STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056113	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alexandria Care Center	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on observation, interview, and record review, the facility failed to ensure a call light device (also known as a call bell or nurse call button, is a device typically found near a patient's bed or within reach consisting of a button that, when pressed, sends a signal to the nursing station or a centralized system, alerting healthcare providers that assistance is required in the room) was within residents reach for three of three sampled residents (Residents 1, 2, and 3). This deficient practice had the potential to result in the delay in the residents' care and not receiving assistance timely. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 8/27/2021, with diagnoses that included unspecified (unconfirmed) chronic kidney disease (CKD-a condition where the kidneys are damaged and cannot filter blood properly, leading to a buildup of waste and fluid in the body), dementia (a progressive state of decline in mental abilities) and essential hypertension (a condition characterized by persistently high blood pressure without an identifiable underlying cause). During a review of Resident 1 ' s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) dated 2/12/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 2/12/2025, the MDS indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required maximum assistance from staff for toileting, showering and personal hygiene. The MDS indicated Resident 1 was always incontinent (unable to control) of bowel and bladder functions. During a review of Resident 1 ' s Care Plan on unwitnessed fall dated 2/28/2025, the Care Plan indicated an intervention that the call light will be within reach. During a concurrent observation and interview on 3/28/2025, at 9:31 a.m., with Resident 1, at Resident 1 ' s bedside, observed Resident 1 ' s call light hanging on the wall. Resident 1 stated she (Resident 1) do not know what a call light was and do not know where it was. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 - Some	During a concurrent observation and interview on 3/28/2025, at 9:32 a.m., with Certified Nursing Assistant 1 (CNA1), at Resident 1 ' s bedside, Resident 1 ' s call light was hanging on the wall. CNA 1 stated Resident 1 ' s call light was on the wall and Resident 1 was unable to reach it. CNA 1 stated he (CNA 1) forgot to check if Resident 1 had the call light. CNA 1 stated sometimes nurses does not put it back within Resident 1 ' s reach. During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted Resident 2 on 3/8/2021, with diagnoses that included unspecified (unconfirmed) dementia, essential hypertension and dysphagia (difficulty in swallowing). During a review of Resident 2 ' s H&P dated 2/12/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 ' s cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 2 required moderate assistance from staff for oral hygiene, dressing and personal hygiene. The MDS indicated Resident 2 was frequently incontinent of bowel and bladder functions. During a review of Resident 2 ' s Care Plan on at risk for fall dated 3/9/2021, the Care Plan indicated an intervention to place call light within reach while resident in bed or close proximity to the bed. During a concurrent observation and interview on 3/28/2025, at 9:38 a.m., with Licensed Vocational Nurse 1 (LVN 1), inside Resident 2 ' s room. Observed Resident 2 ' s call light behind the upper part of the bed on the floor. LVN 1 stated call light was on the floor on the upper part of the bed. LVN 1 stated Resident 2 was unable to reach the call light. LVN 1 stated nurses would not be able to attend to resident needs when Resident 2 calls for assistance. During a review of Resident 3 ' s Admission Record, the Admission Record indicated the facility admitted Resident 3 on 2/9/2018, with diagnoses that included Alzheimer ' s Disease (a disease characterized by a progressive decline in mental abilities), unspecified atrial fibrillation (an irregular and often very rapid heart rhythm) and essential hypertension. During a review of Resident 3 ' s MDS dated [DATE], the MDS indicated Resident 3 ' s cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 3 was always incontinent of bowel and bladder functions. During a review of Resident 3 ' s Care Plan on at risk for fall dated 2/13/2018, the Care Plan indicated an intervention to place call light within reach while resident in bed or close proximity to the bed. During a concurrent observation and interview on 3/28/2025, at 9:38 a.m., with LVN 1, inside Resident 3 ' s room. Observed Resident 3 ' s call light on the floor on Resident 3 ' s right side of the bed. LVN 1 stated call light was on the floor. LVN 1 stated Resident 3 was unable to reach the call light. LVN 1 stated nurses would not be able to attend residents needs when Resident 3 calls for assistance. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/28/2025, at 10:06 a.m. with the Director of Nursing (DON), the DON stated nurses should make sure residents can reach their call lights. The DON stated the facility ' s policy was to make sure residents call light was within reach. The DON stated if residents unable to reach their call lights, residents will not be able to use it to ask for assistance and can result to a delay in care. During a review of facility ' s policy and procedure (P&P) titled, Answering the Call Light, dated 10/24/2024, and last reviewed on 1/2025, the P&P indicated, 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.

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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. 42311 Based on interview and record review, the facility failed to implement a person-centered care plan for one of three sampled residents (Resident 1) by failing to ensure care plan was followed on the use of low air loss mattress (LALM-a mattress designed to distribute the patient's body weight over a broad surface area to prevent skin breakdown and treat pressure ulcers [a localized injury to the skin and or underlying tissue usually over a bone prominence as a result of pressure or pressure in combination with shear and may lead to deep tissue injury]). This deficient practice had the potential for delayed provision of necessary care and services and had the potential for the development of pressure ulcers or injuries for Resident 1. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 8/27/2021, with diagnoses that included unspecified (unconfirmed) chronic kidney disease (CKD-a condition where the kidneys are damaged and cannot filter blood properly, leading to a buildup of waste and fluid in the body), dementia (a progressive state of decline in mental abilities) and essential hypertension (a condition characterized by persistently high blood pressure without an identifiable underlying cause). During a review of Resident 1 ' s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) dated 2/12/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 2/12/2025, the MDS indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required maximum assistance from staff for toileting, showering and personal hygiene. The MDS indicated Resident 1 was always incontinent (unable to control) of bowel and bladder functions. The MDS indicated Resident 1 had pressure reducing device for bed. During a review of Resident 1 ' s Order Summary Report dated 1/31/2025, the Order Summary Report indicated an order for low air loss, weight base, 100-150 every shift for skin maintenance and prevention. During a review of Resident 1 ' s Weights and Vitals Summary dated 3/4/2025, the Weights and Vitals Summary indicated Resident 1 was 111.8 pounds (lbs.-unit of measurement). During a review of Resident 1 ' s Braden Scale for Predicting Pressure Sore Risk dated 3/17/2025, the Braden Scale indicated Resident 1 was at mild risk for pressure sore. During an observation on 3/28/2025, at 9:30 a.m. at Resident 1 ' s bedside, observed Resident 1 ' s LALM control unit at 200 lbs. setting. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/28/2025, at 9:32 a.m., with Certified Nursing Assistant 1 (CNA 1), at Resident 1 ' s bedside. Observed Resident 1 ' s LALM control unit setting at 200. During a concurrent observation and interview on 3/28/2025, at 9:42 a.m. with Licensed Vocational Nurse 1 (LVN 1), at Resident 1 ' s bedside. LVN 1 stated Resident 1 ' s LALM control unit setting at 200. During a concurrent interview and record review on 3/28/2025, at 10:49 a.m., with the Director of Nursing (DON), Resident 1 ' s Care Plan on at risk for skin breakdown dated 1/31/2025 was reviewed. The Care Plan Indicated Resident 1 ' s LALM setting at 100-150. The DON stated Resident 1 ' s LALM setting of 200 was different from the care plan setting of 100-150. The DON stated Resident 1 ' s LALM setting should be from 100-150 as indicated in the Care Plan. The DON stated the importance of following the care plan was to prevent skin breakdown. During an interview on 4/1/2025, at 10:34 a.m., with Treatment Nurse 1 (TN 1), TN 1 stated if LALM setting was over Resident 1 ' s weight, the LALM will be firmer and will not protect Resident 1 ' s skin, causing more pressure instead of relieving the pressure. During an interview on 4/1/2025, at 11:01 a.m., with the Director of Staff Development (DSD), the DSD stated LALM setting is based on comfort and manufacturer but usually is based on resident ' s weight. The DSD stated if care plan indicated 100-150 then setting of the LALM should be at 100-150 and not 200. The DSD stated care plan should be followed. During a review of facility ' s policy and procedure (P&P) titled, Care Plan Comprehensive, dated 8/25/2021 and last reviewed on 1/2025, the P&P indicated, III. PROCEDURE 1. Each resident ' s comprehensive care plan is designed to: a. Incorporate identified problem areas. b. Incorporate risk and contributing factors associated with identified problems. c. Build on the resident's individualized needs, strengths, preferences. d. Build on the resident's individualized needs, strengths, preferences. e. Reflect the resident's expressed wishes regarding care and treatment goals. f. Reflect treatment goals, timetables, and objectives in measurable outcomes. g. Identify the professional services that are responsible for each element of care. h. Aid in preventing or reducing declines in the resident's functional status and/or functional levels. 2. The comprehensive care plan includes the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42311 Based on observation, interview, and record review, the facility failed to ensure a resident received care consistent with professional standards of practice to prevent pressure ulcer (a localized injury to the skin and or underlying tissue usually over a bone prominence as a result of pressure or pressure in combination with shear [occur between the internal body structures and skin tissues typically moving in opposite directions and may lead to deep tissue injury]) for one of three sampled residents (Resident 1) by failing to ensure the low air loss mattress (LALM-a mattress designed to distribute the patient's body weight over a broad surface area to prevent skin breakdown and treat pressure ulcers) machine was functioning as indicated in the Operators Manual. This deficient practice had the potential for Resident 1 to develop pressure ulcers or injuries. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 8/27/2021, with diagnoses that included unspecified (unconfirmed) chronic kidney disease (CKD-a condition where the kidneys are damaged and cannot filter blood properly, leading to a buildup of waste and fluid in the body), dementia (a progressive state of decline in mental abilities) and essential hypertension (a condition characterized by persistently high blood pressure without an identifiable underlying cause). During a review of Resident 1 ' s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) dated 2/12/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 2/12/2025, the MDS indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required maximum assistance from staff for toileting, showering and personal hygiene. The MDS indicated Resident 1 was always incontinent (unable to control) of bowel and bladder functions. The MDS indicated Resident 1 had pressure reducing device for bed. During a review of Resident 1 ' s Order Summary Report dated 1/31/2025, the Order Summary Report indicated an order for low air loss, weight base, 100-150 every shift for skin maintenance and prevention. During a review of Resident 1 ' s Weights and Vitals Summary dated 3/4/2025, the Weights and Vitals Summary indicated Resident 1 was 111.8 pounds (lbs.-unit of measurement). During a review of Resident 1 ' s Braden Scale for Predicting Pressure Sore Risk dated 3/17/2025, the Braden Scale indicated Resident 1 was at mild risk for pressure sore. During an observation on 3/28/2025, at 9:30 a.m. at Resident 1 ' s bedside, observed Resident 1 ' s LALM control unit had the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Cycle time 10 minutes, 15 minutes, 20 minutes and 25 minutes indicator had all light up. 2. Patient weight indicator at 200 lbs. 3. Low pressure light indicator on. 4. Mute button indicator on. During a concurrent observation and interview on 3/28/2025, at 9:32 a.m., with Certified Nursing Assistant 1 (CNA 1), at Resident 1 ' s bedside. Observed Resident 1 ' s LALM control unit had low pressure light on, residents weight at 200 and machine button light on. CNA 1 stated yesterday (3/27/2025), the LALM control unit had low pressure light on and that he (CNA 1) had reported to the Treatment Nurse 1 (TN 1). CNA 1 stated Resident 1 ' s LALM control unit low pressure light was on, all the time. CNA 1 stated he (CNA 1) believed the facility did not fix it. During an interview on 3/28/2025, at 9:38 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated TN 1 was informed of Resident 1 ' s broken LALM control unit yesterday (3/27/2025). During a concurrent observation and interview on 3/28/2025, at 9:42 a.m. with LVN 1, at Resident 1 ' s bedside. LVN 1 stated Resident 1 ' s LALM control unit showed low pressure and weight at 200 lbs. LVN 1 stated if LALM control unit light for low pressure was on it meant that there was not enough air in the LALM and may result to recurrent (condition or symptom that returns or appears again) wound or pressure ulcer. During an interview on 3/28/2025, at 9:53 a.m., with TN 2, TN 2 stated there were no reported issues on LALM today 3/28/2025. TN 1 stated light on low pressure indicator of LALM maybe from air leak, faulty tubing or sensor not working properly. TN 2 stated it can cause pain and Resident 1 can be uncomfortable if low pressure light was on too long. During an interview on 3/28/2025, at 10:06 a.m., with the Director of Nurses (DON), the DON stated if nurses see any light or blinking light on the LALM, nurses should check it as it is a warning sign that LALM might have a problem. The DON stated low pressure light indicator may mean that the machine was not blowing enough air pressure in the bed. The DON stated LALM should have been fixed right away. The DON stated LALM cannot be muted as the warning sound cannot be heard if there was a problem with the machine. During a concurrent interview and record review on 3/28/2025, at 10:49 a.m., with the DON, Resident 1 ' s Care Plan on at risk for skin breakdown dated 1/31/2025 was reviewed. The Care Plan Indicated Resident 1 ' s LALM setting at 100-150. The DON stated Resident 1 ' s LALM setting of 200 was different from the care plan setting of 100-150. The DON stated Resident 1 ' s LALM setting should be from 100-150 as indicated in the Care Plan. The DON stated the facility ' s policy for use of LALM did not indicate when to fix the LALM. The DON stated CNA 1 should have reported it today (3/28/2025) if he (CNA 1) had observed that Resident 1 ' s LALM control unit had lights on. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/1/2025, at 10:34 a.m., with TN 1, TN 1 stated on the morning of 3/27/2025, CNA 1 had reported that Resident 1 ' s LALM was not inflating. TN 1 stated she (TN 1) had fixed the LALM on 3/27/2025 after CNA 1 had reported. TN 1 stated if LALM setting was over Resident 1 ' s weight, the LALM will be firmer and will not protect Resident 1 ' s skin, causing more pressure instead of relieving the pressure. TN 1 stated the mute button should not light up because it will not alarm the staff if the LALM had a problem. TN 1 stated the LALM should have one cycle light on only, whether 10, 15, 20, or 25 minutes. TN 1 stated the cycle indicates alternating pressure. TN 1 stated Resident 1 will be at risk for pressure ulcer if the LALM was not fixed right away. During an interview on 4/1/2025, at 11:01 a.m., with the Director of Staff Development (DSD), the DSD stated LALM setting is based on comfort and manufacturer but usually is based on resident ' s weight. The DSD stated if care plan indicated 100-150 then setting of the LALM should be at 100-150 and not 200. During a review of LALM Operators Manual provided by the facility, the Operators Manual indicated, Drive Support Surfaces are high quality and affordable air replacement mattress systems. Specifically designed to redistribute pressure, these systems offer a solution for the prevention and treatment of pressure ulcers and offers an optimal solution for pressure redistribution and microclimate control. Drive Support Surfaces are designed and constructed to reduce the incidence of pressure ulcers while optimizing patient comfort. Mute Button, the audible/visible alarm turns on either when the pressure is low, or the system fails to alternate. Cycle Time Button can be used to select the appropriate cycle time of the inflation mode. There are 4 different cycle times available: 10, 15, 20 and 25 minutes. The Weight Setting Buttons positive (+) and negative (-) can be used to adjust the pressure. Is based on the patient's weight. Low pressure indicator, this indicator light (red) flickers when the pressure is below the pre-defined level. Maintenance and Storage: Low pressure, examine if there is air leakage between the control unit and the mattress connections or from the air mattress tubes. Set the unit to the highest weight setting. Keep the tubes fully inflated and inspect for air leakage from cells. Make sure that no leakage occurs. If any leakage occurs, please contact your local agent or dealer. If the pressure is consistently low, the audible alarm will beep, and its indicator will light up to attract attention. If there should be obvious leakage, for example caused by loose connection of tubes, the audible/visible alarm will be activated. If the pressure drops below the pre-defined level, the low-pressure indicator will light up accompanied by a beep alarm tone. Operation: Weight Setting Selection, the pressure of the mattress can be adjusted by choosing the patients' corresponding weight setting.

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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. 42311 Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of three sampled residents (Resident 2) by failing to ensure the physician order was followed. This deficient practice had the potential to result in medication error and can cause hypotension (low blood pressure). Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted Resident 2 on 3/8/2021, with diagnoses that included unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities), essential hypertension (HTN- high blood pressure) and dysphagia (difficulty in swallowing). During a review of Resident 2 ' s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) dated 2/12/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2 ' s Minimum Data Set (MDS-a resident assessment tool) dated 3/6/2025, the MDS indicated Resident 2 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 2 required moderate assistance from staff for oral hygiene, dressing and personal hygiene. During a review of Resident 2 ' s Physician Order dated 1/24/2023, the Physician Order indicated the following orders: 1.Carvedilol (medication used to treat HTN) tablet 6.25 milligram (mg-metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth two times a day for HTN, hold for systolic blood pressure (sbp- the pressure in the arteries when the heart contracts and pumps blood throughout the body, the upper number) lower than 100 or diastolic blood pressure (dbp- the pressure in the arteries when the heart is resting between beats, the lower number) lower than 60. 2. Losartan potassium (medication used to treat HTN) tablet 50 mg, give one tablet by mouth two times a day for HTN, hold for sbp lower than 100 or dbp lower than 60. During a review of Resident 2 ' s Medication Administration Record (MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 3/7/2025, the MAR indicated carvedilol, and losartan was given to Resident 2 on 3/7/2025 at 9 a.m., with a blood pressure of 104/53. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/1/2025, at 10:48 a.m., with Licensed Vocational Nurse 1 (LVN 1), Resident 2 ' s Physician Order dated 1/24/2023 and MAR dated 3/7/2025 was reviewed. LVN 1 stated she (LVN 1) had administered carvedilol and losartan to Resident 2 with a blood pressure of 104/53. LVN 1 stated she (LVN 1) should have held the medication and should have notified and clarified the order with the physician. LVN 1 stated administering blood pressure medication without following physician order can result to Resident 2 ' s hypotension (low blood pressure). During an interview on 4/1/2025, at 11:01 a.m., with the Director of Staff Development (DSD), the DSD stated LVN 1 should have held the carvedilol and losartan as ordered by the physician. The DSD stated LVN 1 did not follow the physician order. The DSD stated Resident 2 can have low blood pressure, get dizzy and experience orthostatic hypotension (a condition where blood pressure drops significantly when a person stands up). During an interview on 4/1/2025, at 11:26 a.m., with the Director of Nursing (DON), the DON stated LVN 1 should have held the carvedilol and losartan as per physician order. The DON stated Resident 2 ' s blood pressure will be affected and further cause hypotension. The DON stated LVN 1 should have clarified the order with the physician if the 60 was the dbp or the heart rate. During a review of facility ' s policy and procedure (P&P) titled, Administering Medications dated 4/2019 and last reviewed on 1/2025, the P&P indicated, 4. Medications are administered in accordance with prescriber orders, including any quired time frame 11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056113	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alexandria Care Center	1515 N Alexandria Ave. Los Angeles, CA 90027

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42311 Based on interview and record review the facility failed to maintain accurate and complete medical record for one of three sampled residents (Resident 2). This deficient practice resulted to Resident 2's medical records contain inaccurate documentation and had the potential to cause confusion in Resident 2's care. Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted Resident 2 on 3/8/2021, with diagnoses that included unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities), essential hypertension (HTN- high blood pressure) and dysphagia (difficulty in swallowing). During a review of Resident 2 ' s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) dated 2/12/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2 ' s Minimum Data Set (MDS-a resident assessment tool) dated 3/6/2025, the MDS indicated Resident 2 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 2 required moderate assistance from staff for oral hygiene, dressing and personal hygiene. During a review of Resident 2 ' s Physician Order dated 11/11/2024, the Physician order indicated anticoagulant medication (medications that prevent blood from clotting too quickly or easily) monitor for discolored urine, black tarry (black, sticky, and often foul-smelling) stools, sudden severe headache, nausea, vomiting, diarrhea, muscle joint pain, lethargy (a state of unusual tiredness, sluggishness, and a lack of energy), bruising, sudden changes in mental status and or vital signs (clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions), shortness of breath, nose bleeds-document Y if monitored and none of the above was observed. Document N if monitored and any of the above was observed every shift. During a review of Resident 2 ' s Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 3/2025, the MAR indicated N on the following dates and times: 1. 7 a.m. to 3 p.m.- 3/5/2025 and 3/23/2025 2. 3 p.m. to 11 p.m.- 3/13/2025 and 3/23/2025 3. 11 p.m., to 7 a.m.- 3/1/2025, 3/9/2025, 3/13/2025, 3/17/2025, 3/22/2025 and 3/23/2025. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/28/2025, at 10:49 a.m., with the Director of Nursing (DON), Resident 2 ' s Progress Notes dated 3/2025 was reviewed, The DON stated Resident 2 was on anticoagulant. The DON stated residents on anticoagulant was monitored for signs of bleeding. The DON stated if staff observed signs of bleeding, physician will be notified and documented in progress notes or change of condition. The DON stated there were no documented signs of bleeding in Resident 2 ' s Progress Notes. During an interview on 4/1/2025, at 10:48 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated residents on anticoagulant was monitored for bleeding and documented in MAR. LVN 1 stated she (LVN 1) documented Y for presence of bleeding and N if no bleeding observed. LVN 1 stated she (LVN 1) had mistakenly documented presence of bleeding but had never observed any signs of bleeding. LVN 1 stated the importance of accurate documentation was for accurate monitoring and physician notification. LVN 1 stated inaccurate documentation can cause confusion if presence or absence of bleeding. During an interview on 4/1/2025, at 11:10 a.m., with the Director of Staff Development (DSD), the DSD stated nurses had misread the order and did not document according to physician order. The DSD stated nurse documentation can cause confusion in resident status. During an interview on 4/1/2025, at 11:26 a.m , with the DON, the DON stated she (DON) had asked the nurses, and none had observed any signs of bleeding. The DON stated the nurses had failed to follow the physician order for monitoring and documenting. The DON stated the nurse ' s documentation for anticoagulant monitoring can cause confusion and the order needed to be clarified with the physician. The DON stated the importance of accurate documentation was to create a change of condition and notify the doctor and family if signs of bleeding was observed. During a review of facility ' s policy and procedure (P&P) titled, Anticoagulant-Clinical Protocol dated 11/2018 and last reviewed on 1/2025, the P&P indicated, 1. As part of the initial assessment, the physician and staff will identify individuals who are currently anticoagulated; for example, those with a recent history of deep vein thrombosis (DVT- condition where a blood clot forms in a deep vein, usually in the leg), or heart valve replacement (a surgical procedure to replace a damaged or diseased heart valve with a new one), atrial fibrillation (an irregular and often very rapid heart rhythm) or those who have had recent joint replacement surgery (a surgical procedure to replace some or all of a joint). a. Assess for any signs or symptoms related to adverse drug reactions (an untoward reaction to a medication) due to the medication alone or in combination with other medications. 5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria (blood in urine), hemoptysis (coughing up blood), or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. b. The physician will order measures to address any complications, including holding or discontinuing the anticoagulant as indicated. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility ' s P&P titled, Nursing Documentation dated 6/27/2022 and last reviewed on 1/2025, the P&P indicated, Nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate based on the resident's or patient's condition, situation, and complexity. Procedure: a. Documentation includes information about the patient's status, nursing assessment and interventions, expected outcomes, evaluation of the patient's outcomes, and responses to nursing care. b. Timely entry of documentation must occur as soon as possible after the provision of care and in conformance with time frames for completion as outlined the other policies and procedures. c. The patient's record specifies what nursing interventions were performed by whom, when, and where. d. All patient information will be documented, scanned, or entered in the appropriate section of the clinical record following established guidelines.