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	07/01/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident 1's discharge record was complete and accurately reflected Resident 1's clinical condition and care needs at the time of transfer to a boarding care facility.This deficient practice had the potential to result in the receiving facility being inadequately informed of the resident's needs, placing the resident at risk for inappropriate care, unmet needs, avoidable outcomes, and an unsafe transition.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 resident 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) such as toilet hygiene, oral hygiene, upper body dressing, and personal hygiene.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 Physician Progress Notes (PPN) dated, 8/8/2025, the PPN indicated Resident 1 had a diagnosis of dementia (a general term for a loss of memory, language, problem solving, and other thinking abilities that are severe enough to interfere with daily life) with psychosis (a mental health state characterized by a loss of contact with reality, during which a person's thoughts and perceptions are severely disrupted).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 (a common sleep disorder characterized by persistent difficulty falling asleep), and dementia.During a review of Resident 1's Discharge Summary (DS), dated 5/29/2026, the DS indicated Resident 1's health has improved sufficiently and no longer need the service provided by the facility. The DS indicated diagnosis during stay cerebral infarction (occurs when a blocked or narrowed blood vessel cut off blood flow to the brain), aphasia (a language disorder caused by damage to the brain) following cerebral infarction, heart failure, and type 2 diabetes. The discharge summary did not include a diagnosis of dementia with psychosis.During an interview with social services director (SSD) on 7/1/2026 at 2:15 p.m., the SSD stated that she (SSD) sent an electronic mail to the boarding care personnel on 5/11/2026 at 3:18 p.m. The SSD stated that she (SSD) included a copy of Resident 1's face sheet (a document that provides a quick overview of resident's details, medical history, and current health status), medication review, and history and physical (a comprehensive medical evaluation). The SSD stated the diagnosis of dementia with (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychosis was not recorded in any of the documents she (SSD) sent to boarding care. The SSD stated that she (SSD) was not aware that Resident 1 had a diagnosis of dementia with psychosis. The SSD stated that there was miscommunication between the Medical Doctors and the facility staff. The SSD stated that not providing the boarding care facility with the complete medical record including all the diagnosis can result in inappropriate care and treatment of the resident.During an interview with the Director of Nurses (DON) on 7/1/2026 at 3:15 p.m., the DON stated the boarding care received Resident 1's Medication Administration Record which included a diagnosis of psychosis. The DON stated that the facility failed to update the diagnoses of dementia in the discharge summary (a final, comprehensive document prepared when a resident leaves the facility) and their minimum date set tool. The DON stated the discharge summary needed to include the diagnosis of dementia for accuracy. The DON stated this failure had the potential for ineffective care and treatment of resident while in the boarding care facility.During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised on July 2017, 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.