

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056206	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER University Park Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 230 E Adams Blvd Los Angeles, CA 90011	
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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the discharge summary and plan policy was followed by failing to have the post-discharge plan filled out completely and signed for one of three sampled residents (Resident 1). This failure resulted in Resident 1's post-discharge plan not being completed or signed accordingly. During a review of Resident 1's admission Record, dated 11/20/25 indicated the resident was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) anxiety disorder (symptoms of intense anxiety or panic that are directly caused by a physical health problem) , anemia (a condition where the body does not have enough healthy red blood cells), peripheral venous insufficiency (occurs when the walls and/or valves in the veins are not working effectively, making it difficult for blood to return to the heart).During a review of Resident 1's History and Physical (H&P) dated 5/14/25 indicated the resident had capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 5/17/25 indicated Resident 1 had moderate cognitive (learning, reasoning, thinking, understanding) impairment, and required supervision /touching assistance for Activities of Daily Living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a concurrent interview and record review on 11/18/25 at 3:22 pm with Registered Nurse Supervisor (RNS) 1, Resident 1's Post Discharge Plan of Care was reviewed. RNS 1 verified the document was incomplete: it did not indicate who the plan was developed with, equipment needs, special observations, special training/instructions or post-discharge goals. It was also missing the completed by and accepted by names and dates. RNS 1 stated he was unsure who filled out the document but thinks it was the night shift RN because that is how it is typically done, also the resident should have signed.During a review of the facility's policy and procedure (P&P) titled, Discharge Summary and Plan reviewed 4/17/25, the P&P indicated When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment.The post-discharge plan will be developed by the care planning/interdisciplinary (IDT) team with the assistance of the resident and his or her family and will include:. a description of the resident's stated discharge goals, the degree of caregiver/support person availability. how the IDT will support the resident or representative in the transition to post-discharge care. the resident/representative will be involved in the post-discharge planning process.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 056206	Facility ID: 056206 If continuation sheet Page 1 of 2

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to accurately assess for wandering behaviors for one of three sampled residents (Resident 1). This failure resulted in inaccurate Minimum Data Set (MDS- resident assessment tool) and had the potential to affect the residents care and services. During a review of Resident 1's admission Record, dated 11/20/25 indicated the resident was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) anxiety disorder (symptoms of intense anxiety or panic that are directly caused by a physical health problem) , anemia (a condition where the body does not have enough healthy red blood cells), peripheral venous insufficiency (occurs when the walls and/or valves in the veins are not working effectively, making it difficult for blood to return to the heart). During a review of Resident 1's History and Physical (H&P) dated 5/14/25 indicated the resident had capacity to understand and make decisions. During a review of Resident 1's Health Status note dated 5/16/25 indicated Resident 1 was on monitoring for behavior of wandering. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/17/25 indicated Resident 1 had moderate cognitive (learning, reasoning, thinking, understanding) impairment, and required supervision /touching assistance for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The same MDS further indicated the resident did not have any wandering behaviors. During a concurrent interview and record review on 11/18/25 at 3:41 pm with Director of Nursing (DON) Resident 1's health status note dated 5/16/25 and MDS section for behaviors dated 5/17/25 were reviewed. The health status note indicated the resident was on monitoring for behavior of wandering and the MDS indicated the resident had no behaviors of wandering. The DON confirmed the there was a discrepancy in the assessment and stated she was not aware but the resident was new so those behaviors are not uncommon. During a review of the facility's policy and procedure (P&P) titled, Wandering and Elopements reviewed 1/16/25 indicated The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. During a review of the facility's P&P titled, Resident Assessment reviewed 1/16/25 indicated, a comprehensive assessment of every resident's needs is made. includes a. completion of the Minimum Data Set (MDS). The interdisciplinary team uses the MDS form currently mandated by federal and state regulation to conduct the resident assessment. All members of the care team, including licensed and unlicensed staff members, are asked to participate in the resident assessment process.		