

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER View Park Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 Don Felipe Drive Los Angeles, CA 90008	

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. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, for one of three residents (Resident 1) identified as at high risk for falls, the facility failed to: Develop a comprehensive care plan to prevent falls and or with injuries for Resident 1. Ensure Resident 1's initial Fall Risk Evaluation was complete and accurate. These deficient practices potentially caused Resident 1 to fall on [DATE] at 5 A.M., and experienced pain, to the right hip. Findings: A review of Resident 1's admission Record indicated the facility admitted Resident 1 on [DATE] and was readmitted to the facility on [DATE] with diagnoses including history of falling, hypertension (HTN -high blood pressure), and depression (a serious mood disorder causing persistent sadness, loss of interest, and changes in mood, sleep, appetite, and energy, interfering with daily life and functioning). During a review of Resident 1's Fall Risk Evaluation dated [DATE], the fall risk evaluation section of history, current status, predisposing conditions indicated that, Upon admission and quarterly, at a minimum, thereafter, observe the resident status in the 11 clinical condition parameters listed below by assigning the corresponding score which best describes the resident. If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented on the care plan. Resident 1's fall risk evaluation in the same section questions 6 (vision), 7 and 8 (predisposing diseases), 9 (change in condition), 10 (recent hospitalization), and 11 (six-month hospitalization notes) were blank. The fall risk assessment indicated Resident 1's gait (the pattern or style of how a person walks, involving the coordinated movement of legs, feet, and arms)/balance required the use of an assistive device. The fall risk assessment indicated Resident 1's fall risk score was 7 (A score of 10 or greater indicated the resident is at high risk for fall). During a review of Resident 1's Fall Care Plan initiated on [DATE], indicated that Resident 1 was at a high risk for falls further falls/injury related to history of generalized weakness, reduced mobility, poor safety awareness, depression, history of falls and impaired cognition. The fall care plan interventions indicated that all staff will visibly observe resident frequently. During a review of Resident 1's Interdisciplinary Team (IDT- Interdisciplinary Care Meeting, or Interprofessional Rounds, focusing on holistic patient care through coordinated discussions between various specialists [doctors, nurses, therapists, social workers, etc.]) to create, review, and adjust a unified patient plan, ensuring comprehensive, efficient, and patient-centered care) meeting document dated [DATE], at 7:25 A.M., under additional comments section indicated Resident 1 had a history of falls and care plan implemented. However, the IDT meeting document did not indicate interventions to prevent repeated falls. A review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated [DATE], indicated Resident 1 had impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life), and required substantial/maximal assistance to dependency on staff with activities of daily living (ADL - activities such as bathing, dressing and toileting a person performs daily). The MDS also indicated Resident 1 had a fall prior to admission in the last month. During a review of Resident 1's Situation Background Appearance Review (SBAR - a communication tool used by healthcare workers when there is a change of condition among the residents) dated [DATE], at 5:45 A.M., indicated that on [[DATE]] at 5:45 A.M., [Resident 1] was found on the floor on her right-side yelling in pain. As need (PRN) pain medication Tylenol (medication for pain reliever and fever reducer) was given. At 6 A.M., resident was assessed for injuries with bending her right (R) leg which she was able to move but not straighten, left (L) leg assessed for pain, able to move a little more than the (R), R/L arm stretches able to move both above her head, neuro (neurological - a medical evaluation of the nervous system [brain, spinal cord, nerves, and muscles] to check for issues like weakness, coordination problems, confusion, or numbness) done with hand grip and skin sensitivity, (R) side pain on hip and arm, vitals taken. [On [DATE]] at 5:45 A.M., medical doctor (MD) and resident representative (RP) notified. [On [DATE]] at 6: 45 A.M., 911 emergency unit arrived and departed [on [DATE]] at 6:45 A.M., with resident. Residents' condition was stable and noted with minimal pain on departure. During a review of Resident 1's GACH 1 ED Provider Note dated [DATE], indicated, . presents with right hip pain and status post fall. findings/impression: Fractures: right femoral neck fracture with varus angulation, favored to be intertrochanteric. Assessment/plan: Right hip joint pain; Right intertrochanteric femur fracture. During a review of Resident 1's GACH 2 records under admitting and final diagnosis section dated [DATE], indicated Resident 1 was status post fall with right hip fracture and ORIF. During an interview on [DATE], at 1:36 P.M., Certified Nursing Assistant (CNA) 1 stated that Resident 1 is confused, incontinent (the involuntary loss of</p>		