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	08/09/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure a call light's request for assistance were answered promptly for one of three sampled residents (Residents 4).This deficient practice had the potential to not meet Resident 4's needs.Findings:During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 on 5/5/2025, with diagnoses including left lower limb (leg) cellulitis (a skin infection that causes swelling and redness), pneumonia (an infection/inflammation in the lungs), and history of falling.During a review of Resident 4's History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 5/6/2025, the H&P indicated Resident 4 had the capacity to understand and make decisions.During a review of Resident 4's Care plan on Fall Risk Prevention and Management, dated 5/12/2025, the Care Plan indicated Resident 4 had a history of fall related to limited mobility and an intervention that indicated the following:1. to have call light within reach2. remind resident to use the call lightDuring a review of Resident 4's Minimum Data Set (MDS-a resident assessment tool), dated 5/14/2025, the MDS indicated Resident 4's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 4 required moderate assistance from staff for eating, oral hygiene, and personal hygiene. The MDS indicated Resident 4 needed maximum assistance from staff walking at least 10 feet.During an observation on 8/9/2025, at 11:45 p.m., in the hallway, Resident 4's call light turned on. Respiratory Therapist 1 (RT 1) standing in front of his cart two doors away from Resident 4's room. Observed RT 1 browsing on his cellphone, did not pay attention to his surroundings and did not answer the call light.During an interview on 8/9/2025, at 11:48 a.m., RT 1 still had not answered the call light and stated he (RT 1) did not hear the call light sound, and he (RT 1) should have answered the call light when it turned on. During an interview on 8/9/2025, at 11:51 a.m., Resident 4 stated he cannot find his water pitcher and was also looking for his toothbrush and toothpaste.During an interview on 8/9/2025, at 1:48 p.m., with Licensed Vocational Nurse 7 (LVN 7), LVN 7 stated all staff including RTs are required to answer the call light. LVN 7 stated delay in answering the call light can delay the care and needs of Resident 4.During an interview on 8/9/2025, at 2:28 p.m., with Administrator (Admin), the Admin stated answering call light was everyone's responsibility. The Admin stated Resident 4 could experience delays in care when the call light was not answered.During a review of facility's policy and procedure (P&P), titled, Communication-Call System dated 10/9/2024, the P&P indicated, The Facility will maintain a communication system to allow residents to call for staff assistance from their rooms and toileting/bathing facilities. To ensure that residents have a means of contacting Facility staff for assistance. Facility Staff will answer call alerts promptly and in a courteous mannerDuring a review of facility's Employee Handbook, dated 1/2024, the Employee handbook indicated, The Company recognizes that cell phones and other personal communication devices have become valuable tools in managing our professional and personal lives. However, workplace use of these devices can raise a number of Issues involving safety, security, and privacy.Therefore, the Company has adopted the following rules regarding the use of personal communication devices in the workplace. during working hours. Employees should conduct personal business during lunch breaks and other rest periods. This Includes the use of personal communication devices (including cell phones) for personal business (including personal phone conversations and text messages, personal e-mails, and Internet use for personal reasons). Minimal or incidental use Is permitted (like a child confirming safe arrival at home after school).Violation of this policy may result in discipline, up to and including termination of employment.Unless properly authorized, employees must refrain from the use of any form of personal electronic communication devices during normal work hours.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety 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. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**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, Change of Condition Notification, last reviewed on 4/4/2025 for one of three sampled residents (Resident 1) by failing to notify Medical Doctor 1 (MD 1) when on 7/19/2025 at 4 a.m., Resident 1 who had a diagnosis of type 2 diabetes mellitus (DM - a disease that occurs when your blood sugar [BS] is too high), had a change of condition (COC - a major decline in a resident's status). Resident 1 complained of nausea (a feeling of sickness in the stomach that can be accompanied by an urge to vomit), had one episode of vomiting, a documented blood sugar of 382 milligrams per deciliter (mg/dl - unit of measurement) obtained by Licensed Vocational Nurse 1(LVN 1), and had a physician's order dated 7/15/2025, instructing staff to notify the MD if the BS is greater than 350 mg/dl. This deficient practice resulted in Resident 1 being found unresponsive (not reacting or responding to touch, sounds or verbal commands) on 7/19/2025 at 7:50 a.m. and subsequently died at the facility on 7/19/2025 at 8:05 a.m. On 8/7/2025 at 1:31 p.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) in the presence of the Administrator (ADM) and Registered Nurse (RN) 1 due to the facility's failure to notify MD 1 regarding Resident 1's COC on 7/18/2025 during the 11 p.m. to 7 a.m. shift and on 7/19/2025 at 4 a.m. On 8/9/2025 at 12:54 p.m., the ADM submitted an IJ Removal Plan (a detailed plan that identifies all actions the facility will take to immediately address the IJ findings) for the facility's failure to notify the physician when Resident 1 had a COC on 7/19/2025 at 4 a.m. On 8/9/2025 at 3:01 p.m., while onsite at the facility, the SSA verified and confirmed the facility's full implementation of the IJ Removal Plan through observations, interviews, and record reviews, and determined the IJ situation regarding the facility's failure to notify the physician when Resident 1 had a COC on 7/19/2025 at 4 a.m. was no longer present. The SSA removed the IJ situation on 8/9/2025 at 3:01 p.m., in the presence of the ADM and LVN 8. The acceptable IJ Removal Plan included the following summarized actions: 1. After the IJ was called on 8/7/2025 at 1:31p.m., regarding not notifying the physician of Resident 1's COC, the facility immediately implemented a corrective process requiring all licensed nurses to notify the physician promptly as ordered. The corrective process will include a physical hand-off report (a process of transferring resident care responsibility and information from one healthcare provider to another), called the Shift-to-Shift COC Report, by the licensed nurses every shift. The hand-off report will include any changes of condition that occurred throughout their shift with confirmation that the incoming nurse received the report. The Shift-to-Shift COC Report is audited by the RN 1 and/or designee (assigned Desk Nurse) on every shift. 2. On 8/7/2025 at 2:30 p.m., 6 p.m., and 11 p.m., 8/8/2025 at 2:45 p.m., and ongoing, the Director of Staff Development (DSD) and/or designee provided in-service (training and educational session provided to facility staff) training to the licensed nurses. The training emphasized the importance of timely physician notification, documenting vital signs (measurements of the body's most basic functions), performing resident assessments and observations during a change of condition, following physician's orders and adhering to the facility's P&P, titled Alert Charting Documentation. During the ongoing in-services provided by the Director of Nursing (DON) and/or designee, all licensed nurses will be re-educated and reminded that Licensed Nurses are able to reach out and contact a physician 24 hours a day, seven days a week (24/7), at any given time whether it is early morning or late evening. 3. On 8/7/2025 at 4:28 p.m., RN 1 and DSD had given a verbal one-on-one in-service (individualized training) and a corrective action warning to LVN 1. 4. On 8/7/2025 at 6:06 p.m., the Corporate Office responded after the ADM reached out on 8/6/2025 at 2:25 p.m., stating that there was no specific policy regarding the process for following physician orders. The Corporate Office indicated that a new policy would be developed including procedures to address non-compliance specifically outlining the steps to be taken when a physician's order is not followed and revisions will also be made to the facility's existing P&P titled, Change of Condition Notification. 5. On 8/7/2025 at 7:30 p.m., the ADM initially conducted a facility-wide audit using the Change of Condition Alert Audit Tool to identify any residents with a COC and verify whether the physician was notified. The audit tool indicated the resident's name, room number, physician notification status, any discrepancies found, and the licensed nurse responsible for completing the documentation. From 7/31/2025 to 8/7/2025, no other residents were identified as being affected by the alleged deficient practice. 6. On 8/7/2025 at 7:19 pm, the ADM notified the Medical Director

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for one of three sampled residents (Resident 1) who had a diagnosis of type 2 diabetes mellitus (DM - a disease that occurs when your blood sugar [BS] is too high), had a change of condition (COC - a major decline in a resident's status) on 7/19/2025 at 4 a.m., when Resident 1 complained of nausea (a feeling of sickness in the stomach that can be accompanied by an urge to vomit), had one episode of vomiting, and a documented blood sugar of 382 (normal range is between 70 to 99) milligrams per deciliter (mg/dl - unit of measurement) obtained by Licensed Vocational Nurse 1(LVN 1), and had a physician's order dated 7/15/2025, instructing staff to notify Medical Doctor 1 (MD 1) if the BS is greater than 350 mg/dl. The facility failed to: 1. Follow the physician's order dated 7/15/2025 to notify MD 1 when Resident 1's BS level reached 382 mg/dl on 7/19/2025 at 4 a.m., exceeding 350 mg/dl. 2. Ensure that Resident 1's vital signs (measurements of the body's most basic functions) were obtained during a COC on 7/19/2025 at 4 a.m. 3. Perform a comprehensive nursing assessment of Resident 1 during a COC on 7/19/2025 at 4 a.m. 4. Ensure that License Vocational Nurse 1 (LVN 1) provided a shift endorsement (process where a licensed nurse is transferring responsibility for resident care to another licensed nurse providing a detailed summary of the resident's condition, treatment, and ongoing needs) to the oncoming (7 a.m. to 3 p.m. shift) staff (Registered Nurse 2 [RN 2] and Licensed Vocational Nurse 2 [LVN 2]) regarding Resident 1's COC that occurred during LVN 1's shift on 7/19/2025 at 4 a.m. This deficient practice resulted in Resident 1 being found unresponsive (not reacting or responding to touch, sounds or verbal commands) on 7/19/2025 at 7:50 a.m. and subsequently died at the facility on 7/19/2025 at 8:05 a.m. On 8/7/2025 at 1:31 p.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ - a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) in the presence of the Administrator (ADM) and Registered Nurse (RN) 1 due to the facility's failure to provide treatment and care in accordance with professional standards of practice when Resident 1 had a COC on 7/19/2025 at 4 a.m. On 8/9/2025 at 12:54 p.m., the ADM submitted an IJ Removal Plan (a detailed plan that identifies all actions the facility will take to immediately address the IJ findings) for the facility's failure to provide treatment and care in accordance with professional standards of practice when Resident 1 had a COC on 7/19/2025 at 4 a.m. On 8/9/2025 at 3:01 p.m., while onsite at the facility, the SSA verified and confirmed the facility's full implementation of the IJ Removal Plan through observations, interviews, and record reviews, and determined the IJ situation regarding the facility's failure to provide treatment and care in accordance with professional standards of practice when Resident 1 had a COC on 7/19/2025 at 4 a.m. was no longer present. The SSA removed the IJ situation on 8/9/2025 at 3:01 p.m. in the presence of the ADM and LVN 8. The acceptable IJ Removal Plan included the following summarized actions: 1. After the IJ was called on 8/7/2025 at 1:31p.m., regarding not notifying the physician of Resident 1's COC, the facility immediately implemented a corrective process requiring all licensed nurses to notify the physician promptly as ordered. The corrective process will include a physical hand-off report (a process of transferring resident care responsibility and information from one healthcare provider to another), called the Shift-to-Shift COC Report, by the licensed nurses every shift. The hand-off report will include any changes of condition that occurred throughout their shift with confirmation that the incoming nurse received the report. The Shift-to-Shift COC Report is audited by the RN 1 and/or designee (assigned Desk Nurse) on every shift. 2. On 8/7/2025 at 2:30 p.m., 6 p.m., and 11 p.m., 8/8/2025 at 2:45 p.m., and ongoing, the Director of Staff Development (DSD) and/or designee provided in-service (training and educational session provided to facility staff) training to the licensed nurses. The training emphasized the importance of timely physician notification, documenting vital signs (measurements of the body's most basic functions), performing resident assessments and observations during a change of condition, following physician's orders and adhering to the facility's policy and procedure (P&P), titled Alert Charting Documentation. During the ongoing in-services provided by the Director of Nursing (DON) and/or designee, all licensed nurses will be re-educated and reminded that Licensed Nurses are able to reach out and contact a physician 24 hours a day, seven days a week (24/7), at any given time whether it is early morning or late evening. 3. On 8/7/2025 at 4:28 p.m., RN 1 and DSD had given a verbal one-on-one in-service (individualized training) and a corrective action warning to LVN 1. 4. On 8/7/2025 at 6:06 p.m., the

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff were competent when providing care for one of three sample residents (Resident 1), by failing to:1. Ensure License Vocational Nurse (LVN 1) notified the physician when Resident 1 had a change of condition on 7/19/2025, at 4 a.m. when Resident 1 felt nauseated, had one episode of vomiting and had a blood sugar of 382 milligram per deciliter (mg/dl-unit of measurement).2. Ensure LVN 1 follows physicians order when physicians order indicated to notify physician if Resident 1 blood sugar was greater than 350 mg/dl.3. Ensure LVN 1 obtains Resident 1 vital signs (include body temperature, pulse (heart rate), respiration rate (breathing), and blood pressure. These measurements help healthcare professionals assess a person's overall health and identify potential problems) when Resident 1 had a change of condition.4. Ensure LVN 1 follows an infection control policy and procedure by offering a trash can when Resident 1 had an episode of vomiting.5. Ensure staff competency (a combination of knowledge, skills, abilities, and behaviors that enable an individual to perform a task or role successfully) were performed annually (yearly) for two of five sampled staff (Certified Nursing Assistant 1 [CNA 1], and Registered Nurse 2 [RN2]) and four of five sampled staff (CNA 1, CNA 2,LVN 8 and RN 2) had annual performance evaluationThese failures placed Resident 1 at immediate risk. The resident was subsequently found unresponsive on 7/19/2025, at 7:50 a.m., which ultimately led to his death at 8:05 a.m. the same day. Also had the potential to affect the care necessary to provide nursing care and related services to meet residents' needs safely. Findings: a. During a review of Resident 1’s admission Record, the admission Record indicated the facility initially admitted Resident 1 on 12/3/2021, and readmitted on [DATE], with a diagnoses of type 2 Diabetes Mellites (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar) and hypertension (HTN-high blood pressure). During a review of Resident 1’s History and Physical (H & P), dated 9/13/2024, the H & P indicated that Resident 1 had the capacity to understand and make decisions. During a review of Resident 1’s Minimum Data Set (MDS – a resident assessment tool), dated 6/12/2025, the MDS indicated Resident 1’s thought process was intact and required supervision assistance from staff to complete activities of daily living (ADLs – activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 1’s Physician’s Orders, dated 7/15/2025, the Physician’s Order indicated to monitor Resident 1’s blood sugar before meals and bedtime. Call the physician if blood sugar is greater 350 mg/dl or less than 70 mg/dl before meals and at bedtime. During a review of Resident 1 Progress Notes, dated 7/19/2025, the Progress Notes indicated Resident 1 requested his (Resident 1) blood sugar to be checked due to feeling nauseated and blood sugar result was high. Resident 1 had an episode of vomiting and trash can was provided to Resident 1 in case he had another episode of vomiting. Resident 1’s last blood sugar check was 382 mg/dl. (continued on next page)

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	555117	A. Building B. Wing	08/09/2025

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/5/2025, at 6:24 a.m. with LVN 1, Resident 1 Progress Notes, dated 7/19/2025, were reviewed. The Progress Notes indicated that Resident 1’s last blood sugar check result was high with a result of 382 mg/dl per LVN 1, Resident 1 was nauseated and vomited one time. LVN 1 stated that he (LVN 1) did not notify the physician. LVN 1 stated that he (LVN 1) explained to Resident 1 that Resident 1’s previous standing order of sliding scale insulin was removed and offered ice chips since there was no as needed medication for nausea. LVN 1 stated that Resident 1 requested to receive his (Resident 1) 6 a.m. medication early instead since there was no medication available. LVN 1 stated that he (LVN 1) gave Resident 1’s 6 a.m. medication at around 4:25 a.m. as Resident 1 requested and did not call the physician to report that Resident 1 blood sugar was 382 mg/dl, nauseated, vomited once and did not call that Resident 1 was requesting to take his 6 a.m. medication early. LVN 1 stated he (LVN 1) should have notified the physician right away to get an order for nausea, vomiting and Resident 1’s blood sugar of 382 mg/dl. LVN 1 stated Resident 1 could possibly have another episode of nausea and vomiting again possibly related to hyperglycemia, diabetic ketoacidosis (a serious complication of diabetes characterized by high blood sugar and excess ketones in the blood or urine), and unresponsiveness. During a concurrent interview and record review on 8/5/2025, at 6:24 a.m. with LVN 1, Resident 1’s Medication Administration Record (MAR), dated 7/2025, was reviewed. The MAR indicated that call the physician if Resident 1’s blood sugar was greater than 350 mg/dl and or less than 70 mg/dl. MAR indicated that Resident 1 blood sugar reading at 6:30 a.m. was 394 mg/dl. LVN 1 stated he (LVN 1) did not notify the physician and skimmed the order and assumed that he (LVN 1) would call the physician if Resident 1 blood sugar was greater than 400 mg/dl. LVN 1 stated that it was a typographical error (a mistake made while typing or printing text), and the blood sugar should be 382 mg/dl instead of 394 mg/dl and the blood sugar of 382 mg/dl was taken at 4 a.m. LVN 1 stated he (LVN 1) did not recheck Resident 1 blood sugar since 4 a.m. that it was last check and just record the last reading of blood sugar of 382 mg/dl at 6:30 a.m. LVN stated that he (LVN 1) should recheck and monitor Resident 1 blood sugar to see any changes. During a concurrent interview and record review on 8/5/2025, at 6:24 a.m. with LVN 1, Resident 1’s Vital Signs, dated 7/19/2025, were reviewed. LVN 1 stated there were no recorded vital signs taken on 7/19/2025. LVN 1 stated if it was not documented, it was not done. During a concurrent interview and record review on 8/5/2025, at 9:56 a.m. with RN 1, Resident 1’s Progress Notes, dated 7/19/2025, was reviewed. The Progress Notes indicated that Resident 1’s blood sugar was 382 mg/dl and had episode of nausea and vomiting. RN 1 stated that there was no documentation that LVN 1 checked Resident 1 vital signs at 4 a.m. when Resident 1’s complained of nausea. RN 1 stated that LVN 1 should check Resident 1 vital signs and notify the physician if it’s abnormal. RN 1 stated LVN 1 indicated that Resident 1 was okay, but it would be hard to determine if Resident 1 was okay if LVN 1 did not even recheck blood sugar after getting a 382 mg/dl result, and no monitoring of vital signs was taken for Resident 1 to justify that Resident 1 had no distress. RN 1 stated that LVN 1 should have notified the physician right away because Resident 1’s blood sugar was greater than 350 mg/dl, nauseated and vomited. RN 1 stated it means there was something going on and needed more intervention from the physician. RN 1 stated the physician could possibly order an insulin (medication to lower blood sugar) due to Resident 1’s high blood sugar. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/5/2025, at 9:56 a.m. with RN 1, Resident 1’s Physician Order, dated 7/16/2025, were reviewed. The Physicians Order indicated that to call the physician if Resident 1’s blood sugar was greater than 350 mg/dl. RN 1 stated that physicians ordered to notify the physician when blood sugar was greater than 350 mg/dl. RN 1 stated Resident 1’s condition could worsen and could possibly lead to death. During a concurrent interview and record review on 8/5/2025, at 12:30 p.m. with Director of Staff Development (DSD), LVN 1’s Employee File, dated 5/17/2025, were reviewed. The Employee File indicated that LVN 1 received an orientation skills check on change of condition, notification requirement, documentation requirement and infection control on 5/17/2025. During a concurrent interview and record review on 8/6/2025, at 2:31 p.m. with Infection Preventionist (IP), Resident 1’s Progress Notes, dated 7/19/2025, were reviewed. IP stated it indicated that LVN 1 offered trashcan to Resident 1 in case Resident 1 had an episode of vomiting again. IP stated that LVN 1 should not offer trash can because it contains a lot of bacteria and must offer a clean basin instead. During an interview on 8/6/2025, at 2:49 p.m. with RN 1. RN 1 stated LVN 1 should not offer trash can to Resident 1 and must provide a clean basin due to cross contamination Resident 1 could get infection from the trash can. During an interview on 8/7/2025, at 11:05 a.m. with RN 1. RN 1 stated blood sugar of greater than 350 mg/dl, nausea and vomiting was a change of condition for Resident 1 because this was all abnormal for Resident 1 and needed a proper assessment and intervention from the physician. RN 1 stated if LVN 1 considers this as a change of condition LVN 1 must take the vital signs of Resident 1 and report all the symptoms of Resident 1 to the physician to get a proper intervention. During a review of the facility’s policy and procedure(P&P), titled, “Infection Control – Policies and Procedures,” last reviewed on 4/4/2025, indicated, “To provide infection control policies and procedures required for a safe and sanitary environment.” During a review of the facility’s P&P, titled, “Staff Competency Validation,” last reviewed on 4/4/2025, indicated, “Staff are required to have competency validation based on their job description or assigned duties.” During a review of the facility’s P&P, titled, “Obtaining Vital Signs,” last reviewed on 4/4/2025, indicated, “To take clinical measurements that indicate the stated of a resident’s basic body functions. Vitals signs will be taken with the following frequency but not limited to when there is a change in the resident’s condition.” During a review of the facility’s P&P, titled, “Change of Condition Notification,” last reviewed on 4/4/2025, indicated, “To ensure … physicians are informed of changes in the resident’s condition in a timely manner.” During a review of the facility’s P&P, titled, “Blood Glucose Monitoring,” last reviewed on 4/4/2025, indicated, “Notify the healthcare provider of a Blood Sugar Level lower than 70 mg/dl or higher than 250 mg/dl unless otherwise indicated in the physician order.” (continued on next page)

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	08/09/2025

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility’s P&P, titled, “Diabetic Care,” last reviewed on 4/4/2025, indicated, “In any case where the resident’s blood sugar is less than 70 mg/dl or greater than 350 mg/dl, the Attending Physician must be notified: unless otherwise noted on the Physician’s Order. Nursing staff will monitor the residents for signs and symptom of hypoglycemia (low blood sugar) or hyperglycemia, initiate intervention if necessary, and notify the Attending Physician and responsible party if the signs and symptoms are present.” b. During a concurrent interview, and record review on 8/8/2025, at 12:32 p.m., with the Assistant Director of Staff Development (ADSD), four employee files were reviewed: 1. CNA 1’s Date of Hire was 6/20/2024, and the latest Competency Checklist was dated 8/7/2025. No Performance Evaluation on file. 2. CNA 2’s Date of Hire was 5/15/2024, - No Performance Evaluation on file. 3. LVN 8’s Date of Hire was 6/23/2015, - no Performance Evaluation on file. 4. RN 2’s Date of Hire was 11/22/2016, - and the latest Licensed Nurse Orientation Skills Checklist and Annual Skills Check, was dated 11/19/2023, and the latest Performance Evaluation was dated 11/22/2017. The ADSD stated CNA 1 and RN 2’s competency was not assessed annually. The ADSD stated CNA 1, CNA 2, LVN 8 and RN2’s performance evaluation was not on the employee file. The ADSD stated the Infection Preventionist (IP), and the Director of Staff Development (DSD) are responsible for competency oversight. The ADSD stated she (ADSD) was not sure how frequently staff competency should be assessed but based on the Licensed Nurse Orientation Skills Checklist and Annual Skills Check, competency check should be yearly. The ADSD stated she was not sure also how frequently the performance evaluation was done. During an interview on 8/8/2025, at 1:28 p.m. with the Director of Nursing (DON), the DON stated performance evaluation and competency checklist should be in the employee file. During an interview on 8/8/2025, at 2:48 p.m., with the DON, the DON stated staff competency and performance evaluation should be assessed annually to identify areas that needed further teaching or education. The DON stated the competency and performance evaluation determines if licensed nurses are competent to perform their responsibilities. The DON stated if competency and performance evaluation were not done annually it could result in potential harm for the residents. The DON stated it was her (DON) and the DSD’s responsibility to make sure it was done. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, and record review on 8/9/2025, at 2:28 p.m., with the Administrator (Admin), facility’s policy and procedure (P&P), titled, “Staff Competency Validation”, dated 6/4/2024, and last reviewed on 4/4/2025, the P&P indicated, “Competency validation is completed to evaluate an individual’s performance, evaluate group performance, meet standards set by regulatory agencies, address problematic issues and enhance performance reviews. Competency validation is a determination based on an individual’s satisfactory performance or each specific element of his or her job description and of the specific requirements for the area in which he or she is employed. To protect the health, safety and wellbeing of resident.” The Admin stated the facility’s P&P did not indicate how frequent should the competency check and performance evaluation. The Admin stated CNA’s, LVNs and RNs should be checked for competency annually to ensure the safety of residents and to ensure that all staff are competent when they provide care. The Admin stated the facility does not have a policy on performance evaluation. During a concurrent interview, and record review on 8/9/2025, at 2:28 p.m., with the Administrator (Admin), facility’s Facility Assessment Tool, dated 3/3/2025, was reviewed. The Facility Assessment Tool indicated, “List all staff training and competencies needed by type of staff. Consider if it would be helpful to indicate which competencies are reviewed at the time the staff member was hired and how often they are reviewed after that.” The Admin stated the Facility Assessment Tool did not indicate frequency of competency and performance evaluations. The Admin stated he (Admin) will update the Facility Assessment Tool. [NAME] an interview on 8/9/2025, at 2:50 p.m., with the DON, the DON stated the facility should ensure that staff are competent on an annual basis and if any gaps in competency, the facility can identify it and address it. During a review of facility’s Employee Handbook dated 1/2024, the Employee Handbook indicated, “PERFORMANCE EVALUATIONS: Employees may receive periodic performance reviews. The review will generally be conducted by their supervisor. The first performance evaluation may be after completion of the Introductory Period. After that review, performance evaluations may be conducted annually, on or around their anniversary date. The frequency of performance evaluations may vary depending upon length of service, job position, past performance, changes in job duties or recurring performance problems. Performance evaluations· will Include factors such as the quality and quantity of the work performed, knowledge of the job, their Initiative, their work attitude and their demeanor toward others. Performance evaluations are designed to help employees become aware of progress, areas for Improvement and objectives or goals for future work performance.”

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	555117	A. Building B. Wing	08/09/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of three sampled residents (Residents 5) by failing to follow the physician's order to hold (temporarily suspending its administration) midodrine (medication used to treat low blood pressure) for systolic blood pressure (sbp- the top number in a blood pressure reading, representing the pressure in your arteries when your heart beats) more than 110 millimeter of mercury (mmHg-unit of measurement).This failure had the potential to result in unnecessarily elevating Resident 5's blood pressure.Findings:During a review of Resident 5's admission Record, the admission Record indicated the facility admitted Resident 5 on 5/8/2025, with diagnoses including 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 (a stroke where brain tissue dies due to a lack of blood supply), essential hypertension (persistently high blood pressure for which no specific underlying cause can be identified), and history of falling.During a review of Resident 5's History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 5/16/2025, the H&P indicated Resident 5 had fluctuating capacity to understand and make decisions.During a review of Resident 5's Minimum Data Set (MDS-a resident assessment tool), dated 6/7/2025, the MDS indicated Resident 5's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 5 was dependent on staff for eating and showering.During a review of Resident 5's Physician Order, dated 6/3/2025, the Physician Order indicated midodrine hydrochloride oral tablet five milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), give one tablet enterally (the process of delivering food or medication directly into the gastrointestinal system, allowing for absorption and processing by the body) three times a day for hypotension (low blood pressure). The Physician Order indicated to hold if Resident 5's blood pressure is over 110 mmHg.During a record review of Resident 5's Medication Administration record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 8/2025, the MAR indicated midodrine was administered on the following dates and times:1. 8/2/2025, at 10 p.m., with a blood pressure of 132/80 mmHg.2. 8/4/2025, at 6 a.m. with a blood pressure of 124/87 mmHg.3. 8/7/2025, at 6 a.m. with a blood pressure of 124/76 mmHg.During an interview on 8/9/2025, at 2:50 p.m., with the Director of Nursing (DON), the DON stated the nurses failed to follow the physician's order to hold the midodrine for blood pressure above 110 mmHg. The DON stated Resident 5 could have elevated blood pressure and experienced adverse effects (harmful or undesirable consequences that occur because of a treatment, medication, or medical procedure) from the medication.During a review of facility's policy and procedure (P&P), titled, Medication Administration, dated 1/1/2012, and last reviewed on 4/4/2025, the P&P indicated, Medication will be administered directed by a Licensed nurse and upon the order of a physician or licensed independent practitioner.

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	08/09/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review, the facility failed to maintain an accurate and complete medical record for two of three sampled residents (Resident 1 and Resident 6) when: 1. The facility failed to ensure Licensed Vocational Nurse (LVN) 1 accurately documented Resident 1's glipizide (medication used to treat type two diabetes [DM - a disorder characterized by difficulty in blood sugar control and poor wound healing]) and Protonix (also known as pantoprazole, a medication used to decrease the amount of acid in the stomach) administration, and blood sugar check. 2. The facility failed to document the time and the physician's response after the physician (MD) was notified of Resident 6's urine test result on 8/6/2025. These failures had the potential to cause confusion in the care and the medical records containing inaccurate documentation. Findings: 1. During a review of Resident 1’s admission Record, the admission Record indicated the facility initially admitted Resident 1 on 12/3/2021 and readmitted on [DATE] with diagnoses including type two DM, hypertension (high blood pressure), hyperlipidemia (a medical condition characterized by elevated levels of lipids [fats] in the bloodstream which can increase the risk of cardiovascular diseases such as heart disease and stroke), and chronic kidney disease (a condition where the kidneys are damaged and cannot filter blood as well as they should, leading to a gradual loss of kidney function over time). During a review of Resident 1’s History and Physical (H&P - a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 9/13/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1’s Minimum Data Set (MDS – a resident assessment tool), dated 6/12/2025, the MDS indicated Resident 1’s thought process was intact and required supervision assistance from staff to complete activities of daily living (ADLs – activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 1’s Physician’s Orders, dated 7/15/2025, the Physician’s Order indicated to monitor Resident 1’s blood sugar (BS) before meals and at bedtime and to call MD if BS is greater than 350 milligram (mg – a unit of measure for mass) per (/) deciliter (dl – a unit of measure for volume) and/or less than 70 mg/dl. The physician’s orders indicated to give two glipizide 10 mg by mouth two times a day, before breakfast and dinner, for DM. The physician’s orders indicated to give Protonix tablet delayed release 40 mg one tablet by mouth two times a day related to gastroesophageal reflux disease (GERD - a condition where stomach contents flow back up into the esophagus [body part that connects the throat to the stomach]). (continued on next page)

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	555117	A. Building B. Wing	08/09/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/5/2025 at 6:24 a.m. with LVN 1, Resident 1’s Medication Administration Record (MAR), dated 7/2025, was reviewed. Resident 1’s MAR indicated on 7/19/2025 at 6:30 a.m., LVN 1 documented Resident 1’s BS was 394 mg/dl. LVN 1 stated he (LVN 1) checked Resident 1’s BS at around 4 a.m. and not at 6:30 a.m. LVN 1 stated he (LVN 1) should have documented that he (LVN 1) checked Resident 1’s BS at around 4 a.m. LVN 1 stated Resident 1’s BS was 382 mg/dl at around 4 a.m., not 394 mg/dl. LVN 1 stated he (LVN 1) input 394 mg/dl instead of 382 mg/dl. LVN 1 stated he (LVN 1) did not check Resident 1’s BS at 6:30 a.m. as ordered. Resident 1’s MAR indicated LVN 1 administered glipizide and Protonix to Resident 1 on 7/19/2025 at 6:30 a.m. LVN 1 stated he (LVN 1) did not administer glipizide and Protonix to Resident 1 on 7/19/2025 at 6:30 a.m. and administered both medications to Resident 1 between 4:20 a.m. to 4:25 a.m. per Resident 1’s request. During a concurrent interview and record review on 8/5/2025 at 9:56 a.m. with Registered Nurse (RN) 1, Resident 1’s Progress Notes, dated 7/19/2025, and Resident 1’s MAR, dated 7/2025, were reviewed. Resident 1’s Progress Notes indicated LVN 1 documented Resident 1 had a BS of 382 mg/dl at around 4 a.m. Resident 1’s MAR indicated on 7/19/2025 at 6:30 a.m., LVN 1 documented Resident 1’s BS was 394 mg/dl. RN 1 stated LVN 1 inaccurately documented Resident 1’s BS. During a concurrent interview and record review on 8/5/2025 at 9:56 a.m. with RN 1, Resident 1’s Progress Notes, dated 7/19/2025, and Resident 1’s MAR, dated 7/2025, were reviewed. RN 1 stated LVN 1 administered Resident 1’ glipizide and Protonix early as requested by Resident 1. RN 1 stated LVN 1 documented Resident 1’s glipizide and Protonix administration in the MAR on 7/19/2025 at 6:30 a.m. RN 1 stated LVN 1 documented in Resident 1’s Progress Notes that Resident 1 received his (Resident 1) glipizide and Protonix at 4:20 a.m. to 4:25 a.m. During a review of the facility policy and procedure (P&P) titled, “Completion and Correction,” last reviewed on 4/4/2025, indicated, “The Facility will work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation.” 2. During a review of Resident 6’s admission Record, the admission Record indicated the facility admitted Resident 6 on 7/21/2025, with diagnoses that included right side skull (bone of the head) and facial bones fracture (break in the bone) and history of falling. During a review of Resident 6’s H&P, dated 7/23/2025, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Resident 6’s MDS, dated [DATE], the MDS indicated Resident 6’s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 6 was dependent on staff for toileting, showering, and dressing. The MDS indicated Resident 6 was always incontinent (unable to control) bladder and bowel functions. (continued on next page)

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	555117	A. Building B. Wing	08/09/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/9/2025 at 10:28 a.m. with RN 2, Resident 6’s Progress Notes, dated 8/1/2025 to 8/6/2025, and Urinalysis (urine test) Result, collected on 8/1/2025 at 2:30 p.m. and with a test report date of 8/2/2025 at 9:42 p.m., was reviewed. The Urinalysis Result indicated on 8/6/2025, the physician was notified. RN 2 stated there was no documentation in Resident 6’s medical record of the time the physician was notified on 8/6/2025. RN 2 stated there was no documentation on what the physician’s response was after notification. During an interview on 8/9/2025 at 11:41 a.m. with the Director of Nursing (DON), the DON stated she (DON) cannot find documentation of the time the physician was notified and the physician’s response in the Progress Notes. During an interview on 8/9/2025, at 2:50 p.m., with the DON, the DON stated Resident 6’s medical record was incomplete. The DON stated LVN 3 should have documented that she (LVN 3) spoke to the physician and documented the date and time urine test was received, the date and time the physician was notified, and the physician's response. During a review of facility’s P&P, titled, “Completion and Correction”, dated 1/1/2012 and last reviewed on 4/4/2025, the P&P indicated, “The facility will work to complete and correct medical records in a standard manner to provide the highest quality and accuracy in documentation…. Entries will be complete, legible, descriptive and accurate…. Documentation content… I. Each time a physician is notified via phone or in person regarding the resident’s condition.”

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	555117	A. Building B. Wing	08/09/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 1 followed an infection control policy and procedure for one of three sample residents (Resident 1) by offering a trash can when Resident 1 had an episode of vomiting.This deficient practice had the potential risk of transmission of bacteria that can lead to infection of Resident 1.During a review of Resident 1's admission Record, the admission Record indicated the facility initially admitted Resident 1 on 12/3/2021 and readmitted on [DATE] with a diagnosis of type 2 diabetes mellites with hyperglycemia (body isn't using insulin properly, causing blood sugar and hypertension (high blood pressure).During a review of Resident 1's History and Physical (H & P), dated 9/13/2024, the H & P indicated that Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 6/12/2025, the MDS indicated Resident 1 thought process was intact and required supervision assistance from staff to complete activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily).During a concurrent interview and record review on 8/6/2025 at 2:31 p.m. with Infection Preventionist (IP) 1, Resident 1's Progress Notes, dated 7/19/2025, were reviewed. IP stated it indicated that LVN 1 offered trashcan to Resident 1 in case Resident 1 had an episode of vomiting again. IP stated that LVN 1 should not offer trash can because it contains a lot of bacteria and must offer a clean basin instead.During an interview on 8/6/2025 at 2:49 p.m. with RN 1, RN 1 stated LVN 1 should not offer trash can to Resident 1 and must provide a clean basin due to cross contamination Resident 1 could get infection from the trash can.During a review of the facility policy and procedure titled, Infection Control - Policies and Procedures, last reviewed on 4/4/2025, indicated, To provide infection control policies and procedures required for a safe and sanitary environment.