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	01/28/2026

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2) were free from physical restraint (a strap or other thing that holds a person in place) by failing to monitor Resident 2 on the use of bed alarm device (a safety tool used in hospitals, nursing homes, and home care to detect when a person is attempting to leave their bed, alerting caregivers to prevent falls, or potential emergencies).This failure had the potential to result in unnecessary restraint and placed the residents at risk of agitation (a state of extreme mental and physical restlessness) and entrapment (situation where a resident becomes caught, trapped, or tangled in the bed frame, mattress, or side rails while attempting to move, get out of bed, or during the use of restrictive device).Findings:During a review of Resident 2's admission Record, the admission Record indicated the facility initially admitted Resident 2 on 9/22/2022, and readmitted on [DATE], with diagnoses that included traumatic subdural hemorrhage (a type of bleeding near your brain that can happen after a head injury), unspecified (unconfirmed) chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing) and muscle weakness.During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool) dated 10/31/2025, 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 supervision from staff for hygiene, showering, dressing, transfer and walking.During a review of Resident 2's Physician Order, dated 1/13/2026, timed at 10:46 p.m., the Physician Order indicated Resident 2 may use an alarm device in bed.During a review of Resident 2's Device Informed Consent, dated 1/13/2026, the Device Informed Consent indicated Family Member 1 (FM 1) gave permission for the use of alarm device while in bed.During a review of Resident 2's Care Plan, dated 1/13/2026, about risk of fall, the Care plan indicated an intervention to apply alarm device while Resident 2's in bed and to check for placement and function every shift.During a review of Resident 2's Physician Order, dated 1/14/2026, timed at 7 a.m., the Physician Order indicated Resident 2 may use an alarm device when in bed and to check for placement and function every shift.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 1/15/2026, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.During a concurrent observation, and interview on 1/27/2026, at 9:32 a.m., with Licensed Vocational Nurse 1 (LVN1), inside Resident 2's room, observed a bed alarm device hanging on Resident 2's left side of the bed. LVN 1 stated Resident 2 uses the bed alarm device when in bed to alert staff when resident gets up.During a concurrent interview, and record review on 1/28/2026, at 9:34 a.m., with the Director of Nursing (DON), Resident 2's Physician Order, dated 1/13/2026, and Medication Administration Record (MAR), dated 1/2026, were reviewed. The DON stated Resident 2 was on bed alarm from 1/13/2026. The DON stated a bed alarm device is the least form of (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physical restraint. The DON stated residents on bed alarm should be monitored for the placement and function of the alarm device and monitoring should be documented in the MAR. The DON stated there was no documented monitoring from 1/16/2026 to 1/27/2026. The DON stated the monitoring should be done and documented to make sure the bed alarm device was effective for Resident 2. The DON stated that without monitoring facility would not know if the bed alarm was effective for Resident 2 in preventing falls.During a review of facility policy and procedure (P&P), titled, Use of Restraint, dated 4/2017, and last reviewed on 1/14/2026, the P&P indicated, Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptoms(s) and never for discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. c. A resident placed in a restraint will be observed at least every thirty (30) minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record.19. Documentation regarding the use of restraints shall include: a. Full documentation of the episode leading to the use of physical restraint. This includes not only the resident symptoms but also the conditions, circumstances, and environment associated with the episode b. A description of the resident's medical symptoms (an indication or a characteristic of a physical or psychological condition) that warranted the use of restraints; c. How the restraint use benefits the residents by addressing the medical symptom; d. The type of physical restraint used; e. The length of effectiveness of the restraint time; and f. Observation, range of motion and repositioning flow sheets.

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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	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 observation, interview, and record review, the facility failed to develop and implement a person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for one of three sampled residents (Resident 2).This failure had the potential for confusion of care and had the potential to result in Resident 2's fall. Findings:During a review of Resident 2‘s admission Record, the admission Record indicated the facility initially admitted Resident 2 on 9/22/2022, and readmitted on [DATE], with diagnoses that included traumatic subdural hemorrhage (a type of bleeding near your brain that can happen after a head injury), unspecified (unconfirmed) chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing) and muscle weakness.During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool) dated 10/31/2025, 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 supervision from staff for hygiene, showering, dressing, transfer and walking.During a review of Resident 2's eInteract Change in Condition Evaluation (CIC), dated 1/10/2026, the CIC indicated on 1/10/2026, at 7:15 a.m., LVN 1 heard a loud sound and found Resident 2 lying on his (Resident 2) right side, on the hallway floor between his (Resident 2)'s room and the shower room. The CIC indicated Resident 2 moaning with eyes closed and unable to talk. The CIC indicated physician was notified and ordered to transfer Resident 2 to the General Acute Care Hospital (GACH).During a review of Resident 2's Care Plan, dated 1/13/2026, about risk of fall, the Care Plan indicated the following interventions:Resident in room with direct line of sight of nurse's station.Apply wander guard (a wearable safety system for seniors with memory issues, that prevents them from wandering off) due to poor safety awareness.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 1/15/2026, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.During a review of Resident 2's Physician Order, dated 1/16/2026, timed at 2:37 p.m., the Physician Order indicated discontinuation of wander guard/wander elopement device due to poor safety awareness every shift.During an observation on 1/27/2026, at 9:30 a.m., outside of Resident 2's room, observed Resident 2 walking back and forth inside his (Resident 2) room from the bed to the door with no assistance. Observed Resident 2's room was seven rooms away to the right of the nurse's station.During an interview on 1/27/2026, at 9:32 a.m., with Licensed Vocational Nurse 1 (LVN1), LVN 1 stated Resident 2's room was seven rooms away from the nurse station.During a concurrent interview, and record review on 1/27/2026, at 10:19 a.m., with Registered Nurse 1 (RN 1), Resident 2's Care Plan, dated 1/13/2026, about risk for fall was reviewed. RN 1 stated Resident 2's care plan indicated interventions that Resident 2 should be in direct line of sight of the nurse's station and had a wander guard. RN 1 stated when the facility admitted Resident 2 on 1/13/2026, he (Resident 2) was close to the nurse's station in room A and had a wander guard but on 1/16/2026, he (Resident 2) was moved back to his (Resident 2) previous room in room B and discontinued the wander guard. RN 1 stated care plan was not revised. RN 1 stated care plan should have been revised after the room change since the current Resident 2's room (room B) now was so far from the nurse's station and Resident 2 had no wander guard because it was a secure unit (a specialized, locked, or access-controlled area designed specifically for residents with cognitive impairments).During an interview on 1/28/2026, at 9:34 am with the Director of Nursing (DON), the DON stated the facility should have updated the care plan after Resident 2's room change and when (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurses discontinued the wander guard. The DON stated care plan is nurse's guideline on resident care and intervention. The DON stated if care plan was not updated or revised, nurses could not implement Resident 2's current intervention. The DON stated whoever received the order for the room change, whoever transferred Resident 2 to from room A to room B and whoever discontinued the wander guard should have updated the care plan.During a review of facility's policy and procedure (P&P) titled, Care Plan Comprehensive, dated 8/25/2021, and last reviewed on 1/14/2026, the P&P indicated, Each resident's comprehensive care plan is designed to:Incorporate identified problem areas.f. Reflect treatment goals, timetables and objectives in measurable outcomes.j. Reflect currently recognized professional standards of practice for problem areas and conditions.2. The comprehensive care plan includes the following:a. The services that are to be furnished to attain or maintain the residents highest practicable physical, mental and psychological well-being.7. Assessments of residents are ongoing, and care plans are reviewed and revised as information about the resident and the resident 's condition change.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate and complete medical record for one of three sampled residents (Resident 2) by:Failing to accurately document notification of the physician on 1/10/2026, when Resident 2 had an incident of fall.Failing to ensure Registered Nurse 2 (RN 2) documents her (RN 2) intervention on 1/20/2026, after Resident 2's fall incident.Failing to completely document incidents on Resident 2's fall on 11/13/2025.Failing to document date and time of Family Member 1 (FM 1) notification on 5/16/2023, of Resident 2's change in condition.These failures had the potential to result in the medical records containing inaccurate and incomplete documentation.Findings: a. During a review of Resident 2's admission Record, the admission Record indicated the facility initially admitted Resident 2 on 9/22/2022, and readmitted on [DATE], with diagnoses that included traumatic subdural hemorrhage (a type of bleeding near your brain that can happen after a head injury), unspecified (unconfirmed) chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing) and muscle weakness.During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool) dated 10/31/2025, 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 supervision from staff for hygiene, showering, dressing, transfer and walking.During a review of Resident 2's eInteract Change in Condition Evaluation (CIC), dated 1/10/2026, the CIC indicated on 1/10/2026, at 7:15 a.m., Licensed Vocational Nurse 1 (LVN 1) heard a loud sound and found Resident 2 lying on his (Resident 2) right side, on the hallway floor between his (Resident 2)'s room and the shower room. The CIC indicated Resident 2 moaning with eyes closed and unable to talk. The CIC indicated the physician was notified on 1/10/2026, at 12 midnight and ordered to transfer Resident 2 to the General Acute Care Hospital (GACH).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 1/15/2026, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.During an interview on 1/27/2026, at 9:55 a.m., with LVN 1, LVN 1 stated on 1/10/2026, at 7:15 a.m., she (LVN 1) was in room D, and Certified Nursing Assistant 1 (CNA 1) was in room C when she (LVN 1) heard a loud sound from Resident 2's room in room B. LVN 1 stated when she (LVN 1) responded she (LVN 1) found Resident 2 on the hallway floor outside of room B.During a concurrent interview, and record review on 1/28/2026, at 8:41 a.m., with LVN 1, Resident 2's CIC dated 1/10/2026, was reviewed. LVN 1 stated the fall incident happened on 1/10/2026, at 7:15 a.m. LVN 1 stated the CIC for the time of physician notification was incorrect. LVN 1 stated she (LVN 1) did not call the physician on 1/10/2026 at 12 midnight. LVN 1 stated she (LVN 1) should have documented 7:20 a.m., to 7:30 a.m. LVN 1 stated she (LVN 1) should have documented accurately to show timely intervention was performed. LVN 1 stated Resident 2's CIC on 1/10/2026, was inaccurate.During an interview on 1/28/2026, at 9:34 a.m., with the Director of Nursing (DON), the DON stated the CIC on 1/10/2026, was not accurate since the physician notification was documented on 1/10/2026, at 12 midnight when the incident of fall happened at 7 a.m.b. During an interview on 1/27/2026, at 9:55 a.m., with LVN 1, LVN 1 stated on 1/10/2026, at 7:15 a.m., when she (LVN 1) heard a loud sound from Resident 2's room in room B. LVN 1 stated when she (LVN 1) responded she (LVN 1) found Resident 2 on the hallway floor outside of room B. LVN 1 stated she (LVN 1) called Registered Nurse 2 (RN 2) who assessed Resident 2 and called 911 (number to call for emergency medical response).During a concurrent interview, and record review on 1/28/2026, at 8:41 a.m., with LVN 1, Resident 2's Progress (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notes, dated 1/10/2026, was reviewed. LVN 1 stated there were no documentation by RN 2. LVN 1 stated RN 2 called 911 and called the physician.During an interview on 1/28/2026, at 9:34 a.m., with the Director of Nursing (DON), the DON stated Resident 2's medical record did not indicate RN 2's intervention. The DON stated RN 2 should have documented that she did the head-to-toe assessment after Resident 2's fall and called 911. The DON stated Resident 2's medical record did not indicate RN 2 was notified and responded on Resident 2's fall incident.c. During a review of Resident 2's CIC, dated 11/13/2025, timed at 5 p.m., the CIC indicated Resident 2 had a fall incident. The CIC indicated Resident 2 was found on the floor holding the left side of his (Resident 2) head and face, complaining of left hip pain.During a concurrent interview, and record review on 1/28/2026, at 9:34 a.m., with the DON, Resident 2's CIC dated 11/13/2025, was reviewed. The DON stated the CIC on 11/13/2025, did not indicate if Resident 2 was found inside his room. The DON stated the CIC did not indicate who found Resident 2 first. The DON stated the CIC was not complete.d. During a review of Resident 2's CIC, dated 5/16/2023, the CIC indicated blank on the RP's date and time of notification.During an interview on 1/28/2026, at 9:34 a.m., with the DON, the DON stated the facility had documentation issues. The DON stated all intervention, and correct information should be documented. The DON stated incomplete and inaccurate documentation can possibly result in delay of care.During a review of facility's policy and procedure (P&P), titled, Charting and Documentation, dated 7/2017, and last reviewed on 1/14/2026, the P&P indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team (IDT-a coordinated group of experts from several different fields who work together) regarding the resident's condition and response to care. The following information is to be documented in the resident medical record:a. Objective observations;b. Medications administered;c. Treatments or services performed;d. Changes in the resident's condition;e. Events, incidents or accidents involving the resident; andf. Progress toward or changes in the care plan goals and objectives.3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.7. Documentation of procedures and treatments will include care-specific details, including:a. The date and time the procedure/treatment was provided;b. The name and title of the individual(s) who provided the carec. The assessment data and/or any unusual findings obtained during the procedure/treatment;d. How the resident tolerated the procedure/treatment;e. Whether the resident refused the procedure/treatment;f. Notification of family, physician or other staff, if indicated; andg. The signature and title of the individual documenting.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to implement infection control measures for one of three sampled residents (Resident 1) by failing to provide clean and sanitary utensils to Resident 1. This failure had the potential to place Resident 1 at risk for foodborne illnesses (illness caused by the ingestion of contaminated food or beverage) and placed Resident 1 at risk for infection. Findings:During a review of Resident 1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on 9/9/2025, with diagnoses that included unspecified (unconfirmed) epilepsy (repeatedly uncontrolled electrical activity in the brain, which may produce a jerking movement of a part or the entire body), immunodeficiency (a condition where the body's immune system, its natural defense against illnesses is weakened or not working properly) and essential hypertension (high blood pressure with no single, identifiable medical 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 9/10/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 12/15/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 was independent with eating and required moderate assistance from staff for toileting and showering.During a review of Resident 1's Complaint/Grievance Report, dated 1/14/2026, the Complaint/Grievance Report indicated Resident 1 reported that he (Resident 1) received a dirty spoon with his (Resident 1) breakfast tray. The Complaint/Grievance Report indicated Resident 1 showed the dirty spoon to the Dietary Supervisor (DS) and the Social Service Director (SSD).During an interview on 1/27/2026, at 9:20 a.m., with Resident 1, Resident 1 stated he (Resident 1) received a dirty spoon with dried food on his (Resident 1) breakfast tray. Resident 1 stated the spoon looks like it was used and not washed properly. Resident 1 stated he (Resident 1) was concerned to get a bacterial infection (illnesses caused by harmful bacteria invading the body) from a dirty spoon. Resident 1 stated he (Resident 1) had reported the dirty spoon to the Social Service Director (SSD).During an interview on 1/27/2026, at 9:40 a.m., with the Dietary Supervisor (DS), the DS stated Resident 1 showed the dirty spoon. The DS stated the Dishwasher Staff (DWS) should have checked the utensils after washing. The DS stated the Dietary Aide (DA) should have inspected the spoon and utensils before placing it on the food tray. The DS stated the Certified Nursing Assistant (CNA's) who distributes the food tray should have checked the utensils before delivering to the resident. The DS stated Resident 1 could contract bacterial infection from a dirty spoon. During an interview on 1/27/2026, at 9:51 a.m., with the SSD, the SSD stated on 1/14/2026, at breakfast, SSD saw the dried food residue at the back of Resident 1's spoon. The SSD stated Resident 1 could potentially be exposed to infection with dirty utensils.During an interview on 1/27/2026 at 11:03 a.m., with the Director of Nursing (DON), the DON stated CNA did not notice the spoon was dirty. The DON stated the DA should check if the utensils are clean or not. The DON stated the CNAs should check and remove dirty utensils and provide a clean one to the residents. The DON stated Resident 1 could get an infection from dirty utensils.During a review of facility's policy and procedure (P&P) titled, Sanitation, dated 11/2022, and last reviewed on 1/14/2026, the P&P indicated, All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners are kept in good repair. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions.