STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056206	A. Building B. Wing	06/16/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for one of six sampled residents (Resident 1), the facility failed to ensure:Two staff members assisted to transfer Resident 1 from a car onto a wheelchair (WC) on 6/2/2026 at approximately 4 PM to prevent falls.Resident 1's Family Member (FM 1), was trained on how to assist, and safely use and safely transfer Resident 1 in and out of a wheelchair (WC) according to the facility's policy and procedures (P&P) titled Assistive Devices and Equipment dated 1/15/2026.The facility was aware Resident 1 had a history of falls and was at risk accidents and falls. As a result, on 6/2/2026 at approximately 4 PM, Resident 1 slid off the WC and fell to the ground when certified nursing assistant (CNA 1) and FM 1 were transferring Resident 1 from a car onto a WC placing Resident 1 at increased for injury, hospitalization and deathFindings: During a record review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially 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), cerebral infarction (disruption of blood flow to the brain due to problematic vessels that cause lack of blood supply and oxygen to the brain), muscle weakness, abnormal posture, neuralgia (a sharp, severe, and often burning pain that follows the path of a nerve, caused by nerve irritation, damage, or disease), and readmitted on [DATE] with mood dysregulation disorder (a mental health condition characterized by severe, chronic irritability and frequent, intense temper outbursts that are way out of proportion to the situation) and anxiety (Persistent feeling of dread or panic that can interfere with daily life). During a record review of Resident 1's Minimum Data Set (MDS- resident assessment tool) dated 4/15/2026, The MDS indicated Resident 1 had moderate impaired cognition (ability to think, remember and reason for daily decision making). The MDS indicated Resident 1 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 toileting, shower/bathe, upper and lower body dressing, putting on/taking off footwear, and toilet transfer. Resident 1 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 eating, oral hygiene, personal hygiene, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed transfer. The MDS indicated Resident 1 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) from staff to roll left and right. During a record review of Resident 1's Care Plan (CP) titled Risk for accidents/falls .) dated 4/21/2025, the CP indicated, staff will assist (Resident 1) with all transfers as needed, eliminate potential hazards, and provide safety instruction to resident/family regarding transfers when appropriate to reduce the risk of falls and injury daily. During a record review of Resident 1's Care Plan (CP) At risk for complications due to alteration in musculoskeletal status dated 4/22/2026, the CP indicated, Staff will assist (Resident 1) with the use of supportive devices and educate family/caregivers on safety measures that need to be taken in order to reduce risk of falls. During a record review of Resident 1's Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated Resident 1 was moderate risk for falls due to (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disoriented level of consciousness, history of 1-2 falls in the past three months, being chair bound, decreased muscular coordination, balance problem while walking and standing, and taking narcotics (medications to treat severe pain), psychotropics (Drugs/medications that affect a person's mental state), and sedatives (medications that slows brain activity to induce calmness, relaxation, or sleep). During a record review of Resident 1's Fall Incident, dated 6/2/2026, the Fall Incident (report) indicated Resident 1 had a witnessed fall on 6/2/2026 at around 4 PM during returning from out on pass (an admitted resident has temporary, authorized permission to leave the facility for a few hours or days without being officially discharged) with FM 1. A facility staff assisted Resident 1 to get on the WC, however, the resident slid off the WC. During a record review of Resident 1's Radiology Report dated 6/2/2026, the Radiology Report indicated Resident 1 had no evidence of fracture or dislocation to Resident 1' s bilateral hips. During a phone interview on 6/16/2026 at 9:30 AM with FM 1, FM 1 stated that on 6/2/2026 at approximately 4 PM, Resident 1 and FM 1 returned to the facility from out of pass (OOP) and was greeted by two staff members. FM 1 stated that FM 1 and Resident 1 were outside in a car at the facility entrance. FM 1 stated that CNA 1 and FM 1 assisted to transfer Resident 1 from the car into the WC instead of two trained facility staff members. FM 1 stated that Resident 1 was not properly positioned in the WC and slid from the WC to the ground. FM 1 stated that the facility had not instructed or educated FM 1 on how to properly perform surface transfer the resident. FM 1 stated the incident occurred outside of the facility at the entrance, and that multiple staff members came out to offer assistance but the staff seemed more preoccupied with how Resident 1 fell versus trying to get the resident up off the ground and assess the resident for injuries. FM 1 stated FM 1 attempted to report the incident to Registered Nurse Supervisor (RNS) and also requested RNS of the incident report. FM 1 stated that RNS declined FM 1's request of Resident 1's incident report because RNS had already received a report from a facility staff regarding the incident and that RNS would complete the incident report for Resident 1. FM 1 stated FM 1 was not provided with Resident 1's fall incident report or further information regarding the reporting process. FM 1 stated FM 1 felt the facility staff were trying to cover up Resident 1's fall incident. During a phone interview on 6/16/2026 at 12:15 PM with RNS, RNS stated Resident 1 was at risk for falls. RNS stated that on 6/2/2026 at approximately 4 PM, FM 1 requested assistance to get Resident 1 out of a vehicle when FM 1 and Resident 1 returned to the facility. RNS stated RNS directed CNA 1 and CNA 2 to assist Resident 1 transfer from the car into a WC as resident 1 required a 2 person assist. RNS stated that CNA 1 transferred Resident 1 from the car to a WC. RNS stated that after CNA 1 and CNA 2 transferred Resident 1 to bed, FM 1 reported to RNS that Resident 1 fell during the transfer from the car into a WC. RNS stated that both CNA 1 and CNA 2 denied that Resident 1 fell because Resident 1 did not make contact with the ground. RNS stated that FM 1 insisted that Resident 1 made contact with the ground when being transferred from the car into a WC. RNS stated RNS informed Resident 1's physician of the alleged fall, and the physician ordered an X-ray (Radiograph: type of medical imaging that creates pictures of bones and soft tissue). RNS further stated Resident 1 was probably not seated correctly in the WC and acknowledged that Resident 1 had poor posture and physical limitations, of which the CNAs were aware of. RNS stated RNS would complete an incident report after receiving information from staff regarding Resident 1 fall incident. During a phone interview on 6/16/2026 at 12:08 PM with CNA 2, CNA 2 stated that on 6/2/2026 at approximately 4 PM, RNS asked CNA 2 to help assist CNA 1 to transfer Resident 1 from the vehicle outside the facility into a WC and then bring the resident inside the facility. CNA 2 stated CNA 2 went outside to assist CNA 1 and noticed Resident 1 was hitting CNA1 because that's how Resident 1 typically does to staff and he was aware of it. CNA 2 stated he did not help CNA 1 get Resident 1 out of the car because CNA1 and Resident 1's FM 1 were already getting Resident 1 out of the car. CNA 2 stated that FM 1 assisted CNA 1 to transfer Resident 1 onto the WC and then Resident 1 slid off the WC. CNA 2 stated that the WC did not have footrests. CNA 2 stated Resident 1 is heavy and requires 2 staff assist with surface transfers. During a phone interview on 6/16/2026 at 12:39 PM with CNA 1, CNA1 stated that on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/2/2026 at approximately 3:45 PM, CNA 1 stated that RNS asked CNA 1 to go and assist transfer Resident 1 from the car onto a WC who had just returned from an appointment CNA 1 stated Resident 1 is very aggressive, hits and yells at staff. CNA 1 stated that on 6/2/2026 at approximately 43;45 PM, while CNA 1 attempted to get Resident 1 out of the vehicle, Resident 1 began to hit CNA 1 and that FM 1 was able to calm the resident down. CNA 1 stated that Resident 1 did not fall to the ground but instead slid forward off the WC and that CNA 2 reached to catch Resident 1 before the resident touched the ground. CNA 1 stated that CNA 2 intervened and caught Resident 1 before the resident made contact with the ground. CNA 1 stated that Resident 1 frequently slides during transfers CNA 1 stated that the facility has not provided CNA 1 with recent in-service training on how to perform resident surface transfer. CNA 1 stated that Resident 1 was not optimally seated in the WC while still outside the facility by main entrance. CNA 1 further stated that if two facility staff members had completed Resident 1's transfer from the car to a WC, then CNA 1 and CNA 2 may have been able to position the resident correctly and potentially prevent Resident 1 from sliding off the WC and falling. CNA 1 stated that Resident 1's transfer may not have been performed correctly due to involving FM 1. CNA 1 stated had if CNA 2 had assisted CNA 1 to transfer Resident 1 from the car onto the WC, then Resident 1's transfer could have been completed safely. During an interview on 6/16/2026 at 12:51 PM with the Director of Nursing (DON), the DON stated that on 6/2/2026 at approximately 4:30 PM, DON was walking in the facility when DON observed a group of staff and FM 1 near Resident 1's room. The DON stated FM 1 reported to DON that Resident 1 had slid off the WC asCNA1 turned the WC toward the entrance of the facility. The DON indicated that Resident 1's buttocks may not have been fully positioned on the wheelchair, and that the incident of the resident sliding off a WC is still considered a fall. The DON further stated that Resident 1's WC did not have footrests. The DON stated Resident 1 is a high risk for fall due to dementia and contractures (the permanent tightening or shortening of muscles, tendons, skin, or other soft tissues). The DON stated Resident 1 requires two staff members for surface transfers. The DON stated that fall prevention measures include ensuring that the resident is properly seated in the WC and to exercise caution when maneuvering the WC. The DON acknowledged and stated that Resident 1's WC was faulty/were stuck and could not be put down for Resident 1 to rest his legs and stated that the resident sliding off the WC and falling incident could have been prevented had Resident 1 been properly seated/positioned in the WC and the WC had functional footrests. The DON stated, This failure placed Resident 1 at risk for falls and injury. During a review of the facility's policy and procedures (P&P) titled Assistive Devices and Equipment dated 1/15/2026, the P& P indicated, 4. Staff and volunteers are trained and demonstrate competency on the use of devices and equipment prior to assisting or supervising residents.5. Resident Family and visitors are trained on the safe use of equipment and devices.C. Defective or worn devices are discarded or repaired. During a review of the facility's P&P titled Fall-Clinical Protocol reviewed 1/15/2026, the P&P indicated the following: Assessment and Recognition1. The physician will help identify individuals with a history of falls and risk factors for falling.a. Staff will ask the resident and the caregiver or family about a history of falling.b. The staff and physician will document in the medical record a history of one or more recent falls (for example, within 90 days).c. While many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause.6. Falls should be categorized as: .c. Other circumstances such as sliding out of a chair or rolling from a low bed to the floor.