

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056157	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
NAME OF PROVIDER OR SUPPLIER Alvarado Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (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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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure their policy for Unusual Occurrence Reporting included major accidents and follow it to report a major accidental fall with injury according to the State and Federal regulations for one of three sampled residents (Resident 1). This deficient practice resulted an outdated policy and procedures being implemented when the facility made the decision not to report a major accidental fall with injury to the State Agency (SA). During a review of Resident 1's admission Record dated 7/10/25, indicated the resident was admitted to the facility on [DATE] with diagnosis including unsteadiness on feet, lack of coordination, Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), repeated falls, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage).During a review of Resident 1's History and Physical (H&P) dated 7/9/25 indicated the resident was having memory problems and had fluctuating capacity to make medical decisions. During a review Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 7/7/25 indicated Resident 1 had moderately impaired cognitive (process of thinking, reasoning, judgement or remembering) function. Resident 1 was dependent (helper does all the effort) with toileting, shower, lower body dressing, putting on footwear and sit to stand and transfers. The assessment for walking was not attempted due to medical condition of safety concerns.During a review Resident 1's of the Nurses Notes dated 6/25/25 at 00:20 am indicated, resident again trying to physically fight the nurse. resident started to take steps toward his walker and he lost his balance and fell to the floor. During a review of Resident 1's Nurses Notes dated 6/25/25 at 2:50 am indicated, 911 was called due resident's unrelieved pain. resident transferred to hospital at approximately 3:00 am. During a review of Resident 1's CT (medical imaging procedure that uses X-rays to create detailed cross-sectional images of the body) pelvis (central core of your skeletal system) imaging report dated 6/25/25 at 8:43 am indicated Resident 1 had and fracture of the right femur (long bone of the thigh). During a review of Resident 1's Nurses Notes dated 6/30/25 at 10:48 pm the resident was readmitted to the facility. During a review of the facility's policy and procedures (P&) titled Unusual Occurrence Reporting implemented October 2023, indicated the facility will follow all applicable state and federal laws and regulation regarding the reporting of unusual occurrences. The Facility reports the following events by phone and in writing to the appropriate State or Federal agencies. Other Occurrences. Death of a resident, employee or visitor due to unnatural causes. Allegations of abuse, or neglect. Allegations of misappropriation of resident property; and. Other occurrences that interfere with Facility operations and affect the welfare, safety, or health of residents, employees or visitors. During a review of the California Code Regulations - 72541 - Unusual Occurrences, indicated Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients, personnel or visitors shall be reported by the facility within 24 hours either by telephone (and confirmed in writing) or by telegraph to the local health officer and the Department.During a concurrent interview and record review on 7/10/25 at 1:37 pm with Director of Nursing (DON) of the facility's P&P for Unusual Occurrence Reporting and the California Code of Regulations, 72541 - Unusual Occurrences were reviewed. The DON stated they new how the fracture happened it was from a fall and not an unknown source. Would not be considered an unusual occurrence because they knew how it happened. DON verifies the facility's policy does not mention major accidents as being reportable and states the resident was prone to fractures due to the diagnosis of osteoarthritis. During a concurrent interview and record review on 7/10/25 at 1:50 pm with the facility Administrator (ADM) the California Code of Regulations, 72541 - Unusual Occurrences were reviewed. The ADM stated they didn't think the fracture was reportable because it was a witnessed fall. ADM reviewed the regulation where it indicates major accidents are reportable and ADM has nothing to add stays silent.</p>		