

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 12/09/2025
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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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 0755</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 observation, interview, and record review, the facility failed to ensure that the necessary medication (Biktarvy) used to treat Human Immunodeficiency Virus (HIV- is a virus that attacks the body's immune system. HIV damages the immune system so that the body is less able to fight infection and disease. Without treatment, it can lead to acquired immunodeficiency syndrome- a chronic condition of the disease) was available and administered as ordered by the physician on six consecutive days for one of three sampled residents (Resident 2).This failure resulted in an interruption and delay of treatment for Resident 2, causing emotional and psychological distress for Resident 2, and placed Resident 2 at risk of avoidable decline in health status.During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of HIV.During a review of Resident 2's Minimum Data Set (MDS- a standardized resident assessment and care screening tool), dated 10/31/2025, the MDS indicated Resident 2 had intact cognitive skills for daily decision making. The MDS indicated Resident 2 supervision (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for eating, oral hygiene, toileting, upper body dressing, putting on taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair bed transfer, and shower transfer from staff. The MDS indicated Resident 2 required partial assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for lower body dressing and showering from staff.During a review of Resident 2's Order Summary (part of the resident's medical record that synthesizes all physician orders, ensuring that the resident, their representative, and all facility staff are aware of the comprehensive care plan), dated 10/24/2025, the Order Summary indicated to administer Biktarvy one tablet 50-200-25 milligram (mg- a unit of mass) by mouth one time a day for HIV.During a review of Resident 2's Medical Administration Record (MAR), the MAR indicated Resident 2 was not administered Biktarvy on the following dates:1. 11/9/2025, reason see progress note.2. 11/10/2025, reason see progress note.3. 11/11/2025, reason see progress note.4. 11/12/2025, reason see progress note.5. 11/13/2025, reason see progress note.6. 11/14/2025, reason see progress note.No documentation was found for the reason of the omission on 11/10/2025 thru 11/14/2025 in the medical chart. During a review of Resident 2's Nursing Progress Notes, dated 11/9/2025, the Nursing Progress Notes indicated Licensed Vocational Nurse 1 (LVN 1) spoke to the pharmacy regarding Resident 2's Biktarvy refill to be delivered to the facility by the next morning. No other documentation was found in Resident 2's medical chart for the omitted doses of Biktarvy from 11/10/2025 thru 11/14/2025, when the doses were omitted. During an interview on 12/9/2025 at 1 PM with Resident 2, while in Resident 2's room, Resident 2 was sitting down in bed and stated he was concerned about not having his medication Biktarvy available in the facility because he stated there had been many days when he did not take it due to the staff telling him the medication was not in stock at the facility. Resident 2 stated he had developed diarrhea (watery stools) and was also concerned about having an infection and getting treated for the diarrhea. Resident 2 stated he was supposed to have an appointment to see the doctor to prescribe the medication for his HIV. Resident 2 stated he was worried about the consequences of going without treatment. During a concurrent observation and interview on 12/9/2025 at 1:36 PM with Licensed Vocational Nurse 1 (LVN 1), LVN1 verified that Resident 2 had five oral tablets left of Biktarvy in the medication cart. LVN 1 stated on 11/9/2025, Resident 2 was not administered Biktarvy due to a lack of supply and she had noted this on the progress notes of Resident 2's medical chart. LVN1 stated she believed the medication was very expensive and Resident 2's insurance did not cover the costs but was uncertain as to why he didn't have an alternative treatment for his HIV. LVN 1 stated the facility protocol would be to notify the physician if the medication was not in the facility to determine alternative treatment. LVN 1 stated Resident 2 was required to have an appointment with his physician to refill the prescription, and it was important for the facility to follow up on setting up this appointment for Resident 2 to ensure the medication was available for Resident 2. LVN 1 stated typically the turn around time to get the medication from the pharmacy is one to two days, but it was important not to wait until the last minute to refill the medication to prevent interruption of treatment for Resident 2.During an interview on 12/9/2025 at 3:20 PM with the Director of Nursing (DON), the DON verified Resident 2's Order Summary, MAR, and progress notes, and stated the omission of the medication should have been</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>(continued on next page)</p>

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