STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555004	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Playa Del Rey Center	7716 Manchester Avenue Playa Del Rey, CA 90293

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement intervention by monitoring and recording all meal intakes completely, as indicated in the resident's care plan titled, Resident as at nutritional risk, for one of four sampled residents' (Resident 1). This failure had the potential to delay in identifying the resident's nutritional status and interventions being met and at risk for complications of lack of nutrition such as hospitalization.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 1's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (also known as a stroke, were a blood clot blocks off oxygen from getting to brain tissue) affecting left non-dominant (the side of the body less used or skilled) side. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 3/18/2026, the MDS indicated Resident 1 was cognitively intact (no issues with the ability to think, learn, use judgement, and make decisions). Resident 1 required partial/moderate assistance (helper does less than half the effort) to perform Activities of Daily Living (ADLs) such as eating. Resident 1 required substantial/maximal assistance (helper does more than half the effort) to perform movements such as rolling left and right and was dependent (helper does all the effort) to transfer to and from the toilet. During a review of Resident 1's care plan titled, Resident as at nutritional risk, dated 3/18/2026, the care plan indicated Resident 1 was at nutritional risk due to cardiac disease, diet restrictions, and recent hospitalization. The goal indicated, Resident will consume 75% of at least 3 meals every (q) day for 90 days. The interventions included to, Monitor for changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs, and to report to food and nutrition/physician as indicated). During a review of Resident 1's ADL Meal Log, for the month of 4/2026, Resident 1 did not have any record amount eaten on:4/1/2026 for dinner4/2/2026 for dinner4/6/2026 for breakfast, lunch, and dinner4/8/2026 for breakfast and lunch4/10/2026 for dinner. During a concurrent interview and record review on 4/28/2026 at 2:02 p.m., with Certified Nursing Assistant (CNA) 1, Resident 1's ADL Meal Log, for the month of 4/2026, was reviewed. CNA 1 stated staff did not document how much Resident 1 ate on all meals on 4/1/2026, 4/2/2026, 4/6/2026, 4/8/2026, and 4/10/2026. CNA 1 stated this was not acceptable because the documentation on how much Resident 1 have eaten each meal is used to determine how well the resident was eating. During a concurrent interview and record review on 4/28/2026 at 10:24 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 1's ADL Meal Log, for the month of 4/2026, and care plan titled, Resident is at nutritional risk, were reviewed. LVN 1 stated the care plan interventions are actions staff will implement to solve a problem, reduce a problem or a chance of complication that a resident may have from happening. LVN 1 stated monitoring an intake should include documenting resident's intakes three meals every day. LVN 1 stated Resident 1's care plan titled at nutritional risk indicating to monitor for changes in nutritional status, was not followed when staff did not completely document Resident 1's meals from 4/1/2026 to 4/10/2026. During a (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concurrent interview and record review on 4/29/2026 at 2:12 p.m., with the Director of Nursing (DON), Resident 1's progress notes dated 4/1/2026, 4/2/2026, 4/6/2026, 4/8/2026, and 4/10/2026, were reviewed. The DON stated the staff did not document in Resident 1's progress notes reasons why the resident missed a meal or why not all meal intakes were documented on 4/1/2026, 4/2/2026, 4/6/2026, 4/8/2026, and 4/10/2026. During a review of facility's policy and procedure (P&P) titled, Care Plan Comprehensive, dated 8/25/2021, the P&P indicated, the facility's Interdisciplinary Team, in coordination with the resident and/or his/her family or representative, must implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, physical, and mental and psychosocial needs that are identified in the comprehensive assessment to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. During a review of the facility's P&P titled, Assisting the Resident with In-Room Meals, dated 12/2013, the P&P indicated, the person performing this procedure should record how much of the meal the resident consumed (i.e., 25%, 50%, 75%, etc.) and if the resident refused the meal or to eat, the reason(s) why and the intervention taken, in the resident's medical record.

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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, the facility failed to implement its policy and procedure (P&P) titled, Fall Management, which indicated, patients should be assessed for fall risk and receive appropriate interventions to reduce risk and minimize injury, review, revise or update new care plan to reflect new interventions, for one of four sampled residents (Resident 1).This failure placed Resident 1 at risk for recurring fall and had the potential to sustain injuries, hospitalization, and death.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 1's diagnoses included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (also known as a stroke, were a blood clot blocks off oxygen from getting to brain tissue) affecting left non-dominant (the side of the body less used or skilled) side. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 4/2/2026, the MDS indicated Resident 1 had severe (extreme) cognitive impairment (problems with the ability to think, learn, use judgement, and make decisions). Resident 1 required partial/moderate assistance (helper does less than half the effort) to perform Activities of Daily Living (ADLs) such as eating. Resident 1 required substantial/maximal assistance (helper does more than half the effort) to perform movements such as rolling left and right and was dependent (helper does all the effort) to transfer to and from the toilet. During a review of Resident 1's Nursing Documentation Evaluation, (also known as an admission assessment), dated 3/15/2026, the Nursing Documentation Evaluation did not indicate Resident 1 was at risk for fall. During a review of Resident 1's Care Plan titled, Resident had an unwitnessed Fall, dated 3/17/2026, the interventions included to continue with skilled interventions, educate on use of call light, keep bed in lowest position for safety and keep floor mat next to bed. During a review of Resident 1's Care Plan titled, Resident had an unwitnessed fall out of bed, dated 4/4/2026, the interventions indicated to have call light within reach. No new interventions were added on 4/4/2026. During a review of Resident 1's Interdisciplinary Team (IDT) Care Conference, dated 4/6/2026, the IDT Care Conference indicated, Resident stated he was attempting to adjust himself in the bed and rolled out. The IDT recommended a floor mat next to bed in low position and rehab to screen for change in function. During a concurrent interview and record review on 4/29/2026 at 2:12 p.m., with the Director of Nursing (DON), Resident 1's Nursing Documentation Evaluation, dated 3/15/2026, was reviewed. The DON stated that the Nursing Documentation Evaluation should be completed upon admission and the questions under the section titled, Fall Risk Factor, helped determine if a resident was a fall risk. The DON stated, on 3/15/2026, Resident 1 was assessed/ identified as alert, confused, with weaknesses, to the left and right lower extremities (the legs and feet), the admitting nurse should have marked off Disoriented/confused, Impaired Balance, and Predisposing disease or injury, due to Resident 1's history of stroke. The DON stated by marking that off, it could have triggered and accurately identified Resident 1 at risk for fall. The DON stated the Fall Risk Factor was not completed accurately. If the assessment was done accurately, safety precautions or interventions in the care plan should have been in place. During a concurrent interview and record review on 4/29/2026 at 10:24 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 1's care plans were reviewed. LVN 1 stated Resident 1's care plan did not include an at risk for fall care plan for staff to follow to ensure problems or complications did not occur. LVN 1 stated Resident 1 was alert but confused and exhibited involuntary (doing something automatically, without thought or control) movements. LVN 1 stated because Resident 1 had involuntary movements and a history of stroke, Resident 1 was at risk for falls. During a concurrent interview and record review on 4/29/2026 at 2:12 p.m., with the DON, Resident 1's Nursing Documentation Evaluation, dated 3/26/2026, and progress notes dated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/26/2026, were reviewed. The DON stated the progress notes did not indicate any other readmission assessment was done on 3/26/2026. The DON stated the Nursing Documentation Evaluation should have been completed upon readmission to ensure a plan of care for Resident 1 was in place depending on what was included within the assessment such as fall risk. The DON stated failing to identify Resident 1 as At risk for fall, resulted in the facility not creating interventions for the foreseeable (expected or anticipated in advance) risks and to prevent the possible problem. Resident 1 could have suffered a fall-related injury. During a concurrent interview and record review on 4/29/2026 at 10:24 a.m., with LVN 1, Resident 1's care plan titled, Resident had an unwitnessed fall out of bed, dated 4/4/2026, was reviewed. LVN 1 stated the facility did not change or add other interventions to prevent another fall after the resident fell on 4/4/2026 During an interview on 4/30/2026 at 1:16 p.m., with the DON, the DON stated Resident 1's care plan was not resident-centered and did not focus to prevent further falls and should have included frequent rounding after the fall on 4/4/2026. During a review of the facility's policy and procedure (P&P) titled, Fall Management, dated 5/26/2021, the P&P indicated, patients should be assessed for fall risk as part of the nursing assessment process. Those determined to be at risk should receive appropriate interventions to reduce risk and minimize injury. The P&P also indicated the facility's procedure included identifying patient's fall risk by reviewing the nursing documentation, develop individualized plan of care, review and revise care plan as indicated. If patient falls, update new care plan to reflect new interventions. During a review of facility's P&P titled, Care Plan Comprehensive, dated 8/25/2021, the P&P indicated, Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. During a review of facility's P&P titled, Safety and Supervision of Residents, dated 7/2017, the P&P indicated, the care team should target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. The P&P indicated monitoring the effectiveness of interventions shall include evaluating the effectiveness of interventions and modifying or replacing interventions as needed. The P&P also indicated resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.