

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/04/2026
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)		
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update the care plan titled, Resident is at risk for elopement related to: Resident expresses desire to leave the facility prematurely (not medically ready for discharge), Cognitive loss/dementia quarterly for one of two sampled residents (Resident 1). This failure had the potential to result in a lack of continuity of care based on Resident 1's condition and in staff being unaware of Resident 1's elopement risk interventions, which could compromise Resident 1's safety. Findings:During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including heart failure (a heart disorder which causes the heart not to pump the blood efficiently, sometimes resulting in leg swelling) and type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/03/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 1 required supervision or touching assistance (helper provides cues or touching/contact guard assistance as residents completes the activity) for activities of daily living (ADLs - the basic, routine self-care tasks such as bathing, dressing, and toileting a person performs daily).During a review of Resident 1's History and Physical Examination (H&P - a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 5/14/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Elopement Evaluation, dated 5/14/2025 and timed 1:08 p.m., the Elopement Evaluation indicated, Resident 1 was not at risk for elopement.During a review of Resident 1's Care Plan Report (CP), initiated on 9/6/2025, the Focus indicated Resident is at risk for elopement related to: Resident expresses desire to leave the facility prematurely (not medically ready for discharge), Cognitive loss/dementia. The care plan indicated intervention to monitor the nature and circumstances of attempted elopement during specific activities, involvement of others with resident/patient, pattern and adjust care delivery.During a review of Resident 1's Progress Notes, dated 9/6/2025 and timed 3:51 p.m., the progress note indicated, Patient has been reporting to different CNAs that he's been planning to leave the facility any day now, which he (Resident 1) expressed for the whole week. Wife is concerned and requested to have patient get wander guard instead of being placed in station 4, called the doctor and explained the situation, received an order, noted and carried out.During a review of Resident 1's Progress Notes, dated 9/7/2025 and timed 5:13 p.m., the Progress Note indicated, Family requested to transfer the resident to more secure unit which is located in station 4 due to behavioral concern; resident looking for exit doors and being aggressive towards staff this morning with COC. MD made aware and gave an order to transfer the resident to station 4 for safety. During an interview on 6/4/2026 at 10:39 a.m. with Certified Nurse (CNA) 1, CNA 1 stated that Resident 1 frequently attempted to leave the facility to return home. CNA 1 stated the staff transferred Resident 1 from station 1 to station 4 because Resident 1 attempted to leave the facility on multiple occasions. CNA 1 stated Resident 1 was (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 056113	Facility ID: 056113 If continuation sheet Page 1 of 3

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forgetful and would try to leave the facility at least once a week. During a concurrent interview and record review on 6/4/2026 at 1:02 p.m. with Registered Nurse (RN) 1, Resident 1's care plan report titled, Resident is at risk for elopement related to: Resident expresses desire to leave the facility prematurely (not medically ready for discharge), Cognitive loss/dementia, was reviewed. RN 1 stated that the facility should have revised Resident 1's care plan to evaluate whether the resident's goals had been met. RN 1 stated that the interdisciplinary team (IDT) is responsible for updating and revising Resident 1 care plan after each meeting. RN 1 stated the care plan should be revised quarterly and if there is a change in condition. During a review of the facility's policy and procedures (P&P) titled, Care Planning-Interdisciplinary Team, dated 8/25/202, indicated, Assessment of residents are ongoing, and care plans are reviewed and revised as information about the resident and the resident's condition change. The Interdisciplinary Team (IDT) is responsible for evaluation and updating of care plans at least quarterly.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate medical records for one of two sampled residents (Resident 1), when the facility failed to ensure the Minimal Data Set (MDS) nurse accurately documented diagnoses of unspecified psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with reality), insomnia (trouble falling asleep or staying asleep), and dementia (a progressive state of decline in mental abilities) in section I of Resident 1's Minimum Data Set (MDS - a resident assessment tool). This failure had the potential to result in inaccurate representation of Resident 1's condition and lack of documentation in the medical record. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including heart failure (a heart disorder which causes the heart not to pump the blood efficiently, sometimes resulting in leg swelling) and type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/3/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 1 required supervision or touching assistance (helper provides cues or touching/contact guard assistance as residents completes the activity) for activities of daily living (ADLs - the basic, routine self-care tasks such as bathing, dressing, and toileting a person performs daily). During a review of Resident 1's History and Physical Examination (H&P - a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 5/14/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's medical record, titled Psychiatry Progress Note, dated 9/25/2025, the Psychiatry Progress Note indicated that Resident 1 had diagnosis of unspecified psychosis, insomnia, and dementia. During a concurrent interview and record review on 6/4/2026 at 1:55 p.m. with MDS nurse, Resident 1's medical record titled, Psychiatry Progress notes, dated 9/25/2025, and MDS section I, dated 4/3/2026, were reviewed. The MDS nurse stated that the facility failed to capture the diagnosis of psychosis and insomnia in Resident 1's MDS section I. The MDS nurse stated that she (MDS Nurse) was not sure why Resident 1's diagnosis of psychosis and insomnia were not captured. The MDS nurse stated that medical records and MDS nurse are responsible for capturing Resident 1's active diagnosis. The MDS nurse stated that Resident 1 does not have dementia and that is why the diagnosis of dementia was not captured for Resident 1. During a concurrent interview and record review on 6/4/2026 at 3:07 p.m. with the Director of Nursing (DON), Resident 1's medical record titled, Psychiatry Progress notes, dated 9/25/2025 was reviewed. The DON stated that nursing staff that received the new diagnosis from Psychiatry for Resident 1, should have informed the MDS nurse. DON stated that Resident 1's diagnosis of insomnia, dementia, and psychosis should have been captured by the MDS nurse. DON stated that Resident 1 was being treated for psychosis and insomnia by the psychiatry doctor. DON stated that the Interdisciplinary team (IDT) should have also captured Resident 1's new diagnosis since they review all active medications quarterly. During a review of the facility's policy and procedure (P&P) titled, MDS completion and Submission Timeframes, revised on 10/2023, the P&P indicated that The assessment coordinator or designee is responsible for ensuring resident assessment are submitted in accordance with current federal and state guidelines. During a review of the facility's undated P&P, titled, Charting and documentation, 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 regarding the resident's condition and response to care. Documentation in the medical record will be objective, complete, and accurate.		