STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056293	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alcott Rehabilitation Hospital	3551 West Olympic Blvd. Los Angeles, CA 90019

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on interview and record review, the facility failed to maintain the rights exercised by the resident's representative (RP) for one of three sampled residents (Resident 1). For Resident 1, the facility failed to obtain consent from Resident 1's responsible party (RP) before cutting Resident 1's hair on 12/9/25.This deficient practice resulted in a violation of Resident 1's RP's right to make decisions on behalf of Resident 1. During a review of Resident 1's admission Record, indicated the facility admitted Resident 1 on 11/21/25 with diagnoses including dementia (a progressive state of decline in mental abilities) fracture of right femur (break in thigh bone), lack of coordination, and dysphagia (difficulty swallowing).During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 11/26/25 indicated Resident 1 had severely impaired cognitive skills for daily decision making. Resident 1 was dependent on staff for toileting hygiene, shower/bathe, lower body dressing and putting on/taking off footwear. Resident 1 needed substantial assistance (helper does more than half the effort) with eating, oral hygiene, upper body dressing and personal hygiene. During a review of Resident 1's History and Physical (H&P, a description of the resident's condition and course of care) dated 11/26/25 indicated Resident 1 does not have the capacity to understand and make decisions. During a telephone interview on 12/15/25 at 1:51 p.m., Resident 1's RP stated the facility gave Resident 1 a haircut on 12/9/25. Resident 1's RP stated she did not give consent for Resident 1 to have a haircut. During an interview on 12/23/25 at 8:42 a.m., the Activities Director (AD) stated the facility's hairdresser gave Resident 1 a haircut on 12/9/25. AD stated a consent was not obtained from Resident 1's RP before cutting Resident 1's hair on 12/9/25. AD stated, It was a mistake, sorry about that. AD stated facility needs to get consent from Resident 1's RP before cutting Resident 1's hair. During an interview on 12/23/25 at 11:33 a.m., the Social Services Designee (SSD) stated Resident 1's RP did not give consent before Resident 1 was given a haircut on 12/9/25. During a review of the facility's policy and procedure (P&P) titled, Resident's Rights, revised on 5/2/25 indicated the resident representative has the right to exercise the resident's right to the extent those rights are delegated to the resident representative. The same Policy indicated the resident had the right to be informed in advance of the care to be furnished and the type of care giver or professional that will furnish the care.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056293	A. Building B. Wing	12/23/2025

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056293	A. Building B. Wing	12/23/2025

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents who were dependent on staff for showers and feedings were provided those services for two of three sampled residents (Resident 1 and Resident 2).1.For Resident 1, who had a shower scheduled every Monday and Thursday, the facility failed to give Resident 1 shower on 11/24/25 (Monday), 11/27/25 (Thursday) and 12/1/25 (Monday). The facility also failed to notify Resident 1's responsible party (RP) when Resident 1 did not receive the showers on Resident 1's scheduled shower days. 2.For Resident 2, the facility failed to assist Resident 2 timely during breakfast on 12/23/25. Resident 2's breakfast tray was observed at the bedside table at 7:25 a.m. Resident 2 was not fed until 8:02 a.m.These deficient practices had the potential for Resident 1 to develop including unpleasant odor, skin condition and for Resident 2's food to become cold and lose its palatability.1.During a review of Resident 1's admission Record, indicated the facility admitted Resident 1 on 11/21/25 with diagnoses including dementia (a progressive state of decline in mental abilities) fracture of right femur (break in thigh bone), lack of coordination, and dysphagia (difficulty swallowing).During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 11/26/25 indicated Resident 1 had severely impaired cognitive skills for daily decision making. Resident 1 was dependent on staff for toileting hygiene, shower/bathe, lower body dressing and putting on/taking off footwear. Resident 1 needed substantial assistance (helper does more than half the effort) with eating, oral hygiene, upper body dressing and personal hygiene. During a review of Resident 1's Care Plan revised on 11/26/25, indicated Resident 1 had self-care deficit related to, including dementia and fracture of the right femur. The care plan goal indicated Resident 1 will be groomed and dressed daily and the Activities of Daily Living (ADL, activities such as bathing, dressing and toileting a person performs daily) needs will be met daily for three months. The care plan intervention included shower, shampoo and nail care two times a week as scheduled and as needed.During a concurrent interview and record review with Assistant Director of Nursing (ADON) on 12/23/25 at 9:56 a.m., Resident 1's Task: ADL-Bathing dated 11/24/25 to 12/23/25 was reviewed with the ADON. ADON stated Resident 1's shower schedule was on Monday and Thursday. ADON stated Resident 1 was not given shower on 11/24/25 (Monday), 11/27/25 (Thursday) and 12/2/25 (Monday). Resident 1 was given a shower on 12/4/2025. ADON stated she was unable to find documentation why Resident 1 was not given shower on Resident 1's scheduled shower days. During an interview on 12/23/25 at 10:48 a.m., Certified Nurse Assistant (CNA 1) stated Resident 1 was not given a shower because Resident 1 . fights. CNA1 stated she informed the Registered Nurse Supervisor (RNS) and the RNS told CNA 1 not to give Resident 1 a shower for safety reasons. CNA 1 stated a bed bath was given to Resident 1 instead. During an interview on 12/23/25 at 11:33 a.m., the Social Services Designee (SSD) stated Resident 1 was not given a bath because Resident 1 was . resistive. SSD stated Resident 1's RP should be notified when Resident 1 refused the shower.During a concurrent interview and record review on 12/23/25 at 11:41 a.m., with the Director of Staff Development (DSD) Resident 1's Nurse Progress Notes were reviewed. The DSD stated when Resident 1 was not given the shower, Resident 1‘s RP should have been notified. DSD stated she was unable to find documentation that Resident 1's RP was notified. DSD further added if Resident 1 was not given a shower Resident 1 would feel dirty. 2. During a review of the admission Record indicated the facility admitted Resident 2 on 11/10/25 with diagnoses including dementia, dysphagia and muscle weakness.During a review of the MDS dated [DATE], indicated Resident 1 had severe cognitive impairment. Resident 1 was dependent on staff for oral hygiene, toileting hygiene, shower/bathe, upper/lower body dressing, putting on/taking off footwear and personal hygiene. Resident 2 needed substantial assistance with eating. During observation on 12/23/25 at 7:25 a.m. Resident 2's breakfast tray was observed on top of Resident 2's bedside table located at the foot of her bed.During an interview on 12/23/25 at 7:48 a.m., CNA 2 stated she has three residents to feed including Resident 2. CNA 2 stated she has two other residents to feed before Resident 2's turn. During an interview on 12/23/25 at 8:02 a.m., the restorative nursing assistant (RNA) stated breakfast trays were delivered from the kitchen at around 7 a.m., and the trays are passed to the residents as soon as the trays arrived. RNA stated Resident 2 was a feeder (physical assistance with feeding). RNA stated Resident 2 should be fed as soon as the breakfast tray was taken to Resident 2. RNA stated if the tray is left too long on the bedside table, the food can get cold.During observation, CNA 2 was observed feeding Resident 2. During an interview on 12/23/25 at 8:11 a.m., CNA 3 stated three residents to feed during mealtimes would be too