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	09/05/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a comprehensive care plan for one of two sampled residents (Resident 1). For Resident 1 who was assessed on 5/29/25 as at risk for fall, the facility failed to develop a plan of care to address the risk of fall for Resident 1. This deficient practice had the potential to cause a delay or lack of necessary care for Resident 1. During a review of the admission Record indicated the facility admitted Resident 1 on 5/29/25 with diagnoses including diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), lack of coordination and absence of right leg above knee.During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 6/5/25 indicated Resident 1 had moderately impaired cognition. Resident 1 was dependent on shower, lower body dressing, putting on/taking off footwear, personal hygiene, substantial assistance (helper does more than half the effort) with oral hygiene, toileting hygiene, upper body dressing and moderate assistance (helper does less than the effort) with eating.During a concurrent interview and record review on 9/5/25 at 1:34 p.m., Resident 1's Fall Risk assessment dated [DATE] was reviewed with the director of nursing (DON). The DON stated Resident 1 was admitted on [DATE] and was assessed as having a high risk for fall. The DON stated she was unable to find a care plan developed to address Resident 1's risk of fall. DON stated Resident 1's fall risk care plan would have interventions to prevent falls that would include keeping the environment free of clutter and belongings within reach. During a review of the facility Policy titled Nursing Assessment reviewed on 5/19/25 indicated .the admission assessment will be included in the resident's medical record and will be used to create an initial baseline care plan.for the resident. During a review of the facility's policy and procedures titled Fall Risk Assessment reviewed on 5/19/25, the P&P indicated the facility assesses all residents upon admission and periodically for their risk of falling. The facility uses this information to develop both individualized plans of care and facility wide fall prevention measures.

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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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. Based on interview and record review the facility failed to update and revise the care plan for one of two sampled residents (Resident 1). For Resident 1, the facility failed to update and revise the care plan when Resident 1 had a fall on 8/18/25 and 8/30/25. This deficient practice resulted in the facility failing to develop and implement new interventions for Resident 1 to prevent future falls. Findings:During a review of the admission Record indicated the facility admitted Resident 1 on 5/29/25 with diagnoses including diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), lack of coordination and absence of right leg above knee.During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 6/5/25 indicated Resident 1 had moderately impaired cognition. Resident 1 was dependent on shower, lower body dressing, putting on/taking off footwear, personal hygiene, substantial assistance (helper does more than half the effort) with oral hygiene, toileting hygiene, upper body dressing and moderate assistance (helper does less than the effort) with eating. During a review of the Change of Condition (COC) dated 8/18/25 at 10:56 a.m., indicated Resident 1 fell in the smoking patio and had no injuries. During a review of Resident 1's Post Fall Assessment and Investigation dated 8/18/25 indicated the yes box was marked indicating Resident 1's care plan was updated. During a review of the Change of Condition dated 8/30/25 at 2:16 a.m. indicated Resident 1 was found on the floor on the left side of his bed.During a review of the Post Fall Assessment and Investigation dated 8/30/25 indicated the yes box was marked indicating Resident 1's care plan was updated. During a concurrent interview and record review on 9/5/25 at 2:49 p.m., Resident 1's care plan with a focus on the resident has had an actual fall initiated on 8/11/25, created and revised on 9/5/25 was reviewed with the registered nurse supervisor (RNS 1). RNS 1 stated he created the care plan on 9/5/25. RNS 1 stated the care plan should have been created or revised when Resident 1 had the fall on 8/18/25 and 8/30/25. During a review of the facility's policy and procedures (P&P) titled Fall Management Program reviewed on 5/19/25, the P&P indicated, the nursing staff will develop a plan of care specific to the resident's needs with interventions to reduce the risks of falls. The interdisciplinary team will routinely review the plan of care at a minimum of quarterly, with a significant change in condition and post fall. Interventions will be implemented or changed based on the resident's condition and response. The same policy indicated following a resident's fall, the licensed nurse will review the circumstances of the fall, review the plan of care, implement new interventions as appropriate and revise the plan as indicated. The resident's care plan will be updated as necessary.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview and record review, the facility failed to ensure residents received adequate nutrition for one of two sampled residents (Resident 1). For Resident 1, the facility failed to provide interventions when Resident 1 refused to eat on 8/18/25 at 5:30 p.m. and refused to eat all meals on 8/19/25 and 8/23/25. This deficient practice resulted in Resident 1 not meeting his adequate nutritional status. During a review of the admission Record indicated the facility admitted Resident 1 on 5/29/25 with diagnoses including diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), lack of coordination and absence of right leg above knee.During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 6/5/25 indicated Resident 1 had moderately impaired cognition. Resident 1 was dependent on shower, lower body dressing, putting on/taking off footwear, personal hygiene, substantial assistance (helper does more than half the effort) with oral hygiene, toileting hygiene, upper body dressing and moderate assistance (helper does less than the effort) with eating. During a review of Resident 1's care plan initiated on 6/16/25 indicated Resident 1 was at risk for potential nutritional problems related to mechanical soft (soft texture diet that require less chewing than regular texture food) carbohydrate controlled (CCHO, consistent carbohydrate diet to control diabetes) no added salt soft diet restrictions. The care plan goal indicated Resident 1 will maintain adequate nutritional status as evidenced by maintaining weight, no signs and symptoms of malnutrition and consuming at least 75% of at least three meals daily through the review date. The care plan interventions included for the registered dietitian (RD) to evaluate and make diet change recommendations as needed. During a review of the Resident 1's Documentation Survey Report for 8/25 - Nutrition - Amount Eaten indicated the following:8/18/25 Resident 1 refused to eat at 5:30 p.m.8/19/25 Resident 1 refused to eat at 7:30 a.m., 12 p. m. and 5:30 p.m.8/23/25 - Resident 1 refused to eat at 7:30 a.m., 12 p.m. and 5:30 p.m. During an interview and concurrent review on 9/5/25 at 1:34 p.m., Resident 1's Nutrition - Amount Eaten dated 8/25 and Resident 1's progress notes were reviewed with the director of nursing (DON). The DON stated Resident 1 refused to eat dinner on 8/18/25, refused meals on 8/19/25, had variable intake the following days and refused meals on 8/23/25. The DON stated she was unable to find documentation that Resident 1's physician and registered dietitian were notified. The DON stated the physician, and the RD should be notified immediately to see if they have any recommendations. The DON stated when Resident 1 was refusing meals, Resident 1 could potentially lose weight. During a review of the facility's policy and procedures (P&P) titled Care and Services reviewed on 5/19/25, the P&P indicated the licensed nurse or designee documents and notifies the resident's physician and responsible party of:A. Change in condition, including progress and/or decline in physical or mental functionB. Resident refusal of care or servicesC. Unusual circumstances.

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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 maintain accurate and complete record for one of two sampled residents (Resident 1). For Resident 1 the facility failed to ensure:1.The Fall Risk Assessments dated 8/18/25 and 8/30/25 reflected Resident 1's risk of fall, whether Resident 1 was low risk or high risk for fall. 2.The Fall Risk assessment dated [DATE] accurately reflected that Resident 1 had a history of falls. These deficient practices resulted in an inaccurate and incomplete record for Resident 1. During a review of the admission Record indicated the facility admitted Resident 1 on 5/29/25 with diagnoses including diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), lack of coordination and absence of right leg above knee.During a review of the Minimum Data Set (MDS, a resident assessment tool) dated 6/5/25 indicated Resident 1 had moderately impaired cognition. Resident 1 was dependent on shower, lower body dressing, putting on/taking off footwear, personal hygiene, substantial assistance (helper does more than half the effort) with oral hygiene, toileting hygiene, upper body dressing and moderate assistance (helper does less than the effort) with eating. During a review of Resident 1's Fall Risk assessment dated [DATE] and 8/30/25 did not indicate if Resident 1 was low risk or high risk for fall. During a review of Resident 1's Fall Risk assessment dated [DATE] indicated Resident 1 did not have history of fall. During a concurrent interview and record review on 9/10/25 at 1:48 p.m., Resident 1's Fall Risk assessment dated [DATE], 8/18/25 and 8/30/25 were reviewed with the registered nurse supervisor (RNS 1). RNS 1 stated Resident 1's Fall Risk assessment dated [DATE] and 8/30/25 did not indicate Resident 1's fall risks. RNS 1 stated the Fall Risk Assessments should identify if Resident 1 was low or high risk for fall. RNS 1 further stated the Fall Risk assessment dated [DATE] indicated that Resident 1 had no history of fall. RNS 1 agreed that the Fall Risk assessment dated [DATE] was wrong because Resident 1 had previous history of fall. During a review of the facility's policy and procedures (P&P) titled Documentation - Nursing reviewed on 5/19/25, the P&P indicated nursing documentation will be concise, clear, pertinent and accurate.