

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056113	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/25/2025
NAME OF PROVIDER OR SUPPLIER  Alexandria Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1515 N Alexandria Ave. Los Angeles, CA 90027	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878</b></p> <p>Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm by one resident towards another) for one of two sampled residents (Resident 2) when on 2/17/2025 at 6:25 p.m., Certified Nursing Assistant (CNA) 1 witnessed Resident 3 hit Resident 2 with closed fists, hitting Resident 2 on the right side of Resident 2's head.</p> <p>This deficient practice resulted in Resident 2 being subjected to physical abuse by Resident 3 while under the care of the facility. Resident 2 had pain scale (a tool used by doctors to measure how much pain someone is feeling) of 3 out of 10 (you feel a noticeable pain that might distract you a bit, but you can still manage it and adapt to it), requiring acetaminophen (a pain reliever) 325 milligrams (mg-unit of measurement) two (2) tablets by mouth.</p> <p>Based on the Reasonable Person Concept (the usual behavior of an average person under the same circumstances), due to Residents 2's impaired cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) and medical condition, an individual subjected to physical abuse may have physical pain, psychological (mental or emotional) effects including feelings of hopelessness (a feeling or state of despair or lack of hope), helplessness (the belief that there is nothing that anyone can do to improve a bad situation), and humiliation (the feeling of being ashamed or losing respect for own self).</p> <p>Findings:</p> <p>a. During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted Resident 2 on 4/13/2022 with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and essential (primary) hypertension (HTN-high blood pressure).</p> <p>During a review of Resident 2's Physician orders, dated 4/14/2022, the physician order indicated acetaminophen tablet 325 mg give 2 tablets by mouth every 4 hours as needed for mild pain 1 to 3.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 1/5/2025, the MDS indicated Resident 2's cognition was moderately impaired. The MDS indicated Resident 2 required partial assistance (helper does less than half the effort) with showering, requires supervision (helper provides verbal cues) with oral hygiene, and required set up (helper sets up or cleans up) with eating, toileting, upper and lower body dressing, putting on and taking off footwear and personal hygiene.</p> <p>During a review of Resident 2's Change in Condition (COC - a significant change in resident's health status) Evaluation, dated 2/17/2025 at 6:25 p.m., the COC indicated a resident-to-resident altercation. At around 6:25 p.m. Licensed Vocational Nurse (LVN) 1 was at the station and saw Resident 2 getting linen from the linen cart in front of Room A in the hallway Resident 3 was walking towards the dining room with CNA 1 next to him when all of the sudden, Resident 3 turned around and swung his hand and hit Resident 2 on her (Resident 2) right temporal side. Resident 2 stated a little bit of pain 3 out of 10, acetaminophen 325 mg 2 tablets by mouth given with relief.</p> <p>During a review of Resident 2's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 2/2025, the MAR indicated acetaminophen 325 mg was given on 2/17/2025 at 6:53 p.m.</p> <p>b. During a review of Resident 3's Admission Record, the Admission Record indicated the facility admitted Resident 3 on 2/26/2020 with diagnoses including unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), essential (primary) hypertension (HTN-high blood pressure) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognition was severely impaired. The MDS indicated Resident 2 required partial assistance with toileting, showering, upper and lower body dressing, putting on and taking off footwear and personal hygiene and required supervision with eating and oral hygiene.</p> <p>During a review of Resident 3's Physician Order ,dated 2/6/2023, the physician order indicated to monitor for episodes of psychosis with agitation and hitting staff.</p> <p>During a review of Resident 3's COC Evaluation, dated 2/17/2025 at 6:25 p.m., the evaluation indicated resident to resident altercation. At 6:25 p.m. Resident 3 was walking along the hallway towards the dining room with CNA 1 next to him and Resident 2 was by the linen cart getting a pillowcase and LVN 1 was in front of the linen cart. All of a sudden Resident 3 turned around and swung his hand and hit Resident 2 on Resident 2's right temporal side.</p> <p>During an interview on 2/25/2025 at 12:22 p.m. with Resident 2, Resident 2 stated Resident 3 was always going into Resident 2's room, and will even find him sleeping on her (Resident 2) bed. Resident 2 stated Resident 3 will go into the backyard and knock on my door to come in. Resident 2 stated does not recall the date, but it was at nighttime, Resident 3 was following her in the hallway. Resident 2 stated she told Resident 3, stop following me, and stay away from me. Resident 2 stated she then walked over to the linen cart and that was when Resident 3 with his right closed fist hand hit Resident 2 on her right temporal. Resident 2 stated she was given acetaminophen (Tylenol) for the pain. Resident 2 stated since incident Resident 3 has had a sitter but Resident 2 does not feel safe because Resident 3 has previously come into her room.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/25/2025 at 1:59 p.m. with CNA 1, CNA 1 stated Resident 3 is able to ambulate on his own, is very confused, will hit doors, has history of going to other residents' rooms. CNA 1 stated incident with Resident 2 and Resident 3 occurred on 2/17/2025 around 6 p.m. CNA 1 stated was walking in hallway towards the dining room and saw Resident 2 by the nurses' station at the linen cart and Resident 3 was right next to Resident 2. CNA 1 stated Resident 2 and Resident 3 were not talking or arguing and suddenly Resident 3 with his closed fists, hitting Resident 2's on the right side of her head. CNA 1 stated this would be considered abuse because it was intentional even though the resident is confused.</p> <p>During an interview on 2/25/2025 at 2:27 p.m. with LVN 1, LVN 1 stated Resident 3 gets confused and sometimes will wander into other residents' room with periods of confusion, ambulatory on own, and also has language barrier. LVN 1 stated was working the day of the incident that happened on 2/17/2025 around 6:25 p.m. LVN1 stated was in the nurses' station in front of Room A. LVN 1 stated Resident 2 was taking a pillowcase from cart and the cart was outside of Room A by the door, and then Resident 3 was walking towards dining room and suddenly turned around and hit Resident 2 with his (Resident 3) left hand and not sure if his hands were opened or close. LVN 1 stated Resident 2 then reacted by trying to hit Resident 3 with the pillowcase but LVN1 was able to get in the middle of Resident 2 and Resident 3. LVN 1 stated Resident 2 complained of a little pain 3 out of 10 and was given acetaminophen. LVN 1 stated based on what she knows would think because Resident 3 does not understand but it is still like abuse because there was a hitting incident but cannot say if it was intentional. LVN 1 stated hitting is still hitting because you are going to harm someone. LVN 1 stated it is abuse.</p> <p>During an interview on 2/25/2025 at 3:43 p.m. with the Administrator (Adm), the Adm stated was notified on 2/17/2025 around 6:35 p.m. by LVN 1 that Resident 2 was getting a pillowcase from line cart when Resident 3 swung his hand and hit Resident 2. The Adm stated this incident was considered an altercation because Resident 2 was hit. The Adm stated Resident 3 does have behaviors of wandering that is why he is in memory care unit. The Adm stated Resident 3 will go to Resident 2's room. The Adm stated not sure if this would be considered abuse but the fact that he did hit Resident 2 it happened not sure if it was intentional because it was so sudden with no indication, no interaction, or no argument prior to the incident.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Abuse Prohibition, last reviewed on 10/25/2024, the P&amp;P indicated health care centers prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. Abuse is defined as the willful infliction of injury, unreasonable confinement, or punishment with resulting physical harm, injury, or mental anguish. Physical abuse includes hitting, slapping, pinching, kicking, etc. as well as controlling behavior through corporal punishment.</p>		