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	04/20/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a significant change in condition was appropriately assessed, reported, documented, and incorporated into the comprehensive care plan for one of three sampled residents (Resident 1).This failure resulted in lack of direction for staff to address Resident 1's left knee pain and swelling, and had the potential to result in delayed or inadequate care.During a review of Resident 1's admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of hepatic encephalopathy (a reversible decline in brain function occurring in people with severe liver disease, such as cirrhosis or liver failure), cirrhosis of liver (a type of liver damage where healthy cells are replaced by scar tissue), reduced mobility, cellulitis of left leg (an infection of the deeper layers of skin and underlying tissue. This infection and spread quickly and become life threatening), thrombocytopenia (occurs when your bone marrow doesn't make enough platelets. Platelets are blood cells that form blood clots to help stop bleeding), and muscle weakness.During a review of Resident 1's Minimum Data Set (MDS- resident assessment tool), dated 3/15/2026, indicated, Resident 1 had intact cognitive skills for daily decision making. The MDS indicated Resident 1 was independent to perform oral hygiene, eating, upper body dressing, putting on footwear, personal hygiene, roll left and right, sit to lying, and lying to sitting on side of bed. Resident 1 required supervision assistance for toileting, and set up assistance to shower, lower body dressing, and chair/bed to chair transfer.On 4/14/2026 at 8 AM, a voicemail was received from Resident 1 reporting concerns related to left knee pain and associated issues. Resident 1 stated that she had experienced a fall and reported left knee pain to the nurse; however, she indicated that the nurse did not accurately document the event.Resident 1 expressed dissatisfaction with facility staff not managing her care needs; however, specific details could not be further clarified due to inability to establish direct communication with Resident 1. At the time of entrance to the facility, Resident 1 had already been discharged from the facility, making an in-person interview not feasible. Two attempts were made to contact Resident 1 via telephone on 4/20/2026 at 10:44 AM and 4/21/2026 at 11:29 AM. No response was received, and voicemails were left requesting a return call.During a concurrent interview and record review on 4/20/2026 at 1 PM with Registered Nurse Supervisor (RNS), the RNS verified record review titled Results from the electronic medical record (EMR) revealed that on 2/17/2026, Resident 1 developed pain and swelling to the left knee, and a physician order was obtained for an X-ray to rule out fracture, indicating a significant change in condition. The RNS stated facility process for reporting a change in condition is for Certified Nursing Assistants to report any unusual circumstances to the licensed nurses, write it in the Change of Condition Binder at the nursing station, and the licensed nurses check the binder to ensure prompt and completed assessment of residents. Further review of the medical record showed:No documented assessment identifying the cause of the knee swellingNo documented incident or investigation related to a possible fall or injuryNo evidence of notification or clear documentation of change in condition in the electronic medical record (EMR)No updated or revised care plan addressing pain, altered mobility, or risk for further injury During an interview on 4/20/2026 at 1:30 PM with the Director of Nursing (DON), (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the DON stated that licensed nurses are responsible for:Assessing and documenting changes in conditionReporting and documenting incidents such as fallsUpdating the care plan in the EMR to reflect current needs, goals, and interventionsDespite this stated process, the facility failed to ensure that Resident 1's change in condition was properly assessed, reported, documented, and care planned. During a review of the facility's policy and procedure titled Change of Condition Notification dated October 1, 2023, indicated the licensed nurse will document the following:Date, time, and pertinent details of the incident and the subsequent assessment in nursing notes.The time the attending physician was contacted, method of contact, response time, and orders received.Update the Care Plan to reflect the resident's current status.The incident and brief details in the 24 hour report.Each shift for at least 72 hours.Documentation pertaining to a change in the resident's condition will be maintained in the resident's medical record and on the 24 hour report.

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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 and implement an updated, person-centered care plan following a significant change in condition for one of three sampled residents (Resident 1).This failure resulted in lack of clear interventions and monitoring to address Resident 1's left knee pain and swelling, impaired mobility, or risk for further injury, and had the potential to result in delayed or inadequate care.During a review of Resident 1's admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of hepatic encephalopathy (a reversible decline in brain function occurring in people with severe liver disease, such as cirrhosis or liver failure), cirrhosis of liver (a type of liver damage where healthy cells are replaced by scar tissue), reduced mobility, cellulitis of left leg (an infection of the deeper layers of skin and underlying tissue. This infection and spread quickly and become life threatening), thrombocytopenia (occurs when your bone marrow doesn't make enough platelets. Platelets are blood cells that form blood clots to help stop bleeding), and muscle weakness.During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool), dated 3/15/2026, indicated, Resident 1 had intact cognitive skills for daily decision making. The MDS indicated Resident 1 was independent to perform oral hygiene, eating, upper body dressing, putting on footwear, personal hygiene, roll left and right, sit to lying, and lying to sitting on side of bed. Resident 1 required supervision assistance for toileting, and set up assistance to shower, lower body dressing, and chair/bed to chair transfer.On 4/14/2026 at 8 AM, a voicemail was received from Resident 1 reporting concerns related to left knee pain and associated issues. Resident 1 stated that she had experienced a fall and reported left knee pain to the nurse; however, she indicated that the nurse did not accurately document the event. Resident 1 expressed dissatisfaction with facility staff not managing her care needs; however, specific details could not be further clarified due to inability to establish direct communication with Resident 1. At the time of entrance to the facility, Resident 1 had already been discharged from the facility, making an in-person interview not feasible. Two attempts were made to contact Resident 1 via telephone on 4/20/2026 at 10:44 AM and 4/21/2026 at 11:29 AM. No response was received, and voicemails were left requesting a return call.During a concurrent interview and record review on 4/20/2026 at 1 PM with Registered Nurse Supervisor (RNS), the RNS verified record review titled Results from the electronic medical record (EMR) revealed that on 2/17/2026, Resident 1 developed pain and swelling to the left knee, and a physician order was obtained for an X-ray to rule out fracture, indicating a significant change in condition.Further review of the medical record showed:No documented assessment identifying the cause of the knee swellingNo documented incident or investigation related to a possible fall or injuryNo evidence of notification or clear documentation of change in condition in the electronic medical record (EMR)No updated or revised care plan addressing pain, altered mobility, or risk for further injury During an interview on 4/20/2026 at 1:30 PM with the Director of Nursing (DON), the DON stated that the Care Plan is essential to guide staff in implementing interventions for resident's health problems, make a goal to prioritize interventions for residents and prevent the issues from reoccurring. Licensed nurses are responsible for documenting changes in condition, completing appropriate assessments, and updating the care plan in the electronic medical record (EMR) to guide goals and interventions to meet residents' needs.During a review of the facility's policy and procedure titled Care Planning dated October 1, 2023, indicated the facility will develop a person-centered Care Plan for each resident within 48 hours of admission. The Care Plan will include initial goas, physician orders, therapy services, dietary orders, social services, summary of medications, treatments and services to be administered. The Interdisciplinary Team will revise the Care Plan as needed to address changes in behavior and care, and as dictated by changes in resident's condition.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure that call light systems were functioning properly and that staff consistently verified functionality to promote timely response to resident needs for one of three sampled residents (Resident 2).This failure resulted in inconsistent implementation of monitoring practices, resulting in a non-functioning call light for Resident 2, and had the potential to result in delayed care and unmet resident needs.During a review of Resident 2's admission Record, indicated Resident 2 was admitted to the facility on [DATE] with diagnosis of type 2 diabetes (DM2- A condition that happens because of a problem in the way the body regulates and uses sugar as fuel), hypoglycemia (a condition characterized by blood sugar levels falling below normal. Common in people with diabetes, often due to excess insulin, inadequate food intake, or intense exercise. Symptoms include shakiness, dizziness, sweating, and confusion. Severe cases can lead to seizures or loss of consciousness), and osteoporosis (bone disease that develops when bone mineral density and bone mass decreases, or when the quality or structure of bone changes. This can lead to a decrease in bone strength that can increase the risk of broken bones) with fracture (broken bone).During a review of Resident 2's Minimum Data Set (MDS- resident assessment tool), dated 3/15/2026, indicated, Resident 2 had intact cognitive skills for daily decision making. The MDS indicated Resident 2 required supervision from staff for oral hygiene and eating, substantial assistance for toileting, showering, lower body dressing, personal hygiene, and putting on taking off footwear. Resident 2 required partial assistance from staff for upper body dressing, to roll left and right, sit to lying, sit to stand, and sitting on side of bed.During a concurrent observation and interview on 4/20/2026 at 12:21 PM with Resident 2, in Resident 2's room, Resident 2 was eating her lunch and activated her call light; however, the call light failed to illuminate at the nurse's station, indicating the system was not functioning properly. Resident 2 reported that staff response times are sometimes delayed and stated that at times the call light does not work, contributing to delays in assistance.During an interview on 4/20/2026 at 12:24 PM with Certified Nursing Assistant 1 (CNA1), the CNA1 confirmed that the call light cable was not fully connected. CNA 1 stated she had forgotten to check the call light connection during morning rounds.During an interview on 4/20/2026 at 1:30 PM with the Director of Nursing (DON), the DON stated that department heads are expected to conduct daily rounds to ensure call lights are functioning properly to support timely response to resident needs and prevent delays in care.During a review of the facility's policy and procedure titled Communication - Call System dated February 20, 2026, indicated the facility will provide a call system to enable residents to alert the nursing staff from their beds and toileting facilities. If the primary call system becomes inoperable for any reason, the facility shall provide a bell for each resident room. Additionally, resident safety check rounds shall be conducted at least hourly and documented until the primary call system is operable again.