STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056157	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alvarado Care Center	1154 S.Alvarado St Los Angeles, CA 90006

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 36395 Based on interview and record review the facility failed to develop a person-centered care plan after a change in condition (CIC - clinically important deviation from a patient ' s baseline in physical, cognitive, behavioral, or functional domains that, without intervention, may result in complications or death) for one of four sampled residents (Resident 1). On 8/20/24, Resident 1 alleged that a person came into Resident 1 ' s room and placed a hand over Resident 1 ' s mouth. The facility failed to create a care plan that will address Resident 1 ' s allegations and the interventions and services that would be provided to Resident 1. This deficient practice had the potential for the facility not to meet the needs of Resident 1. Findings: During a review of the Admission Record indicated the facility admitted Resident 1 on 8/15/24 with diagnoses including cerebrovascular disease (condition that affect the blood flow in the brain) with hemiplegia (paralysis that affects only one side of the body) and hemiparesis (weakness in one side of the body) of the right side, diabetes (a condition that happens when the blood sugar [blood glucose] is too high), and anxiety disorder. During a review of the Nurse Progress Notes dated 8/20/24 at 11 p.m. indicated the licensed vocational nurse (LVN) overheard Resident 1 talking on the phone with Resident 1 ' s family member (FM 1). Resident 1 told FM 1 that a person came into Resident 1 ' s room and placed a hand over Resident 1 ' s mouth. The Notes indicated Resident 1 was unable to give detailed information about the incident. Resident 1 was assessed and found no visible injuries. During a review of the Change in Condition dated 8/20/24 at 11:45 p.m., indicated Resident 1 alleged that a person came into Resident 1 ' s room and placed a hand over Resident 1 ' s mouth. The CIC indicated Resident 1 was unable to give a description of the person or a time for the incident. The CIC indicated the primary physician was notified and gave order to monitor Resident 1. During a review of the Minimum Data Set (MDS, standardized care and health screening tool) dated 8/21/24 indicated Resident 1 had severe cognitive impairment. Resident 1 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower/bathe, lower body dressing and substantial assistance (helper does more than half the effort) with upper body dressing. (continued on next page)

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 9/19/24 at 8:34 a.m. with the registered nurse supervisor 1 (RNS 1), Resident 1 ' s CIC and Nurses Progress Notes were reviewed. RNS 1 stated on 8/20/24, Resident 1 was overheard talking on the phone and informed the FM 1 that a person came inside Resident 1 ' s room and placed a hand over Resident 1 ' s mouth. RNS 1 further stated he was unable to find a care plan addressing Resident 1 ' s allegations. RNS stated a care plan should have been created to address Resident 1 ' s allegation. During a concurrent interview and record review on 9/19/24 at 9:57 a.m., the director of staff development (DSD) confirmed there was no care plan created addressing Resident 1 ' s allegation that a person came into Resident 1 ' s room and placed a hand over Resident 1 ' s mouth. The DSD stated there should be a care plan to establish the plan of care for Resident 1. During a review of the facility's Policy and Procedures (P&P) titled Change of Condition Notification, implemented on 10/1/23, indicated, the licensed nurse will document the following that included, update the care plan to reflect the resident ' s current status. The same Policy indicated the licensed nurse will communicate any changes, required interventions to the interdisciplinary team members involved in the resident ' s care. During a review of the facilit's P&P titled Care Planning, implemented on 10/1/23 indicated, the licensed nurse will initiate the care plan, and the plan will be finalized in accordance with MDS guidelines and updated as indicated for change in condition, onset of new problems, resolution of current problems and as deemed appropriate by clinical assessment and judgement on as needed basis.

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 36395 Based on interview and record review the facility failed to provide the necessary social services for one of four sampled residents (Resident 1). For Resident 1, the facility failed to provide social services to Resident 1 who made allegation on 8/20/24 that a person went into her room and placed a hand to cover Resident 1 ' s mouth. This deficient practice had the potential to affect Resident 1 ' s psychosocial well-being and ensure that Resident 1 felt safe. Findings: During a review of the Admission Record indicated the facility admitted Resident 1 on 8/15/24 with diagnoses including cerebrovascular disease (condition that affect the blood flow in the brain) with hemiplegia (paralysis that affects only one side of the body) and hemiparesis (weakness in one side of the body) of the right side, diabetes (a condition that happens when the blood sugar [blood glucose] is too high), and anxiety disorder. During a review of the Nurse Progress Notes dated 8/20/24 at 11 p.m. indicated the licensed vocational nurse (LVN) overheard Resident 1 talking on the phone with Resident 1 ' s family member (FM 1). Resident 1 told the FM 1 that a person came into Resident 1 ' s room and placed a hand over Resident 1 ' s mouth. The Notes indicated Resident 1 was unable to give detailed information about the incident. Resident 1 was assessed and found no visible injuries. During a review of the Change in Condition (CIC - clinically important deviation from a patient ' s baseline in physical, cognitive, behavioral, or functional domains that, without intervention, may result in complications or death) dated 8/20/24 at 11:45 p.m., indicated Resident 1 alleged that a person came into Resident 1 ' s room and placed a hand over Resident 1 ' s mouth. The CIC indicated Resident 1 was unable to give a description of the person or a time for the incident. The CIC indicated the primary physician was notified and gave order to monitor Resident 1. During a review of the Minimum Data Set (MDS, standardized care and health screening tool) dated 8/21/24 indicated Resident 1 had severe cognitive impairment. Resident 1 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower/bathe, lower body dressing and substantial assistance (helper does more than half the effort) with upper body dressing. During a review of the Resident Grievance/Complaint Investigation Report dated 8/21/24 indicated Resident 1 informed the social service designee (SSD) that someone came into Resident 1 ' s room and went towards Resident 1 the previous night (8/20/24). The Report indicated Resident 1 showed body language of hand slightly touching mouth. The immediate corrective action indicated the incident was reported to the administrator and the Resident 1 ' s family member. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/19/24 at 9:29 a.m., the social service designee (SSD) stated Resident 1 alleged that a person came into her room and placed a hand over Resident 1 ' s mouth. SSD stated she went to see Resident 1 on 8/21/24 and spoke to Resident 1. SSD stated she filed a grievance report for Resident 1. SSD stated she did not document in the progress notes what else she did for Resident 1. SSD stated she does not need to document because there was already a grievance report. SSD stated Resident 1 was discharged home on 8/21/24 in the afternoon and she arranged for necessary equipment that Resident 1 needed at home. During an interview on 9/19/24 at 9:57 a.m., the director of staff development (DSD) confirmed the SSD did not document the services rendered to Resident 1. During a review of the facility's Policy and Procedures titled Social Services Program implemented on 10/1/2, indicated, no less than quarterly and upon change of condition, the director of social services evaluates the resident ' s psychosocial status and records his/her observations in a social services progress note that is maintained as part of the resident ' s electronic health record.

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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. 36395 Based on interview and record review the facility failed to maintain medical records that were accurate and concise for one of four sampled residents (Resident 1). On 8/21/24 at 7 a.m., the Nurses Progress Notes indicated Resident 1 alleged that a staff member physically assaulted Resident 1. The registered nurse supervisor (RNS 1) stated Resident 1 ' s allegation that a staff member physically assaulted Resident 1 was wrong. This deficient practice resulted in the inaccurate medical record for Resident 1. Findings: During a review of the Admission Record indicated the facility admitted Resident 1 on 8/15/24 with diagnoses including cerebrovascular disease (condition that affect the blood flow in the brain) with hemiplegia (paralysis that affects only one side of the body) and hemiparesis (weakness in one side of the body) of the right side, diabetes (a condition that happens when the blood sugar [blood glucose] is too high), and anxiety disorder. During a review of the Nurse Progress Notes dated 8/20/24 at 11 p.m. indicated the licensed vocational nurse (LVN) overheard Resident 1 talking on the phone with Resident 1 ' s family member (FM 1). Resident 1 told the FM 1 that a person came into Resident 1 ' s room and placed a hand over Resident 1 ' s mouth. The Notes indicated Resident 1 was unable to give detailed information about the incident. Resident 1 was assessed and found no visible injuries. During a review of the Change in Condition (CIC - clinically important deviation from a patient ' s baseline in physical, cognitive, behavioral, or functional domains that, without intervention, may result in complications or death) dated 8/20/24 at 11:45 p.m., indicated Resident 1 alleged that a person came into Resident 1 ' s room and placed a hand over Resident 1 ' s mouth. The CIC indicated Resident 1 was unable to give a description of the person or a time for the incident. The CIC indicated the primary physician was notified and gave order to monitor Resident 1. During a review of the Minimum Data Set (MDS, standardized care and health screening tool) dated 8/21/24 indicated Resident 1 had severe cognitive impairment. Resident 1 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower/bathe, lower body dressing and substantial assistance (helper does more than half the effort) with upper body dressing. During a review of the Nurse Progress Notes dated 8/21/24 at 7 a.m., indicated Resident 1 was on monitoring due to Resident 1 alleged that .a staff member physically assaulted . Resident 1. (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 9/19/24 at 8:34 a.m. with the registered nurse supervisor 1 (RNS 1), Resident 1 ' s CIC and Nurses Progress Notes were reviewed. RNS 1 stated on 8/20/24, Resident 1 was overheard talking on the phone and informed the FM 1 that a person came inside Resident 1 ' s room and placed a hand over Resident 1 ' s mouth. RNS 1 stated on 8/21/24 at 7 a.m., the Nurses Notes indicated Resident 1 alleged that a staff member physically assaulted Resident 1. RNS 1 stated the Notes that was entered on 8/21/24 at 7 a.m., was not accurate. RNS 1 stated Resident 1 was for monitoring about the allegation that a person entered Resident 1 ' s room and placed a hand over Resident 1 ' s mouth. During a review of the facility's Policy and Procedures titled Documentation - Nursing, implemented on 10/1/24, indicated, nursing documentation will be concise, clear, pertinent, and accurate.