STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555117	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Healthcare Center - LA	3032 Rowena Ave Los Angeles, CA 90039

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. 46445 Based on interview and record review, the facility failed to ensure one of three sampled resident ' s (Resident 1) room change request was accommodated and followed through. This deficient practice had the potential for Resident 1 ' s decreased feelings of self-worth. Findings: During a review of Resident 1 ' s Admission Record (undated), the Admission Record indicated the facility admitted Resident 1 on 12/20/2022 with diagnoses including monoplegia (a paralysis that affects a single limb) of lower limb following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting the left non-dominant side, hemiplegia (inability to move one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction affecting the right dominant side, and chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow). During a review of Resident 1 ' s History and Physical (H&P), dated 12/18/2024, the H&P indicated the resident had unspecified depression (experiencing symptoms that suggest depression [a constant feeling of sadness and loss of interest, which stops the individual from doing normal activities] but does not meet the full criteria for any of the depressive disorder diagnoses). During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 3/27/2025, the MDS indicated Resident 1 ' s cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. The MDS indicated Resident 1 required supervision (assistance may be provided throughout the activity or intermittently) on rolling left and right, sitting to lying, lying to sitting on the side of the bed, and sitting to standing. During an interview on 5/6/2025 at 1:22 p.m. and a concurrent record review of Resident 1 ' s Notification of Room Change, dated 2/14/2025 and 2/19/2025, reviewed with the SSD, the SSD stated Resident 1 requested for a room change on 2/2025. The SSD stated Resident 1 was offered two rooms, but the resident refused both. The SSD stated she was responsible for ensuring resident room change requests were followed through. The SSD stated she did not follow up with Resident 1 ' s room change preference after 2/19/2025. The SSD stated it had the potential for residents to feel their preferences were not honored. The SSD stated the facility failed to follow up Resident 1 ' s room change request. (continued on next page)

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

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/2025 at 4:30 p.m. with the Director of Nursing (DON), the DON stated residents ' room change preferences should be honored as much as possible. The DON stated Resident 1 ' s room change request should have been followed through. The DON stated it had the potential to cause negative psychosocial (the interrelation of social factors and individual thoughts and behavior) effect on the residents. The DON stated the facility failed to ensure Resident 1 ' s room change request was addressed and honored. During a review of the facility ' s policy and procedure (PnP) titled, Room or Roommate Change, last reviewed on 4/4/2025, the PnP indicated the purpose to ensure a resident is able to exercise his right to change rooms or roommates. The PnP indicated when making a change in room or roommate assignment, the resident ' s needs and preferences are considered and will be accommodated to the extent practical. The PnP indicated the Social Services staff or designee will make a follow up visit to assess the resident ' s adjustment to the change.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46445 Based on interview and record review, the facility failed to protect the resident ' s right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for one of four sampled residents (Resident 1). On 4/22/2025 at 8:40 p.m., Resident 1 and Resident 2, who were both inside Room A (Residents 1 and 2 ' s room), had a verbal altercation (a noisy argument or disagreement) that led to a physical altercation (a confrontation or fight involving physical contact or force) in which Resident 2 punched Resident 1 on the left side of the face with a left closed fist. This deficient practice resulted in Resident 1 being subjected to physical abuse by Resident 2 while under the care of the facility. On 4/22/2025, Resident 1 sustained left face swelling and pain level of seven (severe pain) out of ten on the numeric pain rating scale (a pain assessment tool that uses a scale ranging from zero [no pain] to ten [worst pain imaginable], to quantify pain intensity). Resident 1 was sent to General Acute Care Hospital 1 (GACH 1) on 4/23/2025 at 11:25 a.m. where Resident 1 was diagnosed with a displaced nasal bone fracture (occurs when the bone on the nose was broken into two or more parts allowing the bones to shift out of alignment). Findings: During a review of Resident 1 ' s Admission Record (undated), the Admission Record indicated the facility admitted Resident 1 on 12/20/2022 with diagnoses including monoplegia (a paralysis that affects a single limb) of lower limb following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting the left non-dominant side, hemiplegia (inability to move one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction affecting the right dominant side, and chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow). During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 3/27/2025, the MDS indicated Resident 1 ' s cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. The MDS indicated Resident 1 required supervision (assistance may be provided throughout the activity or intermittently) on rolling left and right, sitting to lying, lying to sitting on the side of the bed, and sitting to standing. During a review of Resident 1 ' s Progress Notes, dated 4/22/2025 at 11 p.m., the Progress Notes indicated Resident 1 ' s skin was checked and documented that Resident 1 had left facial swelling related to the altercation with Resident 2. During a review of Resident 1 ' s Neurological Flowsheet (used to assess, monitor, and record specific neurological [referred to anything related to the nervous system including the brain, spinal cord, and nerves] status following an injury resulting in suspected or actual head trauma), dated 4/22/2025 to 4/23/2025, the Neurological Flowsheet indicated on 4/22/2025 at 10 p.m., Resident 1 had seven out of ten on the numeric pain rating scale. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Change in Condition (COC - when there is a sudden change in a resident ' s condition) Evaluation, dated 4/23/2025 at 12:30 a.m., the COC Evaluation indicated Resident 1 had a physical and verbal abuse with Resident 2 on 4/22/2025 (time not indicated). The COC Evaluation indicated Resident 1 had swelling on the face. During a review of Resident 1 ' s Physician Orders, dated 4/23/2025, the Physician Orders indicated transferring Resident 1 to GACH 1 due to facial swelling. During a review of Resident 1 ' s Progress Notes, dated 4/23/2025 at 12:35 p.m., the Progress Notes indicated an ambulance transported Resident 1 to GACH 1 on 4/23/2025 at 11:25 a.m. During a review of Resident 1 ' s Physician History and Physical (H&P - comprehensive assessment conducted by a healthcare provider that includes gathering a thorough medical history from the resident and performing a physical examination to assess their overall health and identify any potential medical concern) from GACH 1, the Physician H&P indicated on 4/23/2025, Resident 1 was admitted to GACH 1 after Resident 2 hit Resident 1 on the face. The Physician H&P indicated Resident 1 had left side nasal and facial pain and swelling. During a review of Resident 1 ' s GACH 1 computed tomography (CT, a procedure that uses a computer to make a series of detailed pictures of areas inside the body) of the face, dated 4/23/2025, the CT indicated Resident 1 had displaced nasal bone fracture. During a review of Resident 2 ' s Admission Record (undated), the Admission Record indicated the facility admitted Resident 2 on 12/3/2021 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), unspecified mood disorder (a person experiencing symptoms related to mood changes that were significant enough to cause distress in daily life but did not meet a mood disorder diagnoses), and schizophrenia (mental disorder in which people interpret reality abnormally). During a review of Resident 2 ' s H&P (from the facility), dated 9/13/2024, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 ' s cognition was intact. The MDS indicated Resident 2 had verbal behavioral symptoms directed toward others such as threatening others, screaming at others, and cursing at others that occurred one to three days. During a review of Resident 2 ' s care plan on aggression, last revised on 3/18/2025, the care plan indicated Resident 2 had the potential for verbal aggression (any communication intended to harm someone through words, tone, or manner, such as threats, insults, or harsh criticism). The care plan interventions indicated to document observed Resident 2 ' s behavior and attempted interventions. During a review of Resident 2 ' s COC Evaluation, dated 4/22/2025, the COC Evaluation indicated Resident 2 had a change of behavior that led to physical aggression (actions that involve inflicting physical harm or damage) and verbal aggression towards Resident 1. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/6/2025 at 9:33 a.m. with Resident 1, Resident 1 stated Resident 2 yelled at Resident 1 to turn the television off. Resident 1 stated he (Resident 1) refused to turn the television off. Resident 1 stated Resident 2 stood up on the right side of Resident 1 ' s bed and punched the resident on the left side of the face twice with a left closed fist. Resident 1 stated he (Resident 1) required assistance on moving and was not able to defend himself from Resident 2 ' s punches. Resident 1 stated the left side of his (Resident 1) face became swollen and painful. Resident 1 stated he (Resident 1) was anxious (feeling fear, dread, and uneasiness) and did not feel safe in the facility knowing Resident 2 was in the facility. Resident 1 stated he (Resident 1) was hesitant to go to the activity room knowing Resident 2 also attended activities. During a telephone interview on 5/6/2025 at 11:19 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she (LVN 1) heard someone yelling with an angry tone. LVN 1 stated she (LVN 1) went inside Room A and found Resident 1 lying in his (Resident 1) bed, while Resident 2 was standing on the right side of Resident 1 ' s bed. LVN 1 stated she (LVN 1) witnessed Resident 2 punching Resident 1 ' s face with his (Resident 2) left closed fist twice. LVN 1 stated Resident 1 and Resident 2 were separated by transferring Resident 1 to Room B. LVN 1 stated maybe one to two hours after Resident 2 punched Resident 1, Resident 1 ' s left side of the face (around the cheekbone) and nose were observed swollen that required an ice pack and pain medication. LVN 1 stated Resident 1 refused the pain medication. LVN 1 stated Resident 2 punching Resident 1 was physical abuse. During an interview on 5/6/2025 at 12:39 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she (CNA 1) heard Resident 2 yelling with an angry tone. CNA 1 stated she (CNA 1) ran to Room A and found Resident 2 standing on the right side of Resident 1 ' s bed. CNA 1 stated Resident 1 ' s face looked shocked and Resident 2 ' s face was mad. CNA 1 stated after Resident 1 was transferred to Room B, Resident 1 ' s left side of the face was observed swollen. CNA 1 stated Resident 2 punching Resident 1 was physical abuse. During an interview on 5/6/2025 at 4:30 p.m. with the Director of Nursing (DON), the DON stated residents should be free from abuse. The DON stated a person intentionally punching another person was considered a physical abuse. The DON stated Resident 2 punching Resident 1 was considered as an abuse. The DON stated Resident 1 sustained injury from Resident 2 ' s punch. The DON stated Resident 1 had the potential for negative psychosocial effects (the interrelation of social factors and individual thoughts and behavior). The DON stated the facility failed to ensure Resident 1 was not subjected to any abuse and to ensure the safety and overall well-being of the residents. During a review of the current facility-provided policy and procedure (PnP) titled, Abuse Prevention, Screening, and Training Program, last reviewed on 4/4/2025, the PnP indicated the purpose is To address the health, safety, welfare, dignity, and respect of residents by preventing abuse The Facility does not condone any form of resident abuse . and develops Facility policies, procedures, training programs, and screening and prevention systems to promote an environment free from abuse Definitions: ' Abuse ' is defined as the willful, deliberate infliction of injury It includes verbal abuse, . physical abuse ' Verbal abuse ' is defined as any use of oral, written, gestured communication, or sounds that willfully includes disparaging and derogatory terms directed to residents within their hearing distance, regardless of age, ability to comprehend, or disability (physical or mental condition that limits a resident ' s movements, senses, or activities) ' Physical abuse ' is defined as, but not limited to, hitting, slapping, punching, and/or kicking

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46445 Based on interview and record review, the facility failed to ensure the medical records of two of three sampled residents (Resident 1 and Resident 2) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to: 1. Ensure Licensed Vocational Nurse (LVN) 1 documented the actual time of Resident 1 and Resident 2 ' s Change of Condition (COC). 2. Ensure LVN 1 documented the actual time Resident 1 and Resident 2 ' s representative and Attending Physician (MD) 1 were notified. 3. Ensure Licensed Nurses documented the level of care provided to Resident 1 and Resident 2 after the resident ' s COC. 4. Ensure the Social Services Director (SSD) documented the level of psychosocial (the interrelation of social factors and individual thoughts and behavior) care and monitoring provided for Resident 1. These deficient practices resulted in inaccurate information on Resident 1 and Resident 2 ' s medical records and had the potential for delayed and inaccurate medical interventions. Findings: A. During a review of Resident 1 ' s Admission Record (undated), the Admission Record indicated the facility admitted Resident 1 on 12/20/2022 with diagnoses including monoplegia (a paralysis that affects a single limb) of lower limb following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting the left non-dominant side, hemiplegia (inability to move one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction affecting the right dominant side, and chronic obstructive pulmonary disease (COPD - a lung disease characterized by long term poor airflow). During a review of Resident 1 ' s History and Physical (H&P), dated 12/18/2024, the H&P indicated the resident had unspecified depression (experiencing symptoms that suggest depression [a constant feeling of sadness and loss of interest, which stops the individual from doing normal activities] but does not meet the full criteria for any of the depressive disorder diagnoses). During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 3/27/2025, the MDS indicated Resident 1 ' s cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. The MDS indicated Resident 1 required supervision (assistance may be provided throughout the activity or intermittently) on rolling left and right, sitting to lying, lying to sitting on the side of the bed, and sitting to standing. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s Interdisciplinary Team (IDT, a team of healthcare professionals from different professional disciplines who work together to manage the physical, psychological and spiritual needs of the patient) Note, dated 4/24/2025, the IDT Note indicated on 4/22/2025 at 8:40 p.m., Resident 2 punched Resident 1 that resulted in Resident 1 ' s left face swelling and pain. The IDT Note indicated ice pack was applied on Resident 1 ' s face. The IDT Note indicated Resident 1 refused the pain medication. The documentation did not indicate the time the ice pack was applied and the time the pain medication was refused. During an interview on 5/6/2025 at 11:19 a.m. with LVN 1, LVN 1 stated military time (a 24-hour clock) should be used on Resident 1 ' s COC Evaluation documentation. During an interview on 5/6/2025 at 1:22 p.m. and concurrent record review of Resident 1 ' s Social Services Note, reviewed with the SSD, the SSD stated Resident 1 should be evaluated every day for 3 days after the resident returned from General Acute Care Hospital (GACH) 1. The SSD stated she did not document Resident 1 ' s evaluation on 4/27/2025 (Resident 1 ' s first day after readmission) and on 4/29/2025 (Resident 1 ' s 3rd day after readmission). The SSD stated incomplete documentation had the potential for delay of services and care for Resident 1. The SSD stated the facility failed to completely and accurately document Resident 1 ' s psychosocial evaluations. During an interview on 5/6/2025 at 3:30 p.m. and a concurrent record review of Resident 1 ' s medical records, reviewed with Registered Nurse (RN) 1, RN 1 stated on 4/22/2025 at 8:40 p.m., Resident 2 punched Resident 1 ' s face. RN 1 stated Resident 1 ' s COC Evaluation, dated 4/23/2025, indicated Resident 1 had a physical and verbal altercation with Resident 2. The COC Evaluation indicated Resident 1 had swelling on the face. RN 1 stated the COC Evaluation was documented on 4/23/2025 at 12:30 a.m., 3 hours and 50 mins after Resident 1 and Resident 2 ' s altercation. The COC Evaluation indicated MD 1 was notified on 4/22/2025 at 9:30 a.m., 12 hours and ten minutes before the incident happened. The COC Evaluation indicated Resident 1 ' s representative was notified on 4/22/2025 at 9:40 a.m., 13 hours before the incident happened. RN 1 stated the facility used military time on documentation. RN 1 stated the time indicated on the COC Evaluation was inaccurate. Resident 1 ' s Neurological Flowsheet (used to assess, monitor, and record specific neurological [referred to anything related to the nervous system including the brain, spinal cord, and nerves] status following an injury resulting in suspected or actual head trauma), dated 4/22/2025 to 4/23/2025, reviewed with RN 1, the Neurological Flowsheet indicated on 4/22/2025 at 10 p.m., Resident 1 had seven out of ten on the pain scale (a tool used to measure and communicate the intensity of pain). Resident 1 ' s Medication Administration Record (MAR) or Progress Note did not indicate the pain interventions provided for Resident 1. The ice pack provided for Resident 1 was not documented on the resident ' s Treatment Administration Record (TAR) or Progress Note. RN 1 stated inaccurate documentation had the potential for delay in resident care. During an interview on 5/6/2025 at 4:30 p.m. with the Director of Nursing (DON), the DON stated the documentation on Resident 1 ' s medical records was incomplete and inaccurate. The DON stated inaccurate and incomplete documentation had the potential for delay in resident care. The DON stated the facility failed to ensure Resident 1 ' s medical records were complete and accurate. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure (PnP) titled, Completion and Correction, last reviewed on 4/4/2025, the PnP indicated entries will be recorded promptly as the events or observations occur. The PnP indicated entries will be complete, legible, descriptive, and accurate. The Documentation Content section indicated treatments, observations during treatments and effectiveness of treatments. The PnP indicated an event is never to be documented before it occurs. B. During a review of Resident 2 ' s Admission Record (undated), the Admission Record indicated the facility admitted Resident 2 on 12/3/2021 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), unspecified mood disorder (a person experiencing symptoms related to mood changes that were significant enough to cause distress in daily life but did not meet a mood disorder diagnoses), and schizophrenia (mental disorder in which people interpret reality abnormally). During a review of Resident 2 ' s H&P, dated 9/13/2024, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 ' s cognition was intact. The MDS indicated Resident 2 had verbal behavioral symptoms directed toward others such as threatening others, screaming at others, and cursing at others that occurred one to three days. During a review of Resident 2 ' s Care Plan on aggression, last revised on 3/18/2025, the care plan indicated Resident 2 had the potential for verbal aggression. The care plan interventions indicated to document observed behavior and attempted interventions. During a review of Resident 2 ' s IDT Note, dated 4/24/2025, the IDT Note indicated on 4/22/2025 at 8:40 p. m., Resident 2 punched Resident 1 on the face. The IDT Note indicated Resident 2 refused to be assessed. The IDT Note indicated on 4/23/2025 Resident 2 exhibited verbal aggression towards other residents in the activity room. During an interview on 5/6/2025 at 3:30 p.m. and a concurrent record review of Resident 1 ' s medical records, reviewed with Registered Nurse (RN) 1, RN 1 stated on 4/22/2025 at 8:40 p.m., Resident 2 punched Resident 1 ' s face. RN 1 stated Resident 1 ' s COC Evaluation, dated 4/23/2025, indicated Resident 2 had a physical and verbal altercation with Resident 1. RN 1 stated the COC Evaluation was documented on 4/23/2025 at 11:55 p.m., 3 hours and 15 mins after Resident 1 and Resident 2 ' s altercation. The COC Evaluation indicated MD 1 was notified on 4/22/2025 at 9:30 a.m., 12 hours and ten minutes before the incident happened. The COC Evaluation indicated Resident 1 ' s representative was notified on 4/22/2025 at 9:40 a.m., 13 hours before the incident happened. RN 1 stated the facility used military time on documentation. RN 1 stated the time indicated on the COC Evaluation was inaccurate. RN 1 Stated Resident 2 had a Physician Order, dated 1/20/2023, the Physician Orders indicated to monitor episodes of mood swings manifested by rapid fluctuation of emotions ranging from calmness to anger every shift and tally by hashmark. The Physician Orders, dated 11/18/2022, indicated to monitor behaviors manifested by inability to cope with activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive) causing anger outbursts. RN 1 stated Resident 2 ' s MAR did not indicate a hashmark for the behaviors the resident exhibited on 4/22/2025 with Resident 1. Resident 1 ' s MAR did not indicate the behaviors Resident 2 exhibited on 4/23/2025 at the activities room. RN 1 stated incomplete and inaccurate documentation had the potential for delay in resident care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/6/2025 at 4:30 p.m. with the Director of Nursing (DON), the DON stated inaccurate and incomplete documentation had the potential for delay in resident care. The DON stated the facility failed to ensure Resident 2 ' s medical records were complete and accurate. During a review of the facility ' s policy and procedure (PnP) titled, Completion and Correction, last reviewed on 4/4/2025, the PnP indicated entries will be recorded promptly as the events or observations occur. The PnP indicated entries will be complete, legible, descriptive, and accurate. The Documentation Content section indicated treatments, observations during treatments and effectiveness of treatments. The PnP indicated an event is never to be documented before it occurs.