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	08/21/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide reasonable accommodations for one of 20 sampled residents (Resident 15) by not ensuring Resident 15's call light (a device used by residents to call for assistance) was within reach. This deficient practice had the potential to cause a delay in staff meeting Resident 15's needs for assistance further resulting in falls and accidents.During a review of Resident 15's admission Record, the admission Record indicated Resident 15 was initially admitted to the facility on [DATE] with diagnoses including cerebral infarction (stroke- loss of blood flow to a part of the brain) and needing assistance with personal care. During a review of Resident 15's Minimum Data Set (MDS- a resident assessment tool) dated 5/10/2025, the MDS indicated Resident 15 had severely impaired cognition (significant difficulty with memory, decision-making, and understanding) and was dependent for help (helper does all of the effort) with toileting hygiene, shower/bathing, lower body dressing, putting on/taking off footwear, and going from lying to sitting on side of the bed. The MDS further indicated Resident 15 required moderate (helper does less than half the effort) to maximal (helper does more than half the effort) assistance with personal hygiene, upper body dressing, and oral hygiene. During a review of Resident 15's Care Plan (CP) dated 4/6/2022, the CP indicated Resident 15 had a communication problem related to stroke and right sided weakness. The CP further indicated for staff to provide a safe environment by ensuring Resident 15's call light is within reach. During a concurrent observation and interview on 8/18/2025 at 10:05 am with Resident 15, Resident 15 was observed lifting his sheets and pillows in bed and stated, I'm looking for my call light. I use that to call the nurses for help. During a concurrent observation and interview on 8/18/2025 at 10:06 am with the Assistant Director of Staff Development (ADSD), Resident 15's call light was observed hanging against the wall and out of Resident 15's reach. The ADSD stated that the call light should always be within the resident's reach because residents use the call system for any needs that they have. If the call light is not in reach, residents could try to get up without staff assistance and fall. During an interview on 8/21/2025 at 1:55 pm with the Director of Nursing (DON), the DON stated sometimes staff forgets to place the call lights within reach after providing care for the residents. The expectation is all call lights should be within the residents' reach when they are in bed or toileting because that is how residents communicate their need for assistance. The DON further explained that not having the call light within the resident's reach could cause that resident to fall or have a medical emergency without alerting staff. During a review of the facility's policy and procedure (P&P) titled Answering the Call Light dated September 2024, the P&P stated, (staff) ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility, and from the floor.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to inform and consult with resident's physician when there was a significant change in the resident's physical status for one of six sample residents (Resident 46) regarding 7.2 pounds weight loss in 14 days. This deficient practice delayed the Medical Doctor (MD) being notified and the resident not being reassessed for the 7.2 pounds weight loss. Findings: During a review of Resident 46's admission Record dated 6/25/2025, the admission record indicated the resident was admitted to the facility on [DATE] and was readmitted on [DATE] to the facility with diagnoses of, but not limited to, Unspecified protein-calorie malnutrition (a nutritional disorder resulting from a lack of adequate protein and caloric intake). Dysphagia (difficulty swallowing), Pneumonitis due to inhalation of food and vomit (inflammation of the lung's air sacs caused by an inhaled substance). Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 46's Minimum Data Set (MDS-a resident assessment tool) dated 7/15/2025, the MDS indicated Resident 46's cognition (thought process) was moderately impaired. The MDS indicated Resident 46 required substantial/maximal assistance partial (helper does more than half the effort) from staff for activities of daily living (ADL's - routine tasks/activities such as bathing, dressing, toileting a person performs daily to care for themselves). During a record review of Resident 46's Weight and Vitals Summary indicated Resident 46 was weighed upon admission on [DATE], listed 122.2 pounds. On 7/10/2025, Resident 46 weighed 115 pounds. On 7/14/2025, Resident 46 weighed 114.6 pounds. During an interview on 8/20/2025, at 2:44 p.m. with Assistant Director of Nursing (ADON) , ADON stated she is responsible for entering the weights on the Residents medical record and is responsible for the weight variance meeting. ADON stated she cannot find any documentation where the MD was made aware of Resident 46 significant weight loss of 7.2 pounds. During an interview on 8/21/2025 at 11:54 a.m. with Director of Nurses (DON) stated, that 5% of weight loss in a month is a significant change and prompt interventions can target the comorbidities that the residents already have. DON stated the interdisciplinary team should be in alignment with weight changes because it important to early identify to prevent decline. During a review of the facility's policy and procedure titled, change in a Resident's Condition or Status, dated February 2025, indicated, a significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff; requires interdisciplinary review and/or revision to the care plan.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure to provide a Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNF ABN, a document that the facility must provide to Medicare beneficiaries when the facility anticipates that Medicare might not pay for certain services) for two of three sampled residents (Resident 44 and Resident 95). This failure had the potential to result in Resident 44 and Resident 95 not being able to make an informed decision (a choice made after carefully gathering and assessing all relevant facts) regarding the care that may not be covered by Medicare (a federal system of health insurance for people over [AGE] years of age and for certain younger people with disabilities) program. Findings:1.During a review of Resident 44's admission Record, the admission Record indicated the facility re-admitted the resident on 2/28/2025 with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (mild or partial weakness or loss of strength on one side of the body), dementia (a progressive states of decline in mental abilities), hyperlipidemia (high levels of cholesterol in the blood), hypertension (high blood pressure), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). The admission Record indicated Resident 44 had a conservator (a person or entity appointed by a court to make healthcare decisions and manage personal affairs for an adult who is unable to do so themselves due to mental or physical incapacitation).During a review of Resident 44's Minimum Data Set (MDS, a resident assessment tool) dated 5/23/2025, the MDS indicated the resident had severe cognitive impairment (a significant decline in mental abilities like memory, thinking, and reasoning that interferes with a person's independence in daily life).During a review of Resident 44's SNF Beneficiary Notification Review form, the SNF Beneficiary Notification Review form indicated the resident's last covered day for Medicare Part A skilled services was on 6/6/2025. The SNF Beneficiary Notification Review Form indicated Resident 44 was not provided with a SNF ABN because the resident's Medicare Part A benefits were exhausted.2.During a review of Resident 95's admission Record, the admission Record indicated the facility re-admitted the resident on 2/28/2025 with diagnoses that included paraplegia (loss of movement and/or sensation, to some degree, of the legs), stage 4 pressure ulcer (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of the left buttock, unstageable pressure ulcer (full-thickness skin and tissue loss where the depth of the damage cannot be confirmed because it is covered by slough (soft, moist, yellow, tan, gray, green, or brown tissue) or eschar (hard or soft, black, brown, or tan tissue) of the sacral region (tailbone area), unstageable pressure ulcer of the right hip, colostomy (a surgical procedure that bring one end of the large intestine out through the abdominal wall to allow waste to leave the body), and muscle weakness.During a review of Resident 95's MDS dated [DATE], the MDS indicated the resident had independent cognitive skills for daily decision making (decisions consistent/reasonable).During a review of Resident 95's SNF Beneficiary Notification Review form, the SNF Beneficiary Notification Review form indicated the resident's last covered day for Medicare Part A skilled services was on 3/3/2025. The SNF Beneficiary Notification Review form indicated the facility initiated Resident 95's discharge from Medicare part A Services when benefit days were not exhausted. The SNF Beneficiary Notification Review form indicated Resident 95 was not provided with a SNF ABN because the resident was no longer skilled.During a concurrent interview and record review on 8/20/2025 at 3:06 PM with the Business Office Assistant (BOA), Resident 44 and Resident 95's SNF Beneficiary Notification Review form were reviewed. The BOA stated Resident 44 was discharged from Medicare part A services on 6/6/2025. The BOA stated Resident 44 remained in the facility after the resident's discharge from Medicare part A services. The BOA stated Resident 44 was not provided with a SNF ABN because the resident's benefits were exhausted. The BOA stated Resident 95 was discharged from Medicare part A services on 3/3/2025. The BOA stated Resident 95 remained in the facility after the resident's discharge from Medicare part A services. The BOA stated Resident 95 was not provided with a SNF ABN. The BOA stated he did not know why Resident 95 was not provided with a SNF ABN. The BOA stated a SNF ABN was supposed to be given to residents 3 days prior to when the resident's skilled services at the facility were ending.During a concurrent interview and record review on 8/21/2025 at 9:34 AM with the BOA, the facility's policy and procedure titled Medicare Advance Beneficiary and Medicare Non-Coverage Notices dated 4/2025 was reviewed. The P&P indicated A resident (who is a Medicare beneficiary) is informed in advance and in writing when Medicare payment denial or change in coverage is likely The facility

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain a clean environment for one of six sample residents (Resident 31). This deficient practice had the potential for an unsafe and unclean resident's environment with the potential for the spread of infection and to place the resident at risk for physical discomfort. During a record review of Resident 31's admission Record dated 6/27/2025, the admission record indicated the resident was admitted to the facility on [DATE], with diagnoses of, but not limited to Gastrostomy-tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), Delayed Milestone in Childhood (a situation where a child does not reach a particular developmental milestone at the expected age). During a review of Resident's 31 Minimum Data Set (MDS-a resident assessment tool) dated 7/4/2025, the MDS indicated Resident 31 is dependent (helper does all the effort) from staff for activities of daily living (ADL'S-routine tasks/activities such as bathing, dressing, toileting a person performs daily to care for themselves). During a concurrent observation and interview on 8/18/2025 at 9:55 a.m. with Certified Nursing Assistant 1 (CNA1) of Resident 31's bedroom it was observed with a thick, dried, brown-colored pasty substance was observed on the top and inner side surfaces of Resident 31's right side bed rail. CNA1 stated the side rail was dirty and was going to get cleaning wipes from housekeeping and was going to clean up the surface of Resident 31's right side rail. During an interview on 8/21/2025 at 2:02 p.m. with Director of Nursing (DON) stated it is important to keep a clean environment because it is a Residents' home, and it is important for the health of the residents. During a review of the facility's policy and procedure titled, Infection Prevention and Control dated April 2025, indicated, all personnel are trained on infection prevention and control policies and procedures upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide nonpharmacological interventions (behavioral interventions that do not involve medications) prior to administering Resident 4 Lorazepam (a medication that helps reduce anxiety) PRN (as needed) for one of five residents sampled for unnecessary medications (Resident 4).This deficient practice increased the risk of Resident 4 experiencing adverse effects (unwanted or dangerous medication-related side effects) related to psychotropic medication therapy (medications that affect brain activities associated with mental processes and behavior), such as drowsiness, low blood pressure, constipation, or increased risk of fall; possibly leading to impairment or decline in her mental or physical condition or functional or psychosocial status. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted on [DATE] with diagnoses including anxiety, depression, psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with reality), delusional disorders (having false or unrealistic beliefs), and auditory hallucinations (false perceptions of sound, such as hearing voices or noises that are not present). During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool) dated 7/17/2025, the MDS indicated Resident 4 had severely impaired cognition (significant difficulty with memory, decision-making, and understanding), moderate depression, and was dependent on help for most cares such as toileting, shower/bathing self, lower body dressing, and putting on/taking off footwear. During a concurrent interview and record review on 8/20/2025 at 12:08 pm with RN Supervisor (RNS) 1, Resident 4's Order Summery Report (OSR- a monthly summary of all active physician orders) dated August 2025 and Medication Administration Record (MAR) dated July 2025 and August 2025 were reviewed. The MAR indicated Resident 4 was prescribed Lorazepam one milligram (mg- a unit of measure for mass) via gastrostomy tube (g-tube- a surgical opening fitted with a device to allow feedings and medication to be administered directly to the stomach) PRN every six hours for anxiety manifested by episodes of crying on 7/14/2025. The MAR and OSR indicated staff did not provide nonpharmacological interventions prior to administering Lorazepam for 37 days. RNS 1 stated nonpharmacological interventions should be done to prevent giving residents unnecessary medications and to decrease the risk of adverse side effects of psychotropic medications like drowsiness and low blood pressure. RNS 1 further stated nonpharmacological interventions are a safer alternative for residents' health and safety.During an interview on 8/21/2025 at 1:55 pm with the Director of Nursing (DON), the DON stated, I don't know why the order (for nonpharmacological interventions) was missed. The DON further stated nonpharmacological interventions should always be provided in an effort to discontinue PRN psychotropic medications due to potential side effects such as hallucinations, loss of appetite, and agitation. During a review of the facility's policy and procedure (P&P) titled Psychotropic Medication Use dated November 2024, the P&P indicated nonpharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) assessment for entry and discharge from the facility were completed within the required time frame for one of three sampled residents (Resident 94).This failure had the potential to result in Resident 94 receiving a delay in care and services at the facility.Findings:During a review of Resident 94's admission Record, the admission Record indicated the facility initially admitted the resident on 6/24/2025 with diagnoses that included chronic respiratory failure (a gradual, long-term condition where the lungs can't effectively exchange oxygen and carbon dioxide, leading to symptoms like shortness of breath, fatigue, and confusion), muscle weakness, seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), encephalopathy (permanent brain damage that causes severe confusion and forgetfulness), glaucoma (a group of eye conditions that damage the optic nerve, often due to increased pressure inside the eye, leading to irreversible vision loss and potential blindness), dysphagia (difficulty swallowing), atrial fibrillation (an irregular and rapid heartbeat), quadriplegia (paralysis from the neck down, including leg and arms, usually due to a spinal cord injury), 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 concurrent interview and record review on 8/20/2025 at 11:02 AM with the MDS Coordinator (MDS), Resident 94's Minimum Data Set Summary was reviewed. The MDS stated Resident 94 was admitted to the facility on [DATE] and discharged from the facility on 7/8/2025. The MDS stated Resident 94 was re-admitted to the facility on [DATE] and then discharged again on 7/27/2025. The MDS stated Resident 94 was then re-admitted to the facility again on 7/31/2025. The MDS stated Resident 94 had an entry MDS assessment dated [DATE] that was completed on 8/6/2025 and submitted on 8/9/2025. The MDS stated Resident 94 had a discharge MDS assessment dated [DATE] that was completed on 8/19/2025 and submitted on 8/20/2025. The MDS stated Resident 94 had another entry MDS assessment dated [DATE] that was completed on 8/19/2025 and submitted 8/20/2025.During a concurrent interview and record review on 8/20/2025 at 11:23 AM with MDS Coordinator 2 (MDS 2) Resident 94's Minimum Data Set Summary was reviewed. MDS 2 stated the entry MDS assessment should be completed within seven days and submitted 14 days after completion. MDS 2 stated the discharge MDS assessment should be completed within 14 days and submitted within 14 days of completion. MDS 2 stated Resident 94's entry MDS assessment date 7/25/2025, discharge MDS assessment dated [DATE], and entry MDS assessment dated [DATE] were not completed within the required timeframe. MDS 2 stated MDS assessments should be completed timely to ensure the resident receives an appropriate plan of care. MDS 2 stated information from the MDS assessments are used to develop the resident's plan of care.During a concurrent interview and record review on 8/20/2025 at 11:28 AM with the Director of Nursing (DON), Resident 94's Minimum Data Set Summary was reviewed. The DON verified and confirmed Resident 94's entry MDS assessment dated [DATE], discharge MDS assessment dated [DATE], and entry MDS assessment dated [DATE] were completed late. The DON stated entry MDS assessments should be completed within 7 days of entry to the facility and the discharge MDS assessment should be completed within 14 days of discharge from the facility. The DON stated there could be potential for Resident 94 to have a delay in care and services the resident received at the facility because of late MDS assessment completion.During a review of the facility's Policy and Procedure (P&P) titled MDS Completion and Submission Timeframes dated 10/2024, the P&P indicated Out facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual.During a review of the Centers for Medicare & Medicaid Services User's Manual (UM) titled Long - Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/2024, the UM indicated In accordance with the requirements at 42 CFR S483.20(f)(1), (f)(2), and (f)(3), long-term care facilities participating in the Medicare and Medicaid programs must meet the following conditions: Completion Timing: For all non-admission OBRA and PPS assessments, the MDS Completion Date (Z0500B) must be no later than 14 days after the Assessment Reference Date (ARD) (A2300).For the other comprehensive MDS assessments, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment, the CAA Completion Date (V0200B2) must be no later than 14 days from the ARD (A2300) and no later than 14 days

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the assessment entry on the Minimum Data Set (MDS- an assessment and care screening tool) related to weight loss was accurately coded to reflect the resident's weight loss of five percent in a month for one of six sampled residents (Resident 46). This deficient practice resulted in incorrect data being transmitted to the Center for Medicare and Medicaid Services (CMS) and had the potential to negatively affect the plan of care and services for Resident 46. During a review of Resident 46's admission Record dated 6/25/2025, the admission record indicated the resident was admitted to the facility on [DATE] and was readmitted on [DATE] to the facility with diagnoses of, but not limited to, Unspecified protein-calorie malnutrition (a nutritional disorder resulting from a lack of adequate protein and caloric intake). Dysphagia (difficulty swallowing), Pneumonitis due to inhalation of food and vomit (inflammation of the lung's air sacs caused by an inhaled substance). During a review of Resident 46's Minimum Data Set (MDS-a resident assessment tool) dated 7/15/2025, the MDS indicated Resident 46's cognition (thought process) was moderately impaired. The MDS indicated Resident 46 required substantial/maximal assistance partial (helper does more than half the effort) from staff for activities of daily living (ADL's - routine tasks/activities such as bathing, dressing, toileting a person performs daily to care for themselves). During a record review of Resident 46's Weight and Vitals Summary indicated Resident 46 was weighed upon:admission on [DATE], listed 122.2 pounds. 2. On 7/10/2025, Resident 46 weighed 115 pounds. 3. On 7/14/2025, Resident 46 weighed 114.6 pounds. During a record review of Nutrition assessment dated [DATE], the nutrition assessment by the Registered Dietitian (RD) indicated a recent weight loss of 7.2 pounds that equals a 5.9 percent weight loss in 14 days. During a review of the care plan dated 7/14/2025, the care plan indicated Resident 46 had a weight loss of 7.2 pounds equal to 5.9 percent weight loss in the last 14 days .During a concurrent interview and record review on 8/20/2025 at 3:29 p.m. with MDS coordinator a review of Resident 46's MDS dated [DATE], Section K0300 Weight Loss indicated Resident 46 has no weight loss in the last one to six months. MDS coordinator stated that he was calculating using the formula in the Resident Assessment Instrument (RAI- manual a guidebook for nursing home staff in gathering resident information). The MDS coordinator stated misinterpreting the results after discussing it with the facility's MDS consultant. The MDS coordinator stated. Not entering residents' data correctly in the MDS assessment can alter the plan of care and would not be able to follow or revised the care plan. During an interview on 8/21/2025at 2:02 p.m. with the Director of Nursing (DON) stated the MDS was coded incorrectly and that the MDS coordinator was guided by the facility's MDS consultant. During a review of the facility's policy and procedure titled, Certifying Accuracy of the Resident Assessment, dated April 2025, indicated any health care professional completing the Minimum Data Set (MDS) is qualified to assess the medical, functional, and/or psychosocial status of the resident and must sign and certify the accuracy of the resident assessment.

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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 interview, and record review, the facility failed to develop a plan of care for one of six sample residents (Resident 46), who had lost 7.2 pounds (5.9 percent) in 14 days after admission. This deficient practice had the potential for delayed provision of necessary care and services. During a review of Resident 46's admission Record dated 6/25/2025, the admission record indicated the resident was admitted to the facility on [DATE] and was readmitted on [DATE] to the facility with diagnoses of, but not limited to, Unspecified-Calorie Malnutrition (a nutritional disorder resulting from a lack of adequate protein and caloric intake). dysphagia (difficulty swallowing), pneumonitis due to inhalation of food and vomit (inflammation of the lung's air sacs caused by an inhaled substance). During a review of Resident 46's Minimum Data Set (MDS-a resident assessment tool) dated 7/15/2025, the MDS indicated Resident 46's cognition (thought process) was moderately impaired. Please add ADL's for eating During a review of Resident 46's Weight and Vitals Summary indicated Resident 46 was weighed :A. on 6/25/2025, listed 122.2 pounds. B. On 7/10/2025, Resident 46 weighed 115 pounds. C. On 7/14/2025, Resident 46 weighed 114.6 pounds. During a record review of Nutrition assessment dated [DATE], the nutrition assessment by the Registered Dietitian (RD) indicated a recent weight loss of 7.2 pounds that equals a 5.9 percent weight loss in 14 days. During an interview on 8/21/2025 at 2:02 p.m. with the facility's Director of Nursing (DON) stated, care plans are patient centered and is how resident's problems are managed. During a review of the facility's policy and procedure titled, Weight Assessment and Intervention, dated February 2025, indicated any weight change of 5 percent or more since the last weight assessment nursing will immediately notify the dietitian in writing and the physician and multidisciplinary effort and includes the physician, nursing staff, the dietician, the consultant pharmacist, and the resident or resident's legal surrogate.

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	056078	A. Building B. Wing	08/21/2025

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

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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 - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure to accurately set the settings of the Low Air Loss mattresses (LAL - medical-grade mattress designed to prevent and treat pressure injuries [PI, injuries to the skin and underlying tissue resulting from prolonged pressure on the skin] by reducing moisture and heat buildup) for two of three sampled residents (Resident 56 and Resident 90) according with the residents' weights per the physician's orders. This failure had the potential to prevent the promotion of skin wound healing for Resident 56 and Resident 90.Findings: 1.During a review of Resident 56's admission Record, the admission Record indicated the facility admitted the resident on 3/14/2025 with diagnoses including dementia (a progressive state of decline in mental abilities), contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion), and PIs. During a review of Resident 56's Order Summary Report, dated 6/7/2025, the Order Summary Report indicated the LAL mattress for skin/wound management and to monitor placement, setting and function every shift and to base the setting according to the resident's weight. During a review of Resident 56's Minimum Data Set (MDS - a resident assessment tool) dated 6/11/2025 indicated the was at risk for developing pressure ulcers and the resident had one or more pressure ulcers. The MDS indicated Resident 56 had a pressure-reducing device for the bed. During a record review of Resident 56's Care Plan Report, dated 7/9/2025, the Care Plan Report indicated the LAL mattress for skin management was initiated. The Care Plan Report indicated to maintain Resident 56's skin integrity with interventions to adjust air mattress to a desired firmness according to the resident's weight. The Care Plan Report indicated interventions to check the mattress settings for accuracy. During a concurrent observation and record review on 8/18/2025 at 9:27 AM in Resident 56's room, the Weight and Vitals Summary, dated 8/6/2025, was reviewed. The resident was lying in bed sleeping, the side rails (are adjustable metal or rigid plastic bars that attach to the bed) were up on both sides of the bed, and the call light (a device used by a patient to signal his or her need for assistance) was within reach. Resident 56 was on a LAL mattress set at 160 pounds (lbs., a unit of weight). The Weight and Vitals Summary indicated Resident 56 weighed 145 lbs. During an interview on 8/18/2025 at 9:41 AM with Licensed Vocational Nurse (LVN 1), LVN 1 stated she (LVN1) did not know why Resident 56's LAL was set to 160 lbs., and that Resident 56 weighed 145 lbs. LVN 1 stated that the LAL machine had weight settings at 120 and at 160, and that the weight setting at 160 would be closest to Resident 56's weight. LVN 1 stated there was a sticker on the LAL machine to place the setting at 160. During an interview on 8/20/2025 at 9:00 AM with the Treatment Nurse (TN), the TN stated there were tubes in the mattress that distributed air and alternate to distribute pressure. The TN stated that to prevent further PIs for Resident 56, whose PIs were resolved, the LAL should be adjusted as accurately as possible. The TN stated the LAL set to 160 lbs., would not be as accurate to Resident 56's weight of 145 lbs. 2.During a review of Resident 90's admission Record, the admission Record indicated the facility admitted the resident on 6/20/2025 with diagnoses including cellulitis (a skin infection that causes swelling and redness), contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion), and pressure ulcers (a skin injury that develops when prolonged pressure is applied to the same area of the body). During a review of Resident 90's Order Summary Report dated 6/21/2025, the Order Summary indicated to monitor the settings of the LAL mattress for skin/wound management. The Order Summary indicated the LAL mattress settings should be based on Resident 90's weight. During a review of Resident 90's MDS dated [DATE], the MDS indicated the resident had functional limitations to the lower legs, needed partial to substantial assistance with showering, toileting, and dressing. The MDS indicated Resident 90 had a pressure ulcer, had a risk for developing PIs, and had a pressure reducing device for the bed. During a review of Resident 90's Care Plan Report dated 7/9/2025, the Care Plan Report indicated the use of a LAL mattress for skin management with an intervention to check and monitor the settings for accuracy and function. The Care Plan Report indicated to set the settings based on Resident 90's weight. During a concurrent observation and record review on 8/18/2025 at 10:09 AM in Resident 90's room, the Weight and Vitals Summary dated 8/5/2025, was reviewed. Resident 90 was lying in bed, the side rails were up on both sides of the bed, and the call light was within reach. Resident 90's was on a LAL mattress and the monitor was set to 160. The label on Resident 90's LAL monitor indicated LAL setting at 80-160. The Weights and Vitals Summary indicated Resident 90 weighed 117 lbs. During an interview on 8/18/2025 at 10:16 AM with the TN stated that the treatment nurses (unspecified) monitor the

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure that one of six sample residents (Resident 46) who was assessed at risk for weight loss, and were provided with timely nutritional intervention to prevent continuous significant weight loss, including: 1.Failure to follow Registered Dietitian (RD) interventions for Resident 46 to have dental evaluation. 2.Failure to have interdisciplinary (IDT-team-a coordinated group of experts from several different fields) meeting to strive to prevent, monitor, and intervene Resident 46's undesirable weight loss as indicated in the facility's policy and procedure on Nutrition (Impaired) Unplanned Weight Loss-Clinical Protocol revised on July 2025. 3.Failure to implement the RD interventions nutritional plan of care by not notifying the attending physician regarding Resident 46's significant weight loss and by not providing the resident with double protein with meals, and multi-vitamin as recommended by RD. 4. Failure to ensure IDT revised plan of care for Resident 46 that had a weight loss of 7.2 pounds in 14 days. 5. Failure to ensure Resident 46 was accurately reassessed by the Dietary Manager (DM). These deficient practices placed Resident 46 at risk for complications associated with weight loss. During a review of Resident 46's admission Record dated 6/25/2025, the admission record indicated the resident was admitted to the facility on [DATE], and was readmitted on [DATE] with diagnoses of but not limited to, unspecified protein-calorie malnutrition (a nutritional disorder resulting from a lack of adequate protein and caloric intake). dysphagia (difficulty swallowing), pneumonitis due to inhalation of food and vomit (inflammation of the lung's air sacs caused by an inhaled substance). diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 46's Minimum Data Set (MDS-a resident assessment tool) dated 7/15/2025, the MDS indicated Resident 46's cognition (thought process) was moderately impaired. The MDS indicated Resident 46 required substantial/maximal assistance partial (helper does more than half the effort) from staff for activities of daily living (ADL's - routine tasks/activities such as bathing, dressing, toileting a person performs daily to care for themselves). During a review of Resident 46's Weight and Vitals Summary indicated Resident 46 was weighed upon admission on [DATE] listed 122.2 pounds and on 7/10/2025 Resident 46 weighed 115 pounds. Resident 45 was re-weighed on 7/14/2025 indicating 114.6 pounds. During a record review of Nutrition assessment dated [DATE], the nutrition assessment by the RD indicated a recent weight loss of 7.2 pounds that equals a 5.9 percent weight loss in 14 days. The RD Dietary interventions are to discontinue current diet and change to Consistent Carbohydrate Hydrohydrate (CCHO) diet, puree texture thin consistency, double protein with meals, multivitamins daily, and dental consultation with a desired goal weight of 125-135 pounds. During an interview on 8/20/2025 at 2:44 p.m. with the ADON, ADON stated it is her responsibility of the RD to make recommendations if there are weight changes in residents. The ADON stated the process for weight loss residents is to notify the RD, physician, and the resident or family. ADON stated once there is a change of condition the facility monitors through SBAR. The ADON stated Resident 46 was seen by RD on 7/14/2025 after readmission on [DATE] and that the RD did not provide the Resident 46's documented interventions for nursing to follow through. ADON stated that RD did not communicate to any staff. During an interview on 8/21/2025 at 2:39 p.m. with Dietary Manager(DM), DM stated Resident 46 admission weight of 122.2 on 6/26/2025 was automatically copied to his readmission assessment on 7/10/2025 and did not obtain the most current weight. DM stated he missed the significant change of weight loss of 7.2 pounds. DM stated that it is important to obtain current weight to address any issues such as weight loss or change of diet that the resident might have experienced when out of the facility. During a review of the facility's policy and procedure titled, Nutrition (Impaired) Unplanned Weight Loss-Clinical Protocol revised in July 2025, indicated, the staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake.

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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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to explain medications that were administered to one of nine sampled residents (Resident 35) observed during medication pass, as indicated in the facility's policy and procedure (P&P), titled Medication Administration - General Guidelines, dated 10/2017 and Charge Nurse/Nurse Supervisor Competency Assessment, dated 10/2020. This deficient practice failed to provide information to Resident 35 regarding his medications before Licensed Vocational Nurse 1 (LVN1) administered the medications.Findings:During a review of Resident 35's admission Record (a document containing demographic and diagnostic information), dated 8/21/2025, the admission Record indicated the facility admitted Resident 35 on 11/27/2024 with diagnoses that included but not limited to moderate protein-calorie malnutrition, muscle weakness, pressure ulcer, rhabdomyolysis (severe muscle damage leading to kidney failure), depression (a mood disorder characterized by persistent feelings of sadness or loss of interest), schizophrenia (a mental illness that is characterized by disturbances in thought), essential hypertension (HTN - high blood pressure) and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 35's Minimum Data Set (MDS, a resident assessment tool) dated 5/26/2025, the MDS indicated Resident 35's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was intact. The MDS indicated Resident 35 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, needed supervision or touching assistance for oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on/taking off footwear and needed moderate assistance for personal hygiene. During a concurrent observation and interview on 8/19/2025 at 9:39 AM with LVN1 1 in Resident 35's room, LVN 1 checked Resident 35's blood pressure. LVN 1 stated Resident 35's blood pressure reading was systolic blood pressure (SBP - the pressure caused by heart while contracting) of 128 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 76 mmHg, and heart rate was 64 beats per minute. LVN 1 stated Resident 35 rated his pain level at 6 (pain scale, no pain 0, 1 to 3 mild, 4 to 6 moderate, 7 to 10 severe), on the left hip and requested acetaminophen (a medication used to treat pain and fever). LVN 1 prepared and administered the following eight medications to Resident 35 without identifying medications by their name and/or explaining their purpose and indications to Resident 35 before administering them. 1. One tablet of docusate sodium (a medication used to treat constipation) 100 milligrams ([mg] a unit of measurement for mass). 2. One tablet of ferrous sulfate (a medication used to treat low levels of iron) 325 mg (65 mg elemental iron). 3. One tablet of folic acid (a medication used to treat low levels of folic acid) 1 mg. 4. One and one-half table of metoprolol tartrate 25 mg (37.5 mg dose) with parameters to hold the dose if SBP less than 110 mmHg or HR less than 60. 5. One tablet of multivitamins with minerals. 6. One tablet of vitamin B1 (also known as thiamine) (a vitamin used to treat low levels of vitamin B1) 100 mg. 7. One tablet of vitamin C (a vitamin used to treat low levels of vitamin C) 500 mg. 8. Two tablets of acetaminophen 325 mg. During a review of Resident 35's Order Summary Report (a document containing a summary of all active physician orders), dated 8/21/2025, the order summary report indicated, but not limited to, the following physician orders: 1. Acetaminophen tablet 325 mg, give 2 tablets by mouth every 6 hours as needed for mild to moderate pain (1-6), do not exceed 3 grams of acetaminophen (APAP) from all sources in 24 hours, order date 8/3/2025, start date 8/3/2025. 2. Docusate sodium oral tablet 100 mg, give 1 tablet by mouth two times a day for constipation, hold if loose bowel movement, order date 12/8/2024, start date 12/8/2024. 3. Ferrous Sulfate tablet 325 mg (65 Fe) mg, give 1 tablet by mouth one time a day for supplement, give with food, order date 12/9/2024, start date 12/10/2024. 4. Folic Acid oral tablet 1 mg, give 1 tablet by mouth one time a day for supplement, order date 11/27/2024, start date 11/28/2024. 5. Metoprolol Tartrate oral tablet 75 mg, give 0.5 tablet by mouth every 12 hours for HTN. Hold for SBP<110 or HR<60; administer with food, (0.5 mg = 37.5 mg), order date 06/20/2025, start date 6/20/2025. 6. Multivitamin-minerals oral tablet, give 1 tablet by mouth one time a day for supplement, order date 12/10/2024, start date 12/11/2024. 7. Thiamine hydrochloride (HCl) oral tablet 100 mg, give 1 tablet by mouth one time a day for supplement, order date 11/27/2024, start date 11/28/2024. 8. Vitamin C oral tablet 500 mg (Ascorbic Acid), give 1 tablet by mouth two times a day for supplement, order date 08/9/2025, start date 8/10/2025. During an interview on 8/19/2025 at 10:25 AM with LVN 1, LVN 1 stated she (LVN1) would introduce herself to residents because I

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Alta View Post Acute	831 S Lake Street Los Angeles, CA 90057

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to:1. Ensure to inform the facility nursing staff (in general) to maintain the medication refrigerator's temperature with the correct reference range of 36-to-46 degrees Fahrenheit ([F] is a unit of temperature) (2-to-8 degrees Celsius ([C] is a unit of temperature) in accordance with the regulatory standards, manufacturer's specifications and the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, dated 1/2025, for the storage and monitoring of refrigerated medications for one of one inspected medication room (Medication Room). 2. Ensure Resident 84's empty, punctured, opened vial of single-use Epogen ([generic name - epoetin alfa] a medication used to treat anemia [low red blood cell count]) was discarded in accordance with facility's P&P titled, Medication Storage in the Facility, dated 1/2025, in one of one inspected medication room (Medication Room). These failures had the potential to result in medication errors, and for the residents to receive medications that were deteriorated, ineffective, or toxic due to improper storage and labeling possibly leading to adverse health consequences (harmful, unintended result) such as anemia and hospitalization.Findings: 1. During a concurrent observation, interview, and record review on 8/19/2025 at 1:02 PM with the Director of Nursing (DON) and Licensed Vocational Nurse 3 (LVN) 3, in the Medication Room, the medication refrigerator thermometer and temperature logbook were reviewed. The medication refrigerator thermometer indicated the temperature to be 34 F. The DON stated the temperature was 34 F. The temperature went up to 36 F within two to three minutes of opening the refrigerator. The DON stated she (DON) could not remember the required temperature range for storage of refrigerated medications. The DON opened the medication refrigerator temperature logbook as a reference which indicated documented temperatures for the month of August 2025 with a statement on the bottom of the page, Acceptable Range: Refrigerator: 35-40F Freezer: -0 to -20 Notify maintenance if out of range. The temperature logbook indicated 34 F as the documented medication refrigerator temperature for the morning of 08/19/2025. The DON stated the facility should have ensured the medication refrigerator temperature reference range and logbook indicated the correct required temperature range of 36 F to 46 F. During an interview on 8/20/2025 at 5:18 PM with the Pharmacist (RPH) 2 at Pharmacy (PH), RPH 2 stated the reference range for storage of medications in the refrigerator at the facility should be 36 F to 46 F. RPH 2 stated if the facility had the reference range to be 35 F to 40 F, it would not be an acceptable reference range. RPH 2 stated the stability of medications would be questionable in those circumstances where the reference range was 35 F to 40 F. During an interview on 8/21/2025 at 9:38 AM with the Consultant Pharmacist (RPH) 1, RPH 1 stated the reference range for storage and monitoring of medications in the refrigerator should be 36 F to 46 F (2 C to 8 C). RPH 1 stated the medication refrigerator temperature logbook that indicated the reference range as be 35 F to 40 F was incorrect. RPH 1 stated he (RPH1) would need to make sure that the facility provided additional training and education to the facility's nursing staff (in general) regarding medication refrigerator temperatures that must stay within a reference range of 36 F to 46 F. RPH 1 stated it was misleading that would misguide the facility nursing staff (in general) because of the incorrect reference range in the logbook which and not in accordance with the regulatory standards of 36 F to 46 F. 2. During a concurrent observation and interview on 8/19/2025 at 1:02 PM with the DON, in the Medication Room, the medication refrigerator contained a single-use vial of Resident 84's Epogen 10,000 units per milliliters ([mL] a unit of measurement for volume) stored in an amber vial and plastic bag with a note that indicated, Reordered 08-15-2025 PCC. The DON stated the nursing staff would keep the single-use Epogen vial for Resident 84's in the refrigerator to remind them (nursing staff in general) that it was reordered. The DON stated the vial was empty. The DON stated the nursing staff (unidentified) should have discarded the vial after one use or after a partial dose has been used from vial to prevent infection. According to the manufacturer's product labeling, unopened single-use vials should be stored between 2 and 8 C (36 and 46 F) and opened single-use vials and unused portions of single-use should be discarded and not reused. During a review of Resident 84's Order Summary Report dated 8/20/2025, the Order Summary Report indicated, but not limited to the following physician orders: Epoetin Alfa solution 10,000 units/mL, inject 10,000 units subcutaneously one time a day every Friday for anemia, hold if hemoglobin ([HgB] protein in red blood cells that carries oxygen from the lungs to the body's tissues and transports carbon dioxide back to the lungs) more than 11, order date 4/17/2025, start date 4/18/2025. During a review of the facility's P&P titled, Medication Storage in the Facility, dated 01/2025, the P&P indicated, Medications and biologicals are stored safely, securely, and properly, following

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 expired food was not stored in the kitchen for 76 of 84 residents who received food from the facility's kitchen. This deficient practice had the potential to cause food-borne illnesses to the residents related to ingestion of expired food and has a potential to lead to foodborne illnesses which can be life-threatening. During an initial kitchen tour observation on 8/18/2025 at 8:08 a.m. with the Dietary Manager (DM), it was observed to have undated and expired food items stored in the refrigerator: Undated prepared peanut butter and jellied sandwiches were stored in one of four refrigerators. Expired deli turkey slides were stored inside one of four refrigerators in a container with a label to use by 8/17/2025. During a concurrent observation and interview on 8/18/2025 at 8:08 a.m. with the Dietary Manager DM stated the label for the peanut butter and jellied sandwiches must have fallen off and that it should have a label when it was prepared and when to use by. DM stated the turkey deli should have been discarded. During an interview on 8/21/2025 at 2:02 p.m. with Registered Dietitian (RD) stated food must be labeled to avoid giving residents expired food which if given to residents, they can have gastrointestinal issues such as bacteria overgrowth. During a review of the facility's policy and procedure titled, Food Receiving and Storage, dated November 2024, states that all refrigerated or frozen foods must be labeled with a use-by date. Foods are monitored and either used by that date or discarded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to observe infection control measures by failing to wear appropriate personal protective equipment (PPE) while feeding residents on enhanced barrier precautions (EBP- infection control measures that require targeted use of gowns and gloves during high-contact resident care activities along with strict hand hygiene) for three of four sampled residents (Resident 39, Resident 44, and Resident 81)This failure had the potential to spread disease and infection among residents and staff. 1. During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was initially admitted to the facility on [DATE] with diagnoses including Candidiasis (C. auris- a multidrug resistant fungus that causes life-threatening infections) and cerebral infarction (stroke- loss of blood flow to part of the brain). During a review of Resident 39's Minimum Data Set (MDS- a resident assessment tool) dated 5/22/2025, the MDS indicated Resident 39 had severely impaired cognition (significant difficulty with memory, decision-making, and understanding) and upper body impairment. During a review of Resident 39's Order Summary Report (OSR- a monthly summary of all active physician orders) dated August 2025, the OSR indicated an order to place Resident 39 on Enhanced Barrier Precautions for C. auris. During a review of Resident 39's Care Plan (CP) dated 6/27/2024, the CP indicated Resident 39 is at risk for complications related to C. auris and to: always observe EBP and maintain infection control practices daily.During an observation on 8/18/2025 at 1:17 pm, a sign that stated Enhanced Barrier Precautions was posted in front of Resident 39's room. The sign indicated to wear gloves and a gown for high-contact resident care activities such as feeding. While at Resident 39's room, certified nursing assistant (CNA) 2 was observed leaning against Resident 39's side rail and spoon feeding Resident 39 without PPE. CNA 2 was also observed touching the food on Resident 39's tray with her bare hands and wiping Resident 39's mouth with a napkin without wearing gloves.During an interview on 8/18/2025 at 1:28 pm with CNA 2, CNA 2 stated she did not need to wear PPE while feeding residents on EBP because feeding was not considered a high contact activity. CNA 2 further explained feeding only referred to gastrostomy tubes (g-tube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach).During an interview with licensed vocational nurse (LVN) 1 on 8/18/2025 at 1:25 pm, LVN 1 explained that feeding did not only refer to g-tube feedings, but for the feeders who assist the residents to eat their meals as well. LVN 1 further stated feeders should always wear PPE when feeding the residents on EBP to prevent spreading infection and hospitalization for the residents. 2. During a review of Resident 44's admission Record, the admission Record indicated Resident 44 was admitted to the facility on [DATE] with diagnoses including methicillin resistant staphylococcus aureus (MRSA- a bacteria that does not respond to antibiotics) and stroke. During a review of Resident 44's MDS dated [DATE], the MDS indicated Resident 44 had severely impaired cognition and required touching assistance and supervision with eating (helper provides touching/steadying and or contact guard assistance as resident completes activity).During a review of Resident 44's OSR dated August 2025, the OSR indicated an order to place Resident 44 on EBP for MRSA. During a review of Resident 44's CP dated 8/13/2025, the CP indicated Resident 44 is on EBP for MRSA and to maintain EBP and hand hygiene, always observe EBP.During an observation on 8/18/2025 at 1:18 pm, a sign that stated Enhanced Barrier Precautions was posted in front of Resident 44's room. While on Resident 44's room, CNA 4 was observed leaning against Resident 44's side rail and spoon feeding Resident 44 without PPE. CNA 4 was also observed handling the food on Resident 44's tray with her bare hands and wiping Resident 44's mouth with a napkin without wearing gloves.During a concurrent record review and interview on 8/18/2025 at 1:20 pm with CNA 4, the EBP sign in front of Resident 44's door was reviewed. The EBP sign indicated to wear gloves and a gown for high-contact resident care activities such as feeding. CNA 4 stated, I should have been wearing PPE when feeding [Resident 44]. 3. During a review of Resident 81's admission Record, the admission Record indicated Resident 81 was admitted to the facility on [DATE] with diagnoses including C. auris and stroke. During a review of Resident 81's MDS dated [DATE], the MDS indicated Resident 81 had severely impaired cognition and upper body impairment. During a review of Resident 81's OSR dated August 2025, the OSR indicated an order to place Resident 81 on Enhanced Barrier Precautions for C. auris. During a review of Resident 81's CP dated 1/25/2025, the CP indicated Resident 81 is on EBP related to C. auris and to maintain EBP practice and maintain good hand hygiene (before, in between, and after care).During an observation on 8/18/2025 at 1:04 pm, a sign that stated Enhanced Barrier Precautions was posted in front of

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	056078	A. Building B. Wing	08/21/2025

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Alta View Post Acute	831 S Lake Street Los Angeles, CA 90057

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their protocol for Antibiotic (medicine that kill or stop the growth of bacteria) Stewardship for one of three sampled residents (Resident 62) by failing to complete an Infection Surveillance Outcome form (a tool used in healthcare to document and analyze infections and monitor antibiotic use in a facility) for Resident 62. This deficient practice had the potential to increase antibiotic resistance and provide antibiotics without justification for Resident 62. During a review of Resident 62's admission Record, the admission Record indicated Resident 62 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty breathing), skin cancer (uncontrolled growth of abnormal skin cells), and surgery of the scalp (the skin covering the top of the skull).During a review of Resident 62's Minimum Data Set (MDS- a resident assessment tool) dated 7/31/2025, the MDS indicated Resident 62 was cognitively intact and able to make decisions for herself. During a concurrent interview and record review on 8/20/2025 at 8:30 am with the Infection Preventionist (IP), Resident 62's Order Summary Report (OSR- a monthly summary of all active physician orders) dated August 2025 and Infection Surveillance Outcome form dated 7/25/2025 were reviewed. The OSR indicated Resident 62 was on the following medications: 1. Vancomycin (an antibiotic) for brain abscess (a localized collection of pus caused by infection) ordered on 7/25/2025 2. Meropenem (an antibiotic) for brain abscess ordered on 7/25/2025 3. Erythromycin (an antibiotic) ointment for inflammation of the eyelids ordered on 8/15/2025 4. Bacitracin Zinc (an antibiotic) ointment for status post scalp debridement (the removal of dead, damaged, or infected tissue to promote healing of a wound) ordered on 7/25/2025.The Infection Surveillance Outcome form indicated Resident 62's order for Vancomycin and Meropenem were not reviewed by the IP. The IP stated an Infection Surveillance Outcome should have been completed for the Vancomycin and Meropenem but was not done. The IP further stated proper review of antibiotic orders are important to determine if residents are on appropriate antibiotic therapy and to protect residents from developing multidrug resistant organism (MDRO- a germ that is resistant to many antibiotics) infections. During an interview with the Director of Nursing (DON) on 8/21/2025 at 1:55 pm, the DON stated the IP is responsible for the facility's Antibiotic Stewardship Program and the Infection Surveillance Outcome form should be completed for all residents that are on antibiotics. The DON further stated that when a resident is admitted to the facility with antibiotics, proper review and documentation should be completed with physician notification by the IP. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes dated April 2025, the P&P indicated: 1. Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. 2. As part of the facility's Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the IP, or designee. 3. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the pneumococcal vaccine (PVC 20) was administered to one of three residents sampled for immunizations (Resident 62) after Resident 62 consented to receive the vaccine.This failure had the potential to result in Resident 62 contracting, transmitting, and experiencing complications related to pneumococcal diseases such as pneumonia (an infection in the lungs), meningitis (inflammation of brain and spinal cord membranes), and sepsis (a life-threatening blood infection). During a review of Resident 62's admission Record, the admission Record indicated Resident 62 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty breathing), skin cancer (uncontrolled growth of abnormal skin cells), and surgery of the scalp (the skin covering the top of the skull).During a review of Resident 62's Minimum Data Set (MDS- a resident assessment tool), the MDS indicated Resident 62 was cognitively intact and able to make decisions for herself.During a concurrent interview and record review on 8/20/2025 at 8:30 am with the Infection Preventionist (IP), Resident 62's immunization record dated 8/20/2025, the consent records dated 8/5/2025, and medication administration record (MAR) dated July 2025 and August 2025 were reviewed. The consent records indicated Resident 62 consented and requested to receive the PVC 20 vaccine on 7/26/2025 but the immunization record indicated Resident 62 had not received the PVC 20 vaccine. The MAR dated July 2025 and August 2025 indicated Resident 62 had not been administered with the PVC 20 vaccine, resulting in a delay of 25 days since Resident 62 requested to receive the vaccine. The IP stated residents should have an order for the PVC 20 vaccine once residents sign the consent to receive it, but that was not done for Resident 62.During an interview with the Director of Nursing (DON) on 8/21/2025 at 1:55 pm, the DON stated the IP is responsible for ordering and administering the PVC 20 vaccine within 72 hours of obtaining consent from the residents, therefore Resident 62 should have received the PVC 20 vaccine three days after her consent was signed. The DON stated that ensuring the residents are up to date with the PVC 20 vaccines protects those residents from pneumococcal related diseases such as pneumonia. During a review of the facility's policy and procedure (P&P) titled Pneumococcal Vaccine dated January 2025, the P&P stated, Pneumococcal vaccines are administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol. The P&P further stated, All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer COVID-19 vaccines for three of three residents sampled for immunizations (Resident 4, resident 62, and Resident 96). This deficient practice had the potential to result in Resident 4, Resident 62, and Resident 96 contracting, transmitting, and experiencing complications related to COVID-19 such as acute respiratory distress syndrome (ARDS- life-threatening lung injury), pneumonia (an infection/inflammation in the lungs), respiratory failure requiring oxygen, and sepsis (overwhelming infection spreading throughout the body).1. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted on [DATE] with diagnoses including anxiety, depression, psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with reality), delusional disorders (having false or unrealistic beliefs), and auditory hallucinations (false perceptions of sound, such as hearing voices or noises that are not present). During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool) dated 7/17/2025, the MDS indicated Resident 4 had severely impaired cognition (significant difficulty with memory, decision-making, and understanding). During a concurrent interview and record review on 8/20/2025 at 8:30 am with the Infection Preventionist (IP), Resident 4's immunization record dated 8/20/2025 and consent records dated 7/14/2025 were reviewed. The immunization record indicated Resident 4 received her last dose of the COVID-19 vaccine on 9/22/2022. The consent records indicated Resident 4 did not receive information on the COVID-19 vaccine and was not offered COVID-19 vaccination when admitted to the facility. The IP stated Resident 4 should have been screened and consented for the COVID-19 vaccine upon admission and was not. 2. During a review of Resident 62's admission Record, the admission Record indicated Resident 62 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty breathing), (uncontrolled growth of abnormal skin cells), and surgery of the scalp (the skin covering the top of the skull). During a review of Resident 62's Minimum Data Set (MDS- a resident assessment tool) dated 7/31/2025, the MDS indicated Resident 62 was cognitively intact and able to make decisions for herself. During a concurrent interview and record review on 8/20/2025 at 8:30 am with the Infection Preventionist (IP), Resident 62's immunization record dated 8/20/2025 and consent records dated 8/5/2025 were reviewed. The immunization record indicated Resident 62 had no historical records of receiving the COVID-19 vaccine. The consent records indicated Resident 62 did not receive information on the COVID-19 vaccine and was not offered COVID-19 vaccination when admitted to the facility. The IP stated Resident 62 should have been screened and consented for the COVID-19 vaccine upon admission and was not. 3. During a review of Resident 96's admission Record, the admission Record indicated Resident 96 was admitted to the facility on [DATE] with diagnoses including paraplegia (loss of movement and/or sensation, to some degree, of the legs) and urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 96's hospital records dated 8/14/2025, the hospital records indicated Resident 96 was alert and oriented to person, place, and time and appropriately responsive to questions. During a concurrent interview and record review on 8/20/2025 at 8:30 am with the Infection Preventionist (IP), Resident 96's immunization record dated 8/20/2025 and consent record as of 8/20/2025 was reviewed. The medical records indicated Resident 96 received her last dose of the COVID-19 vaccine on 12/13/2023. The consent records indicated Resident 96 did not receive information on the COVID-19 vaccine and was not offered COVID-19 vaccination when admitted to the facility. The IP stated Resident 96 should have been screened and consented for the COVID-19 vaccine upon admission but was not. During an interview with the Director of Nursing (DON) on 8/21/2025 at 1:55 pm, the DON stated the IP is responsible for screening, consenting, and administering the COVID-19 vaccine to residents upon admission. The DON further stated Resident 4, Resident 62, and Resident 96 should have been consented for the COVID-19 vaccine when admitted to the facility. Ensuring the residents are up to date with the COVID-19 vaccine is important to protect them from contracting and spreading COVID-19. During a review of the facility's P&P titled Coronavirus Disease (COVID-19) - Vaccination of Residents dated April 2025, the P&P indicated each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated, or the resident is fully vaccinated. The P&P further indicated the resident is provided with education regarding the benefits, risks, and potential side effects associated with the COVID-19 vaccine. COVID-19 vaccine education, documentation and reporting are overseen by the infection preventionist and

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview and record review, the facility failed to ensure kitchen freezer #1 and freezer #2 was maintained at 0-degree Fahrenheit (F-unit of measurement) temperature while hashbrowns, whipped topping, french fries, assorted vegetables, sweet potato fries were store. This deficient practice placed 76 of 84 residents residing in the facility at risk for foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages). During a concurrent initial kitchen tour observation on 8/18/2025 at 8:03 a. m. and interview with the Dietary Manager (DM), the following were observed. a. Freezer #1 is located outside the storeroom. The internal thermometer reads 12 degrees F. b. Freezer #2 located inside the storeroom, the internal thermometer reads 10 degrees F. During an interview with DM, stated the staff had moved items around to fit new incoming food supplies that were to be delivered. DM stated staff had been opening the freezers for breakfast preparation and that's why the temperature was not 0 degrees or less. During a subsequent observation on 8/18/2025 at 10:15 accompanied by the DSS the freezer temperature internal thermometer read 10 degrees F. The freezer located inside storeroom internal thermometer temperature reading was 0 degrees F. During an observation on 8/19/2025 at 8:10 a.m. Freezer #1 located outside the storeroom the internal thermometer read 12 degrees F. The DM stated staff had been opening the freezer for breakfast preparation and that's why the temperature was not 0 degrees. During an observation on 8/19/2025 at 4:08 p.m. the freezer internal thermometer temperature was 10 degrees F. During an interview with DM on 8/19/2025 at 8:12 a.m. stated the freezer should be at 0 degrees F or below. DM stated, if the freezer it is not with the correct temperature the food can get spoiled and if the food is fed to the residents, they can get sick depending on the severity the resident can end up in the hospital. During a telephone interview on 8/19/2025 at 10:02 p.m. The Registered Dietitian (RD) stated that the freezer should be at 0 degrees F or below and rechecked after 15 minutes if it is out of range. RD stated the refrigerator/freezer temperatures are monitored in the morning and afternoon and are logged in to prevent danger zone, bacteria overgrowth and spoil food. RD stated spoiled food is given to the residents, it can impact on the residents' health. During a review of the facility's policy and procedure titled, Refrigerators and Freezers dated and revised on November 2024, indicated acceptable ranges are less than 0 degrees F for freezers.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review the facility failed to ensure 12 hours required in-service training for one of two sampled Restorative Nursing Assistant (RNA). This deficient practice has a potential to compromise residents safety due to RNA training was insufficient. Findings:During a concurrent interview and record review on 8/21/2025 at 8:19 AM with Interim Director of Staff Development (IDSD)IDSD and RNA 1 employee file out of five sampled employees, the IDSD stated there is no training prior to going on the floor for RNA 1, The employee file packet does not have the required in-service training for RNA 1. IDSD stated employee file was missing a documentation of the required mandatory in-service. IDSD stated that Dementia in-service training hours as of August 2024-August 2025 only showed 1 hour and abuse in-service hours as of August 2024-Agust 2025) showed a total of 9 hours accordingly. IDSD stated that it is not enough trainings before taking care of elderly can put residents at risk to get abused or unable to meet demented resident's needs. During a record review of the in-service's binder for the year 2024, on Dementia mandatory training, one (1) hour was provided to the staff on the month of August 2024. During a record review of the in-service's binder for the Abuse mandatory training titled Elder Abuse, the binder shows 9 hours for the months August 2024-August 2025 t During a review of the facility's policy and procedure titled, In-Service Training, All Staff , dated , April 2025 (revised), the P&P indicated, in the Policy Statement, All staff must participate in initial orientation and annual in-service training. and under Policy Interpretation and Implementation (1) All staff are required to participate in regular in-service education. In-service education participation is considered working time for which staff are paid their regular wages., and (2) For the purposes of this policy, Staff means all new and existing personnel, individuals providing services under contractual agreement, and volunteers.