

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 12/15/2025
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Cross Reference F686Based on interview, and record review, the facility failed to ensure physician orders were implemented on 11/29/2025 and 12/1/2025 for five out of five sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, and Resident 5), who required daily treatment for wound (a physical injury to the body, like a cut or tear in the skin) management to maintain the highest practicable physical well-being. This failure resulted in lack of daily wound treatment for: a. Resident 1's stoma (a surgically created opening in the body, usually on the abdomen, that connects an internal organ (like the bowel or urinary system) to the outside, allowing waste (urine or feces) to exit into a collection bag), left ischium (the curved bone forming the base of each half of the pelvis), perineal area (the diamond-shaped region of skin and muscle between the anus and the genitals, extending from the pubic bone to the tailbone), scrotum, and sacrococcyx (lower part of the spine and tail bone). b. Resident 2's prevention of wound injury. c. Resident 3's bilateral extremities. d. Resident 4's left arm cast. e. Resident 5's left foot, left plantar, right heel, right ischium, right lateral foot stump. The residents at risk for delayed wound healing and further skin breakdown. A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of quadriplegia (The complete inability to move due to severe disability frailty caused by another medical condition without physical injury or damage to the spinal cord), colostomy (a surgical procedure where a surgeon creates an opening in the abdominal wall so that stool can leave the body through the abdomen instead of the rectum) status, and open wound of left buttock. A review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 11/1/2025, indicated Resident 1 had intact cognition (the mental ability to think, remember and reason) for decisions of daily living, and required maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for eating. The MDS indicated Resident 1 was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) on staff for toileting, lower body dressing, putting on/off footwear, and showering, rolling left and right, sit to lying, lying to sitting on side of bed, and transferring to the shower. The MDS indicated Resident 1 was at risk of developing pressure injuries (an injury that breaks down the skin and underlying tissue when an area of skin is placed under pressure). A review of Resident 1's Order Summary, dated 6/17/2025, indicated for Resident 1, to cleanse with normal saline (NS- a mixture of sodium chloride and water that is used to clean wounds), pat dry apply skin prep around stoma, apply colostomy bag everyday shift for colostomy management. Apply Santyl collagenase (is a prescription medication used to remove dead or damaged tissue from chronic skin ulcers and severe burns. This process helps promote the formation of healthy new tissue and wound healing) ointment to left ischium and perineal area to scrotum, topically every day for surgical wound for 30 days, cleanse with NS, apply collagen pellets, apply calcium alginate and cover with DD. Apply Zinc Oxide to Sacro-coccyx topically everyday shift for healed wound management. A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses of dementia (progressive impaired ability to think, remember or make decisions that interferes with doing everyday activities) and difficulty in walking. A review of Resident 2's MDS, dated [DATE], indicated Resident 2 had moderate impaired cognition (ability to think, remember and reason) for decisions of daily living, and required supervision (Helper provides verbal cues and/or touching/steading and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for eating, 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 oral hygiene, and maximal assistance for toileting, showering, upper and lower body dressing, putting on taking off footwear, personal hygiene, rolling left and right, sit to lying, lying to sitting on side of bed, and chair transfer. The MDS indicated Resident 2 was at risk of developing pressure injuries. A review of Resident 2's Order Summary, dated 6/4/2025, indicated to monitor functionality of low air loss mattress (LAL, a bed that alternates pressure to help heal and prevent pressure injuries) every shift for skin management. A review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses of contractures (the permanent tightening and shortening of muscles, tendons, skin, or other tissues around a joint, making it stiff, difficult to bend or straighten, and restricting normal movement, often caused by injury, nerve damage, inactivity, scarring) to arms and ankle, and muscle weakness. A review of Resident 3's MDS</p>		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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<p>F 0686</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** Cross Reference F684 Based on interview, and record review, the facility failed to ensure physician orders were implemented on 11/29/2025 and 12/1/2025 for five out of five sampled residents (Resident 1, Resident 2, Resident 3, and Resident 5), who required daily treatment for wound (a physical injury to the body, like a cut or tear in the skin) management to prevent the development of and or deterioration of pressure injuries (Pressure sore/ulcer-is localized damage to skin and underlying tissues from intense or prolonged pressure, often over bony areas like hips, heels, or tailbone, due to reduced blood flow, exacerbated by friction, shear, and moisture). This failure resulted in lack of daily wound treatment for: a. Resident 1's stoma (a surgically created opening in the body, usually on the abdomen, that connects an internal organ (like the bowel or urinary system) to the outside, allowing waste (urine or feces) to exit into a collection bag), left ischium (the curved bone forming the base of each half of the pelvis), perineal area (the diamond-shaped region of skin and muscle between the anus and the genitals, extending from the pubic bone to the tailbone), scrotum, and Sacro-coccyx (lower part of the spine and tail bone). b. Resident 2's prevention of wound injury. Resident 3's bilateral extremities. Resident 5's left foot, left plantar, right heel, right ischium, right lateral foot stump placing the residents at risk for delayed wound healing and further skin breakdown. Findings: A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of quadriplegia (The complete inability to move due to severe disability frailty caused by another medical condition without physical injury or damage to the spinal cord), colostomy (a surgical procedure where a surgeon creates an opening in the abdominal wall so that stool can leave the body through the abdomen instead of the rectum) status, and open wound of left buttock. A review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 11/1/2025, indicated Resident 1 had intact cognition (the mental ability to think, remember and reason) for decisions of daily living, and required maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for eating. The MDS indicated Resident 1 was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) on staff for toileting, lower body dressing, putting on/off footwear, and showering, rolling left and right, sit to lying, lying to sitting on side of bed, and transferring to the shower. The MDS indicated Resident 1 was at risk of developing pressure injuries (an injury that breaks down the skin and underlying tissue when an area of skin is placed under pressure). A review of Resident 1's Order Summary, dated 6/17/2025, indicated for Resident 1, to cleanse with normal saline (NS- a mixture of sodium chloride and water that is used to clean wounds), pat dry apply skin prep around stoma, apply colostomy bag everyday shift for colostomy management. Apply Santyl collagenase (is a prescription medication used to remove dead or damaged tissue from chronic skin ulcers and severe burns. This process helps promote the formation of healthy new tissue and wound healing) ointment to left ischium and perineal area to scrotum, topically every day for surgical wound for 30 days, cleanse with NS, apply collagen pellets, apply calcium alginate and cover with DD. Apply Zinc Oxide to Sacro-coccyx topically everyday shift for healed wound management. A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses of dementia (progressive impaired ability to think, remember or make decisions that interferes with doing everyday activities) and difficulty in walking. A review of Resident 2's MDS, dated [DATE], indicated Resident 2 had moderate impaired cognition (ability to think, remember and reason) for decisions of daily living, and required 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, 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 oral hygiene, and maximal assistance for toileting, showering, upper and lower body dressing, putting on taking off footwear, personal hygiene, rolling left and right, sit to lying, lying to sitting on side of bed, and chair transfer. The MDS indicated Resident 2 was at risk of developing pressure injuries. A review of Resident 2's Order Summary, dated 6/4/2025, indicated to monitor functionality of low air loss mattress (LAL, a bed that alternates pressure to help heal and prevent pressure injuries) every shift for skin management. A review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses of contractures (the permanent tightening and shortening of muscles, tendons, skin, or other tissues around a</p>		