STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056237	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Terrace Convalescent Hospital	1240 S Hoover St Los Angeles, CA 90006

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** REVIEWEDBased on observation, interview and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect in full recognition of her individuality for three (3) out of the 6 sampled residents (Resident 78, Resident 111 and Resident 180). This deficient practice had the potential to affect the Residents self-esteem and self-worth. During a meal observation on 9/29/2025 at 12:00 p.m., in the facility common dining room, Certified Nursing Assistant (CNA) 4, CNA5 and CNA6, were observed standing while feeding lunch to Resident 78, Resident 111 and Resident 180. The 3 residents, Resident 78, Resident 111 and Resident 180, were observed extending their necks up at CNA 4, CNA5 and CNA6 as they were being fed lunch. A review of Resident 78's admission Record indicated the resident was originally admitted to the facility on [DATE] and re-admitted on [DATE] , with diagnoses including but not limited to, dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), dysphagia (difficulty or discomfort when swallowing), protein calorie malnutrition (a nutritional deficiency caused by a lack of sufficient protein calories in the diet), type 2 diabetes (chronic condition where the body either doesn't produce enough insulin to regulate blood sugar levels), difficulty walking, abnormal gait mobility (unusual/abnormal walking pattern) and hypertension (high blood pressure). A review of Resident 78's Quarterly Minimum Data Set (MDS - a resident assessment tool) dated 10/16/2025, indicated the resident had severely impaired cognitive skills for daily decision-making. The MDS indicated that the resident needed setup or clean up assistance with eating, partial moderate assistance with oral hygiene, and supervision with bed mobility, transfers and upper body dressing. A review of Resident 111's admission Record indicated the resident was originally admitted to the facility on [DATE] and re-admitted on [DATE] , with diagnoses including but not limited to, dementia, type 2 diabetes, chronic gastritis (the inflammation, irritation, or swelling of the stomach lining), dysphagia, anxiety disorder (excessive worry, fear, and nervousness that is out of proportion to the situation and interferes with daily life), bipolar disorder (a mental health condition that causes significant and extreme shifts in mood, energy, activity levels, and concentration), abnormal gait mobility and hypertension. A review of Resident 110's MDS dated [DATE], indicated the resident had severely impaired cognitive skills for daily decision-making. The MDS indicated that the residents needed supervision or touching assistance with eating, partial moderate assistance with oral hygiene, and supervision with bed mobility, transfers and substantial maximum assistance with upper and lower body dressing. A review of Resident 180's admission Record indicated the resident was originally admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses including but not limited to, dementia, dysphagia, failure to thrive concerning food and fluid intake (clinical decline, primarily caused by inadequate nutrition), difficulty walking, abnormal gait mobility and hypertension. A review of Resident 180's MDS dated [DATE], indicated the resident had severely impaired cognitive skills for daily decision-making. The MDS indicated that the resident needed supervision or touching assistance with eating, partial moderate assistance with oral hygiene, and supervision with bed mobility, transfers and partial moderate assistance with upper (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	body dressing. During an interview with CNA4 on 9/29/2025 at 12:09 PM, CNA4 stated she had a lot of Residents (number not provided), and she had no chair to sit on. During an interview with CNA5 on 9/29/2025 at 12:10 PM, CNA5 stated she usually feeds the Residents while standing up. During an interview with CNA6 on 9/29/2025 at 12:11 PM CNA6 stated he usually feeds the Residents while standing up. During an interview with the Director of Nursing (DON) on 11/20/2025 at 12:47PM, the DON stated staff should sit down at eye-to-eye level with the Residents, talk to the Resident and encourage the Resident and monitor the Resident while the Resident eats, chews and properly swallows their food for dignity, DON stated Residents feel more comfortable and engaged resulting in positive outcomes. DON stated feeding Residents while standing looks hurried, is impersonal, there is no connection with the Resident. A review of the facility policy and procedures titled Assistance with Meals, dated 5/5/2025, indicated, Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example, not standing over residents while assisting them with meals.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 4 protected one of three residents (Resident 13) identifiable personal information displayed on a computer screen when LVN 4 was walking away from the computer. This deficient practice violated Resident 13's right for privacy and confidentiality. Findings: A review of Resident 13's admission record (face sheet - a document containing demographic and diagnostic information) indicated Resident 13 was admitted to the facility on [DATE] and re-admitted on [DATE] with the following diagnoses: type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), generalized muscle weakness (lack of physical or muscle strength), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), essential (primary) hypertension (abnormally high blood pressure not caused by a medical condition), and cardiomegaly (an enlarged heart; a condition that makes a heart use extra effort to pump blood). A review of Resident 13's History and Physical (H&P - a physician's complete patient examination) dated 8/18/2025 indicated, Resident 13 was able to make decisions for activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 13's Minimum Data Set (MDS - a resident assessment tool) dated 10/07/2025, indicated, Resident 13 made poor decisions, and required cues and supervision. The MDS also indicated, Resident 13 was dependent on staff with her Activities of daily Living (ADL). A review of Resident 13's care plan (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) on impaired ambulation (act of walking) dated 3/25/2025, indicated, Resident 13 had a diagnosis of self-care deficits. The CP goal indicated Resident 13 will be clean, dry, and well-groomed daily. A review of the facility's In-Service Education (a professional development for workers aimed to enhance their skills, knowledge, and competence to improve job performance) sign-in sheet dated 8/08/2025 indicated, LVN 4 signed in and received HIPAA (Health Insurance Portability and Accountability Act - is a federal law that sets a national standard to protect medical records and other personal health information) education. During a concurrent observation on 9/29/2025 at 10:58 AM, at nurses' station 2, the surveyor observed a facility computer with the screen open on (medication(med) cart 2. There was no staff at the nurses' station or at med cart 2. The surveyor touched the track pad on the computer and the computer's screen instantly opened to Resident 13's personal information which included the resident's name, date of birth , social security number, address, and medical diagnoses. Approximately two minutes later, LVN 4 came to nurses' station 2. During a concurrent interview, LVN 4 stated that she was assigned nurses' station 2. LVN 4 stated, I thought I left the screen (computer) hidden. LVN 4 stated, I am exposing [Resident 13's] privacy, personal information, you know, identity theft. A review of the facility policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled HIPAA Training Program with a review date of 5/20/2025 indicated, . To ensure the confidentiality or our resident's protected health information (PHI) and facility information (PHI) . A review of the facility's P&P titled Resident Rights with a review date of 5/20/2025 indicated, the facility will provide privacy and confidentiality to all of their residents. A review of the facility P&P titled Confidentiality of Information and Personal Privacy dated 5/20/25, indicated, Our facility will protect and safeguard resident confidentiality and persosonal privacy. I. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records.

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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. REVIEWEDBased on interview and record review, the facility failed to develop a comprehensive care plan for one of seven sampled residents (Resident 9) in accordance with the facility's policy and procedures (P&P) titled Care Plans, Comprehensive Person-Centered with review date of 5/20/2025, by failing to have a care plan for Resident 9's schizoaffective (a mental health condition that combines symptoms of both schizophrenia [a chronic brain disorder that affects how a person thinks, feels, and behaves, making it difficult to distinguish reality from imagination] and a mood disorder, such as bipolar [a mental health condition characterized by unusual and extreme shifts in mood, energy, and activity levels, which include periods of intense highs (mania) and lows (depression - a common, serious medical illness that affects how a person feels, thinks, and acts, characterized by a persistent sad or low mood and a loss of interest in activities once enjoyed)] disorder and bipolar disorders.This deficient practice had the potential to negatively affect the delivery of necessary care and services needed for Resident 9.A review of Resident 9's admission Record indicated the facility admitted Resident 15 on 4/6/2011 and readmitted Resident 9 on 9/25/2025 with diagnoses including schizoaffective disorder, bipolar disorder, and hypertension (HTN -high blood pressure). A review of Resident 9's Minimum Data Set (MDS - a resident screening tool) dated 10/7/2025, indicated Resident 9 was cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 9 required substantial/maximal assistance to dependency on staff with activities of daily living (ADL -routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). A review of Resident 9's Multidisciplinary Progress Record (a team of professionals from different fields who are all working on the same project or for the same person) dated 10/20/2025, indicated .assessment -schizophrenia. During a concurrent interview and record review, on 11/20/2025, at 8:58 A.M., with Licensed Vocational Nurse (LVN) 2, Resident 9's electronic and paper chart was reviewed. LVN 2 stated that a care plan identifies a problem, has a goal, and the interventions as to what staff will do to help reach that goal. LVN 2 stated that if the care plan for a resident is missing for an identified problem, it may put the resident at risk for not receiving care for that problem properly to prevent the condition from worsening. LVN 2 stated that Resident 9 had an active diagnoses of schizoaffective disorder and bipolar disorder, however, there was no care plan noted in Resident 9's electronic or paper chart for both diagnoses. During an interview, on 11/20/2025, at 12:51 P.M., with the Director of Nursing (DON), the DON stated that a care plan is used to follow the plan for the residents' care so that the appropriate interventions and care regarding the resident's condition can be given. The DON stated that a care plan is initiated as soon as a condition occurs. The DON stated that if the resident does not have a specific care plan for schizoaffective and bipolar disorders then behaviors may not be addressed specifically and cause the condition to worsen. A review of the facility policy and procedures (P&P), titled Care Plans, Comprehensive Person-Centered with review date of 5/20/2025 indicated, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. REVIEWING Based on interviews and concurrent record review, the facility failed to complete the annual performances evaluations and annual skills competencies for six out of six employees according to facility policies and procedures titled, Performance Evaluations and Competency Assessments.This failure had the potential to result in inadequate care, skills, and nursing services to the residents.Findings: During an interview on 10/1/25 at 8:42 AM, Director of Satff Development (DSD) stated the importance of staff annual skills competencies is to ensure the nurse skills are following the correct protocol and to make sure the nurses are capable of caring out the skills to complete their job efficiently. ˆDSD stated performance evaluations are to be completed annually to so that the managers and supervisors can identify areas of improvement for all the staff. During an interview on 10/1/25 at 9:32 a.m., Certified Nursing Assistant (CNA) 3 stated she does not remember the last time she completed annual skills competency. CNA 3 stated she has not completed abuse training since hire. During an interview and concurrent record review on 10/1/25 at 10:09 a.m., seven out of seven employee files were reviewed with the Director of Staff Development (DSD) and the following were noted/identified:1. License Vocational Nurse (LVN) 4 was hired on 12/22/2022. There was no documented evidence that LVN 4 completed the annual performance for 2023, and no documented evidence LVN 4 completed the annual competencies for year 2023 and 2025. 2. LVN 5 was hired on 7/11/2012. There was documented evidence that LVN 5 completed annual competencies for 2023, 2024, and 2025, and no documented evidence that LVN 5 completed annual skills check for 2023, 2024, and 2025.3. The Assistant Director of Nursing (ADON) was hired on 5/14/2013. There was no documented evidence that the ADON completed annual competency for 2023.4. CNA 3 was hired on 2/25/2024. There was no documented evidence that CNA 3 completed annual competencies for 2025.5. CNA 4 was hired on 10/20/2004. There was no documented evidence that CNA 4 completed annual competencies for 2022, 2023, and 2024.6. CNA 5 was hired on 5/9, 2024. There was no documented evidence that CNA 5 completed annual performance evaluation for 2025. During an interview with the Director of Nursing (DON) on 11/20/25 12:46 PM, the DON stated all staff are supposed to complete annual competencies and annual performance evaluations upon hire and annually. DON stated if the staff do not complete annual competencies yearly, they can forget how to care for the residents and could make mistakes with certain skills. DON stated it is very important that all the staff training is completed on time to prevent harm to the residents and to ensure all the residents receive the best possible care and to see if there are any areas of improvement that are needed to ensure the staff provide good care to residents. During a review of the facility policy and procedures (P&P) titled Performance Evaluations with a revised date of 5/20/2025, indicated, Policy Statement: The job performance of each employee shall be reviewed and evaluated at least annually. A review of the facility P&P titled Competency Assessments with a revised date of 5/20/2025, indicated, Policy: Employees will be assessed for competency upon hire and annually.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure dietary aides (DA) 1, DA 2 and DA 3 wore hairnets at all times while in the kitchen. This deficient practice had the potential for hair to fall in food resulting in food borne illness illness to residents who consume food prepared in the facility kitchen. Findings: During a concurrent observation and concurrent interview on 9/29/2025 at 9:51 AM, DA 1, DA 2 and DA 3, were not wearing hairnets while performing tasks in the kitchen. DA 3 stated, I thought there is one on my head. DA 1 stated I forgot. When asked why DA 2's hairnet was sitting on top of DA 2's hair bun instead of covering the entire head, DA 2 stated, Oh I didn't know. DA 1, DA2, and D3 all stated they (Residents) will get sick when asked the potential harm for not wearing hairnets and not cover the head with hairnets. DA 2 added, we are supposed to wear the hairnet while working here. A review of the facility policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Sanitation and Infection Control with a review date of 5/20/2205 indicated, A hair net or head covering which completely covers all hair should be worn at all times.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** REVIEWEDBased on interview, and record review, the facility failed to ensure necessary care was provided consistently for a resident who was receiving hospice service (a program designed to provide a caring environment for meeting the physical and emotional needs of the terminally ill) for one of one sampled residents (Resident 4), by failing to maintain the resident's current hospice certification of terminal illness in the resident chart. This deficient practice had the potential to lead to Resident 4 not receiving the needed and necessary services. A review of the admission record indicated the facility admitted Resident 4 on 9/13/2011 and readmitted on [DATE], with diagnoses that included cerebral atherosclerosis (the narrowing of the arteries in the brain due to build of a fatty deposits which can lead to a stroke), heart failure (condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen) and atrial fibrillation (an irregular heartbeat that can lead to blood clots and increases the risk of stroke and other heart complications). A review of Resident 4's Physician's Order 4/17/2024, indicated to admit Resident 4 to the facility under the services of hospice care. A review of Resident 4's History and Physical, dated 4/15/2025 indicated the resident's condition declined during the past year and the resident remained on hospice care. A review of Resident 4's Hospice Certification of Terminal illness dated 8/14/2025 indicated Resident 4 was eligible for the hospice services effective 8/10/2025 to 10/8/2025. A review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 10/10/2025, indicated the resident had severely impaired cognitive skills for daily decision making. The MDS also indicated the resident received hospice care while a resident. A review of Resident 4's hospice binder on 11/20/2025 at 9:15 AM indicated there was no hospice certification of terminal illness after 10/8/2025. During a concurrent interview and record review on 11/20/2025 at 10:02 AM, with Licensed Vocational Nurse (LVN) 3, Resident 4's hospice chart was reviewed. LVN 3 stated Resident 4 was currently receiving hospice services. LVN 3 stated Resident 4's hospice chart did not have the hospice certification of terminal after 10/8/2025. LVN 3 stated the resident's hospice chart should contain the current certification of terminal illness and the hospice has to recertify Resident 4 every three months to ensure that the resident still qualifies for hospice. During an interview on 11/20/2025 at 12:55 PM, the Director of Nursing (DON) stated the hospice certification of terminal illness is completed every three months. The DON further stated the certification of terminal illness should be in the hospice chart to ensure the resident requires hospice services and so that the resident receives the care they require. A review of the hospice and facility contract, dated 7/31/2009, indicated, The patient medical records and documentation maintained by each party shall be available for review and inspection by the other party as necessary for the proper evaluation, screening, provision of services to patients under this agreement. A review of the facility policy and procedures (P&P), titled Hospice Program, reviewed 5/230/2025, indicate, In order for a resident to qualify for the Hospice benefit under Medicare, he or she must be certified as being terminally ill. The facility coordinates care provided to the resident by the facility staff and the hospice staff and the facility is responsible for obtaining the physician certification and recertification of the terminal illness specific to each resident.

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** ReviewedBased on observation, interview and record review the facility failed to ensure that one of 57 residents rooms (room [ROOM NUMBER]/320) accommodated no more than 4 residents per room. Five residents were observed residing in room [ROOM NUMBER]/320. room [ROOM NUMBER]/320 could accommodate six residents.This deficient practice had the potential to result in inadequate space for the residents and for the staff to provide safe nursing care and privacy to the residents in room [ROOM NUMBER]/320.During a tour on 9/29/2025 at 9:59 AM, room [ROOM NUMBER]/320 was observed to have six beds. At the time, none of the residents residing in the room were present. The room had access to the hallway via one door. Outside of the door was two nameplates that indicated the room was for room [ROOM NUMBER] and 320.During an concurrent interview and observation on 9/29/2025 2:40 PM with the Maintenance Staff (MS) 1, MS 2 and MS 3, room [ROOM NUMBER]/320 were observed and measured. room [ROOM NUMBER]/320 measured 507 square feetDuring an interview on 9/30/2025 at 7:05 AM, MS 1 stated they were employed at the facility since 1977. MS 1 further stated room [ROOM NUMBER]/320 were never separated and the rooms never had separated entrances.A review of the facility's Client Accommodation Analysis, dated 9/29/2025, indicated there was a room [ROOM NUMBER] and a room [ROOM NUMBER]. The form also indicated room [ROOM NUMBER] measured 252 square feet and the approved capacity was for three residents. The form also indicated room [ROOM NUMBER] measured 247 square feet and the approved capacity was for three residentsA review of facility map indicated room [ROOM NUMBER] was located between room [ROOM NUMBER] and room [ROOM NUMBER]. A review of the facility map also indicated there was no room [ROOM NUMBER]. During an observation with the Administrator (ADM) on 9/30/2025 at 1:20 PM, room [ROOM NUMBER]/320 was observed. The ADM stated the room319/320 is one room and has never been two separate rooms. The ADMIN further stated he did not know why the rooms are considered two separate rooms.During an interview on 11/20/2025 at 8:43 AM Interview inside room [ROOM NUMBER]/320, Resident 106 stated they currently resided in room [ROOM NUMBER]/320. Resident 106 stated the room contained adequate space for the resident's personal items and self when all residents of the room were present at the same time. Resident 106 further stated they would prefer for the facility to erect a partition or block off one side of room [ROOM NUMBER]/320 to make two separate rooms that could accommodate three residents each in order to provide Resident 106 with more privacy. Yes directions toA review of Resident 106's face sheet indicated the resident resided in room [ROOM NUMBER].During an interview on 11/20/2025 at 8:53 AM, Certified Nursing Assistant (CNA) 1, stated room [ROOM NUMBER]/320 provided enough room to complete her duties.During an interview on 11/20/2025 at 12:41 PM, the ADM stated six residents could reside within room [ROOM NUMBER]/320 at one time. The ADM stated he has requested a copy of the original facility plans but was unable to get them at this time.A review of the facility policy and procedures (P&P) titled, Bedrooms, reviewed 5/20/2025, indicated, All residents are provided with clean, comfortable and safe bedrooms that meet federal and state requirements. Bedrooms accommodate no more than two residents at a time. The P&P further indicated all resident rooms have: a. Direct access to an exit door;b. At least one window to the outside; andc. a floor above grade level.