

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/15/2025
NAME OF PROVIDER OR SUPPLIER Flower Villa, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 1480 S. LA Cienega Bl Los Angeles, CA 90035	
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to assess and notify the physician immediately when the resident had a change of condition with severe weakness, unable to eat, and unable to speak on 12/11/2025 AM shift for one of three sampled residents (Resident 3). This failure resulted in Resident 3 declining further and requiring a transfer to General Acute Care Hospital (GACH) via 911 (a telephone number used to reach emergency medical, fire, and police services) for further evaluation and treatment. During a review of Resident 3's admission Records, the Records indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), hypertensive heart disease (when the heart had to work too hard, making its muscle thicken and stiff leading to problems like chest pain and heart attack), anxiety disorder (a mental health condition with feeling of worry, anxiety, or fear interfering with one's daily activities). During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 10/28/2025, the MDS indicated, Resident 3 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) to make decisions on self-care activities, Resident 3 was dependent on staff partially (Helper does less than half the effort. Helper lifts, holds, or supports trunks or limbs, but provides less than half the effort) for rolling left and right, sitting to lying, toilet transfer (the ability to get on and off a toilet or commode), uses a manual wheelchair for mobility. During a review of Resident 3's History and Physical (H&P) dated 12/5/2025, the H&P indicated Resident 3 was alert and verbally responsive, able to make needs known. Resident 3 had a history of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow), hypertension (when the pressure in your blood vessels is too high). During a review of Resident 4's Progress Note dated 12/15/2025, the Progress Note indicated, on 12/11/2025 around 7 AM, Resident 3 did not verbally respond, and did not eat breakfast. Vitals signs (body temperature, blood pressure, pulse [heart rate], and breathing rate to help assess the general physical health of a person) indicated, Blood pressure 118/62, heart rate 59, Oxygen saturation 94%. Respiration rate (how many times you breathe in and out in one minute, measured when you're resting) not indicated. The same Progress Note indicated at approximately 8:20 AM Resident 3's vital signs were checked due to change in behavior and bradycardia (slow heart rate, defined as fewer than 60 beats per minute in adults) noted earlier. Repeat vital signs indicated Blood pressure 115/65, heart rate 40, respiration rate 16, oxygen saturation 89% on nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). Resident 3 continued to be quiet with limited verbal output. During a review of Resident 3's Change in Condition Evaluation dated 12/11/2025, The Change in Condition Evaluation indicated Resident 3 had altered level of consciousness (ALOC), primary physician recommendations to transfer Resident 3 to GACH via 911. During an interview on 12/15/2025 at 1:36 PM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, during the morning shift of 12/11/2025 I was informed by staff that Resident 3 was refusing to eat food, his heart rate was trending down. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 2 also stated, when I Spoke to Resident 3, he was not verbal, he was not at his base line. I called the physician and sent Resident 3 to hospital by the physician's order. During an interview on 12/15/2025 at 2:20 PM with LVN 1, LVN 1 stated, on 12/11/2025 morning, Resident 3 was not communicating verbally, he (Resident 3) was slow to respond, his (Resident 3's) heart rate was gradually going slower. LVN 1 stated, I left Resident 3 to rest more, I though he needed more time to sleep, I didn't think he was having a change of condition. Later in the morning the desk (charge or resource nurse sitting at a nursing station) nurse was notified by one of the staff members that Resident 3 was not feeling well and needed licensed staff's attention. When LVN 1 went to Resident 3's room to assess vital signs, Resident 3's heart rate was 40 (normal heart rate 60-100 beats per minutes). LVN 1 stated, I asked the desk nurse to notify the physician, [Resident 3] was transferred to hospital via 911 for slow heart rate, decline from baseline, refusing to eat, unable to speak. During an interview on 12/15/2025 at 2:58 PM with the Director of Nursing (DON), the DON stated, Resident 3 was transferred to GACH (acute general hospital) for change of condition and slow heart rate. The DON also stated, it is a resident safety risk to delay resident assessment and notification of change of condition to a physician. During a review of the facility's Policy and Procedures (P&P) titled Change in a Resident's Condition or Status revised 1/8/2025, the P&P indicated The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been a significant change in the resident's physical/emotional/mental condition. During a review of the facility's P&P titled Vital Signs revised 1/9/2025, the P&P indicated Vital signs are indicators of health status, including temperature, pulse, blood pressure, respiratory rate, oxygen saturation, and pain. Licensed nurses are responsible for knowing the usual range of a resident's vital signs, analyzing and interpreting routine vital signs, and notifying the physician of abnormal findings. Acceptable ranges for adults: Pulse (heart rate) 60-100 beats per minutes.		