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	06/27/2025

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on interview and record review the facility failed to notify the resident's Power of Attorney (POA, allows someone else to manage the personal and financial matters of another person) for one of two sampled residents (Resident 1). For Resident 1, the facility failed to notify Resident 1's POA when Resident 1 had an appointment for Magnetic Resonance Imaging (MRI, medical imaging procedure for making images of the internal structures of the body) on 6/25/25. This deficient practice resulted in Resident 1 and Resident 1's POA not given their right to participate in decision making before services were provided.Findings. During a review of the admission Record indicated the facility admitted Resident 1 on 11/21/24 with diagnoses including dementia (a progressive state of decline in mental abilities), hypertension (high blood pressure) and depression. During a review of the History and Physical dated 2/15/25 indicated Resident 1 does not have the capacity to understand and make decisions. During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 5/30/25 indicated Resident 1 had moderately impaired cognitive function. Resident 1 was dependent on toileting hygiene, needed maximal assistance (helper does more than half the effort) with shower/bathe, lower body dressing, putting on/taking off footwear and needed moderate assistance (helper does less than half the effort) with eating, oral hygiene, upper body dressing and personal hygiene. During a review of the Physician Order dated 5/19/25 at 12:23 p.m., Resident 1's physician gave an order for MRI of the brain for evaluation of confusion.During a review of the Physician Order dated 6/16/25 at 10:02 am., indicated Resident 1 had an appointment on 6/25/25 at 11 a.m. for the MRI of the brain. During an interview on 6/25/25 at 3:03 p.m. Resident 1's POA stated the facility failed to notify her that Resident 1 had an appointment for the MRI. POA stated she always accompany Resident 1 for Resident 1's appointments because Resident 1 could not advocate for herself. During an interview on 6/27/25 at 11:19 a.m., licensed vocational nurse (LVN 1) stated she arranged Resident 1's MRI appointment but did not notify Resident 1's POA. LVN 1 stated Resident 1's POA should have been notified about Resident 1's appointment. During an interview on 6/27/25 at 12 p.m., the director of nursing (DON) stated Resident 1's POA should be notified about the appointment because Resident 1 was unable to decide for herself. During a review of the facility Policy titled Resident Rights reviewed on 5/19/25 indicated residents had the right to choose a physician and treatment, participate in decisions and care planning, .including involving representatives. The same Policy indicated the residents had the right to be fully informed and participate in their treatment in a language they can understand.

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

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	06/27/2025

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview and record review the facility failed to properly use the low air loss mattress (LAL, specialized mattress that prevents pressure ulcers [damage to an area of the skin caused by constant pressure on the area for a long time], according to the professional standard of practice for one of the two sampled residents (Resident 1). During observation on 6/27/25 at 9:20 a.m., Resident 1 had a blue reusable pad (chux) while lying on the LAL mattress. This deficient practice had the potential to affect Resident 1's comfort level and delay healing of Resident 1's pressure ulcer. Findings: During a review of the admission Record indicated the facility admitted Resident 1 on 11/21/24 with diagnoses including dementia (a progressive state of decline in mental abilities), hypertension (high blood pressure) and depression. During a review of Resident 1's Care Plan initiated on 11/22/24 indicated Resident 1 had saccrococcyx (lower back and tail bone) pressure injury. The Care Plan goal included Resident 1 will have no complications related to the saccrococcyx pressure injury through the next review date. The care plan interventions included to follow the facility protocols for treatment of pressure injury, identify/document causative factors and to eliminate/resolve where possible. During a review of Resident 1's Physician Order dated 12/30/24 at 3:34 p. m., indicated an order for LAL mattress and to monitor for proper setting, functioning and placement everyday shift for skin management. During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 5/30/25 indicated Resident 1 had moderately impaired cognitive function. Resident 1 was dependent on toileting hygiene, needed maximal assistance (helper does more than half the effort) with shower/bathe, lower body dressing, putting on/taking off footwear and needed moderate assistance (helper does less than half the effort) with eating, oral hygiene, upper body dressing and personal hygiene. During concurrent observation and interview on 6/27/25 at 9:32 a.m., certified nursing assistant (CNA 1) stated Resident 1 was lying on the chux with white draw sheet (small bed sheet that cover the area between a person's upper back and thighs). CNA 1 stated the chux should be removed because Resident 1 was lying in a special mattress. During an interview on 6/27/25 at 9:40 a.m., licensed vocational nurse (LVN 2) stated the chux should not be used with the LAL mattress because the chux defeats the purpose of the LAL mattress because the chux can cause the build up of pressure in the mattress. During an interview on 6/27/25 at 12 p. m., the director of nursing (DON) stated the chux should not be used for Resident 1 while on the LAL mattress.During a review of the LAL Mattress Operator's Manual (item number 14029DP) indicated to cover the mattress with a cotton sheet to avoid direct contact and improve the comfort level. During a review of the facility Policy titled Care Standards reviewed on 5/19/25 indicated all residents receive necessary care and services that are evidence based and in accordance with accepted professional clinical standards of practice.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review the facility failed to ensure medications were administered as ordered by the physician for one of two sampled residents (Resident 1). For Resident 1, the facility failed to document medications were administered as soon as given and failed to document the reasons why the medications were not administered.These deficient practices resulted in the facility failing to determine if the medications were administered to Resident 1, prevent the potential for medication errors, medication duplication and delay in care and treatment to meet the needs of Resident 1. Findings:During a review of the admission Record indicated the facility admitted Resident 1 on 11/21/24 with diagnoses including dementia (a progressive state of decline in mental abilities), hypertension (high blood pressure) and depression. During a review of the History and Physical dated 2/15/25 indicated Resident 1 does not have the capacity to understand and make decisions. During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 5/30/25 indicated Resident 1 had moderately impaired cognitive function. Resident 1 was dependent on toileting hygiene, needed maximal assistance (helper does more than half the effort) with shower/bathe, lower body dressing, putting on/taking off footwear and needed moderate assistance (helper does less than half the effort) with eating, oral hygiene, upper body dressing and personal hygiene. During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 6/2025 indicated the following:1.Ascorbic acid 500 milligrams (mg., metric unit of measurement, used for medication dosage and/or amount) give one table one time a day for supplement was not signed as given at 9 a.m. on 6/13/25 and 6/17/25.2.Famotidine 20 mg. give one tablet by mouth in the morning for hyperacidity and to give before breakfast was not signed as given at 6:30 a.m. on 6/3/25, 6/20/25, 6/24/25 and 6/25/25.3.Ferrous Sulfate tablet 325 mg. give one tablet by mouth one time a day for supplement at 9 a.m. on 6/13/25 and 6/17/25. 4. Folic acid 1 mg. give one tablet by mouth one time a day for supplement was not signed as given at 9 a.m., on 6/13/25 and 6/17/25.5. Lisinopril oral tablet 10 mg. give one tablet by mouth one time a day for hypertension was not signed as given at 9 a.m. on 6/2/25, 6/13/25, 6/14/25 and 6/17/25.6. Multiple Vitamin Tablet give one tablet by mouth one time a day for supplement was not signed as given at 9 a.m. on 6/13/25 and 6/17/25. 7.Zinc Sulfate oral tablet 220 mg. give one tablet by mouth one time a day for supplement not signed as given at 9 a.m. on 6/13/25 and 6/17/25.8. Docusate Sodium 100 mg. give one capsule by mouth two times a day for constipation not signed as given at 9 a.m. on 6/13/25 and 6/17/25.9.Prostat oral liquid give 30 milliliters (ml., measure of volume) by mouth two times a day for supplement not signed as given at 9 a.m. on 6/13/25 and 6/17/25. During an interview on 6/27/25 at 12 p.m., Resident 1's MAR was reviewed with the director of nursing (DON). DON stated the MAR should be signed as soon as the medications were administered to Resident 1. DON agreed that if the MAR was not signed the medications were not given. During a review of the facility Policy titled Medication Administration reviewed on 5/19/25 indicated the licensed nurse will chart the drug, time administered and initial his/her name with each medication administration. The time and dose of the drug or treatment administered will be recorded in the resident's individual medication record by the person who administers the drug or treatment. Initials may be used, provide that the signature of the person administering the medication or treatment is also recorded on the medication or treatment record.