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

Printed: 05/05/2026
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 02/05/2026
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 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. Based on interview and record review, the facility failed to notify the resident's physician timely for one of three sampled residents (Resident 1). The facility failed to notify Resident 1's physician when Resident 1 had been refusing to take Depakote (medication used to treat including mental and mood conditions). This deficient practice had the potential for Resident 1's symptoms of paranoid schizophrenia (a mental illness that is characterized by disturbances in thought) manifested by delusions (having false or unrealistic beliefs) to worsen.During a review of the admission Record indicated the facility admitted Resident 1 on 11/7/24 with diagnoses including paranoid schizophrenia, psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and muscle weakness.During a review of the Physician Order dated 12/4/24 at 4:29 p.m., indicated physician's order to give Resident 1 Depakote tablet 125 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) delayed release by mouth for schizophrenia two times a day.During a review of Resident 1's care plan initiated on 12/4/24 and revised on 3/23/25 indicated Resident 1 was on Depakote 125 mg. two times a day for paranoid schizophrenia. The care plan goal indicated Resident 1 will not have side effects from the medication for three months. Interventions included assess daily for behavior manifested, notify the physician if the medication can be reduced, monitor the behavior and report monthly to the physician/psychiatrist to assist to assure lowest possible therapeutic dose.During a review of the Minimum data set (MDS, resident assessment tool) dated 11/4/25 indicated Resident 1 was cognitively intact. Resident 1 needed set-up assistance (helper sets up or cleans up, resident completes activity) with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 1/26 indicated Resident 1 refused to take the Depakote 125 mg. orally the following dates and time.1/1/26 - refused at 9 a.m. and 5 p.m.1/2/26 - refused at 9 a.m.1/3/26 - refused at 9 a.m.1/4/26 - refused at 9 a.m.1/5/26 - refused 9 a.m.1/6/26 - refused at 9 a.m. and 5 p.m.1/7/26 - refused at 9 a.m. and 5 p.m.1/8/26 - refused at 9 a.m. and 5 p.m.1/9/26 - refused at 9 a.m.1/10/26 - refused at 9 a.m.1/11/26 - refused at 9 a.m.1/12/26 - refused at 9 a.m. and 5 p.m.1/13/26 - refused at 9 a.m. and 5 p.m.1/14/26 - refused at 9 a.m.1/15/26 - refused at 9 a.m.1/16/26 - refused at 9 a.m. and 5 p.m.1/17/26 - refused at 9 a.m.1/18/26 - refused at 9 a.m. and 5 p.m.1/19/26 - refused at 9 a.m. and 5 p.m.1/20/26 - refused at 9 a.m. and 5 p.m.1/21/26 - refused at 9 a.m. and 5 p.m.1/22/26 - refused at 9 a.m.1/24/26 to 1/30/26 - refused at 9 a.m. and 5 p.m. During a review of the Change of Condition dated 1/30/26 at 1:51 p.m., indicated Resident 1 continued to refuse taking her medications, including laboratory tests. The COC indicated Resident 1's primary physician was notified. During an interview on 2/5/26 at 11:17 a.m. licensed vocational nurse (LVN 1) stated Resident 1 had been refusing her medications including Depakote. LVN 1 stated when Resident 1 refuses her medication, (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

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 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Healthcare Center	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 will be offered the medication two times and when she continues to refuse the medication, the physician should be notified. During a review and concurrent interview on 2/5/26 at 11:58 a.m., Resident 1's MAR for 1/26 was reviewed with the registered nurse supervisor (RNS 1). RNS 1 stated Resident 1 had been refusing to take the Depakote sometimes in the morning. RNS 1 stated Depakote is for Resident 1's delusion and when she does not take the Depakote, Resident 1's delusions will not be controlled. RNS 1 stated the change of condition was created on 1/30/26 and Resident 1's primary physician was notified on 1/30/26. During a review and concurrent interview on 2/5/26 at 12:55 p.m., the director of nursing (DON) stated when Resident 1 refuses to take the Depakote, the refusal to take the Depakote . will exacerbate her condition. DON stated she was unable to find any other documentation that the primary physician or psychiatrist were notified before 1/30/26. During a review of the facility's policy and procedures titled Change in a Resident's Condition or Status reviewed on 1/15/26 indicated the facility promptly notifies the resident, his or her attending physician and the resident representative of changes in the resident's medical/mental condition and or status. The same Policy indicated the nurse will notify the resident's attending physician or physician on call when there has been refusal of treatment or medications two or more consecutive times.