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	04/07/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to follow professional standards of nursing practice for one of four sampled residents (Resident 1) by failing to ensure licensed nurses appropriately assessed and monitored Resident 1's medical status following the resident's Change of Condition (COC) on 3/26/2026 related to the resident's reported facial trauma. This deficient practice had the potential to result in the failure to identify continued or worsening clinical deterioration, thereby placing Resident 1 at risk for adverse health outcomes and compromised safety.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on 8/7/2024 with diagnoses including Parkinson's disease (a progressive brain disorder that causes problems with movement, balance, and muscle control), age-related osteoporosis (a disease that makes bones thin, weak, and brittle, increasing the risk of fractures [broken bones]), and osteoarthritis (occurs when the cartilage that cushions the ends of bones in the joints gradually wears away). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 2/13/2026, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making was intact. During a review of Resident 1's Change in Condition Evaluation, dated 3/26/2026, the Change in Condition Evaluation indicated on 3/26/2026 at 7:30 p.m., another resident hit Resident 1 on the nose and both cheeks. The Provider Notification and Feedback section indicated Resident 1's Attending Physician (MD) 1 was notified on 3/27/2026 at 10 p.m., 26 hours and 30 minutes after the resident's reported COC. The Change in Condition Evaluation indicated MD 1's recommendation was to monitor Resident 1's nose and both cheeks for any changes and pain. During a review of Resident 1's Care Plan, initiated on 3/26/2026, the Care Plan indicated the resident reported another resident hit him on the nose and both cheeks. The Care Plan Interventions indicated the licensed nurses to check and assess Resident 1's body. During an interview on 4/7/2026 at 11:05 a.m. with Resident 1, Resident 1 stated Resident 2 (Resident 1's previous roommate) came into the room, stood on Resident 1's left side of the bed, and punched him on the face. A picture of Resident 1's face was taken two days after Resident 2 allegedly punched Resident 1. The picture of Resident 1's face indicated a purplish-blue colored bruise on the right lower orbital area (a bony socket in the skull that includes the eye socket, eye lids, eyebrow, and surrounding skin). Resident 1 refused to provide a copy of the picture. During an interview on 4/7/2026 at 1:09 p.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated on 3/27/2026, Resident 1's right lower eyelid had a purple bruise from the inner lower eyelid extending to the middle lower eyelid. CNA 3 stated Resident 1's bruise was the size of the tip of her (CNA3) fifth digit (pinky or little finger). During a concurrent interview and record review on 4/7/2026 at 1:26 p.m. with Licensed Vocation Nurse (LVN) 3, Resident 1's Progress Notes, dated 3/26/2026 to 3/29/2026, were reviewed. LVN 3 stated on 3/27/2026, Resident 1's right lower eyelid was observed with a dime-sized, purplish colored bruise. LVN 3 stated there was no documented evidence of Resident 1's right lower eyelid bruise. LVN 3 stated Resident 1 should be monitored every shift for 72 hours after a change of condition. LVN 3 stated Resident 1's Progress Notes indicated there was no documented evidence that the resident was monitored on the following shifts:a. On 3/27/2026 (7 a.m. to 3 p.m. shift),b. On 3/28/2026 (7 a.m. to 3 p.m. shift), andc. On 3/29/2026 (7 a.m. to 3 p.m. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shift).LVN 3 stated that failure to document Resident 1's right lower eyelid bruise and the monitoring provided after the resident's change of condition could cause the resident discomfort and pain. During an interview on 4/7/2026 at 3:19 p.m. with the Director of Nursing (DON), the DON stated she (DON) was not made aware of Resident 1's right eyelid bruise. The DON stated Resident 1 should be monitored every shift for at least 72 hours following COC. The DON stated there was no confirmed documented evidence of monitoring on the identified shifts. The DON stated failure to monitor Resident 1 every shift after a COC could result in worsening of the resident's condition. The DON stated that care not documented was considered not provided. The DON acknowledged and stated the facility failed to identify, document, and monitor Resident 1's change of condition. During a review of the facility's policy and procedure (PnP) titled, Change in Condition: Notification of, last reviewed on 1/14/2026, the PnP indicated a facility must immediately inform the resident, consult with the resident's physician and/or NP .where there is a significant change in the resident's physical, mental, or psychosocial status. a need to alter treatment significantly. During a review of the facility's PnP titled, Charting and Documentation, last reviewed on 1/14/2026, the PnP 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 regarding the resident's condition and response to care. The PnP indicated the following information is to be documented in the resident's medical record.changes in the resident's condition. progress toward or changes in the care plan goals and objectives. Documentation in the medical record will be objective, complete, and accurate.