 stated she (CNA2) went to approach Resident 1 in front of the shower room. CNA 2 stated she (CNA2) did not ask Resident 1 why she (Resident 1) was refusing a shower. CNA2 stated Resident 1 refused shower care before (unidentified date and time). CNA 2 stated she (CNA2) offered to provide shower to Resident 1 on 3/6/2026. CNA2 stated Resident 1 completed the shower without complaints. During an interview on 4/8/2026 at 2:31 PM with CNA 1, CNA 1 stated the alleged incident occurred on 3/6/2026 during the shower care of Resident 1. CNA 1 stated she (CNA1) was assigned to care for Resident 1 and was scheduled for a shower that day (3/6/2026). CNA 1 stated while in the shower room, Resident 1 verbalized refusal, stating she (Resident 1) did not want to shower. CNA1 stated she (CNA1) confirmed with Resident 1 if she (Resident 1) was sure, at which time Resident 1 threw a towel toward her (CNA1) and stood up from the shower chair. CNA 1 stated the Licensed Vocational Nurse (LVN unidentified) was outside the shower room. CNA 1 reported the refusal to the LVN (unidentified) and requested to monitor Resident 1 while she (CNA1) obtained assistance. CNA 1 stated she (CNA1) sought assistance from CNA 2. CNA 1 stated CNA 2 approached Resident 1, helped with the shower, and Resident 1 did not refuse care. CNA 1 stated CNA 2 assumed care of Resident 1 and completed the shower. CNA 1 stated she (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
	056078	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alta View Post Acute	831 S Lake Street Los Angeles, CA 90057

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(CNA1) did not chart the incident. During a concurrent interview and record review on 4/8/2026 at 3:40 PM with the Medical records Director (MRD), Resident 1's medical record was reviewed. MRD stated after a thorough review of Resident1's medical record, there was no documentation of the shower refusal that occurred on 3/6/2026 or related behavioral incident were found. The MRD stated that the facility's process required that when a resident (in general) refused care, the CNA (in general) would report the refusal to the charge nurse, and the charge nurse then reported it to the supervisor. The MRD stated that Resident 1's shower refusal should have been documented as part of medical record of Resident 1's care information. During a concurrent interview and record review on 4/8/2026 at 4:49 PM with the Director of Nursing (DON), the alleged incident staff interview document of LVN1, dated 3/27/2026, was reviewed. The DON stated LVN 1 interview document indicated that LVN 1 heard someone (unidentified) inside the shower room yelling, I don't want to take a shower, and that Resident 1 verbally expressed to her she (Resident 1) did not want to take a shower. The DON stated LVN1 interview document indicated Resident 1 later agreed to take a shower with the assistance of CNA 2 and continued medication administration after CNA 2 assumed care. The DON stated that the shower refusal and behavior event on 3/6/2026 were not documented in the progress notes and were not reported to the supervisor. The DON stated there was a failure to document Resident 1's shower refusal incident. During a review of the facility's P&P titled Charting and Documentation, last reviewed on 7/2025, the P&P indicated that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The P&P also indicated that linens should not be stored in the shower room. The P&P indicated documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. The P&P indicated entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN [Registered Nurse] LPN [Licensed Practical Nurse]/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. The P&P indicated Certified Nursing Assistants may only make entries in the residents' medical chart as permitted by facility policy. The P&P indicated Documentation of procedures and treatments will include care-specific details, including: a. The date and time the procedure/treatment was provided. b. The name and title of the individual(s) who provided the care. c. The assessment data and/or any unusual findings obtained during the procedure/treatment. d. How the resident tolerated the procedure/treatment. e. Whether the resident refused the procedure/treatment. f. Notification of family, physician or other staff, if indicated; and g. The signature and title of the individual documenting.