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	05/15/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 develop and implement a person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for four of four sampled residents (Residents 1, 4, 5, and 6) by failing to: 1. Develop a care plan for Resident 1's use of cane (walking stick). 2. Develop a care plan for Residents 1, 4, 5, and 6's out on pass (a resident is temporarily allowed to leave a hospital, long-term care facility, or rehabilitation center without being officially discharged). These failures had potential for Residents 1, 4, 5, and 6's delays in the delivery of necessary care and services and could place the residents at risk of accidents. Findings: 1. During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 11/4/2025, with diagnoses that included unspecified (unconfirmed) fracture (break in the bone) of the left tibia shaft (between the knee and ankle), and difficulty in walking. 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 11/11/2025, 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 2/12/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 used wheelchair (a mobility device with wheels, a seat, and footrests, designed to help people move around when walking is difficult or impossible) and needed supervision with ambulating. During a review of Resident 1's Care Plan, dated 11/4/2026, on activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily), the Care Plan indicated an intervention to provide assistance with ADL care as needed. During a review of Resident 1's Progress Notes, dated 5/11/2026, timed at 5:32 p.m., the Progress Notes indicated Resident 1 requested to go out on pass. The Progress Notes indicated Licensed Vocational Nurse (LVN) 3 notified the Physician and the Physician approved Resident 1's out on pass for four hours.During a review of Resident 1's Physician Order, dated 5/11/2026, the Physician Order indicated Resident 1 may go out on pass today (5/11/2026) to be with family for maximum of four hours. During an interview on 5/14/2026 at 9:42 a.m. with LVN 2, LVN 2 stated on 5/11/2026, at 6:20 p.m., Resident 1 left the faciity on out on pass, took his (Resident 1) cane and left the wheelchair at the facility. LVN 2 stated she (LVN 2) informed Resident 1 where to place his (Resident 1) wheelchair. LVN 2 stated she (LVN 2) had only seen Resident 1 use the wheelchair and was not sure where he (Resident 1) got the cane. LVN 2 stated she (LVN 2) knows Resident 1 depends on his (Resident 1) wheelchair. During a concurrent interview and record review on 5/14/2026 at 10:11 a.m. with the Minimum Data Set Nurse (MDSN), Resident 1's MDS, dated [DATE], and Care Plans were reviewed. The MDSN stated the MDS, dated [DATE], indicated Resident 1 needed supervision to limited assistance with walking and uses front wheeled walker (FWW-a lightweight, height-adjustable metal frame with two small wheels on the front legs and stationary rubber caps or glides on the back legs) and wheelchair. The MDSN stated there were no care plans developed for the use of cane. The (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 - Some	MDSN stated she (MDSN) had never seen Resident 1 use a cane before. The MDSN stated Resident 1 had a higher chance of falling using a cane. During a concurrent interview and record review on 5/14/2026 at 10:30 a.m., with the Director of Rehabilitation (DOR), Resident 1's Care Plan dated 4/29/2026, was reviewed. The DOR stated residents were assessed for use of durable medical equipment (DME-reusable medical devices prescribed by a doctor for long-term use in home) for safety before use. The DOR stated Resident 1 was assessed with the use of FWW with Restorative Nursing Assistant (RNA) and the use of wheelchair on his (Resident 1) own. The DOR stated there were no care plans developed for the use of cane. During an interview on 5/14/2026 at 10:37 a.m. with the DOR, the DOR stated there was no documentation on Resident 1's medical record for the use of cane. The DOR stated the FWW provides more support for balance than a cane. The DOR stated there is a higher risk for fall with using cane than FWW. During an interview on 5/14/2026 at 10:44 a.m. with the Director of Nursing (DON), the DON stated Resident 1 left the facility using a cane. The DON stated Resident 1 could have safety issues with the use of cane and could fall as a result. The DON stated if she was informed that Resident 1 used the cane, she (DON) would have asked rehab to evaluate Resident 1 for the safe use of cane and care plan would have been created for Resident 1's safety. The DON stated if rehab did not evaluate Resident 1 for cane it means cane was not safe for Resident 1's use.During a concurrent interview and record review on 5/15/2026 at 8:42 a.m., with LVN 4, Resident 1's Care Plans, were reviewed. LVN 4 stated there was no care plan developed for Resident 1's out on pass. 2a. During a review of Resident 4?s admission Record, the admission Record indicated the facility admitted Resident 4 on 4/23/2026, with diagnoses that included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN - high blood pressure) and unsteadiness on feet. During a review of Resident 4's H&P, dated 4/24/2026, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 4 needed moderate assistance from staff for ambulating 10 feet and used wheelchair. During a review of Resident 4's Physician Order, dated 5/11/2026, the Physician Order indicated Resident 4 may go out on pass with the Administrator (ADM) on 5/11/2026, until 11:59 p.m. 2b. During a review of Resident 5?s admission Record, the admission Record indicated the facility admitted Resident 5 on 3/2/2023, with diagnoses that included HTN, DM and localized edema (swelling in one specific area of your body caused by trapped fluid). During a review of Resident 5's Physician Order, dated 8/10/2025, the Physician Order indicated Resident 5 may go out on pass for four hours if not in conflict with care. During a review of Resident 5s H&P, dated 2/13/2026, the H&P indicated Resident 5 had the capacity to understand and make decisions. During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognitive skills for daily decisions were intact. The MDS indicated Resident 5 uses walkers and wheelchair. 2c. During a review of Resident 6?s admission Record, the admission Record indicated the facility admitted Resident 6 on 12/14/2022, with diagnoses that included lymphedema (an abnormal buildup of protein-rich lymph fluid in the body's tissues that causes persistent swelling), and acute thyroiditis (the swelling or inflammation of your thyroid gland. Located in the front of your neck, thyroid is a small, butterfly-shaped organ that acts as the body's engine, producing hormones that control metabolism and energy). During a review of Resident 6's Physician Order, dated 9/30/2025, the Physician Order indicated Resident 6 may go out on pass for four hours.During a review of Resident 6's H&P, dated 12/5/2025, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive skills for daily decisions were intact. The MDS indicated Resident 6 used wheelchair. During a review of facility's Resident Out on Pass Log, the Out on Pass Log indicated the following:1. Resident 6 signed out on pass on 3/12/2026, at 1:30 p.m.2. Resident 5 signed out on pass on 4/12/2026, at 1 p.m.3. Resident 4 signed out on pass on 5/11/2026, at 9: 20 a.m.4. Resident 1 signed out on pass on 5/11/2026, at 6:20 p.m. During an interview on 5/15/2026 at (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8:42 a.m. with LVN 4, LVN 4 stated the nurses do not develop a care plan for residents out on pass order. LVN 4 stated care plan should have been developed to list interventions specific to residents' care while on out on pass and to monitor if treatment is effective or not and for residents' safety. During an interview on 5/15/2026 at 9:18 a.m. with the DON, the DON stated care plans are problems and ongoing intervention that communicates care to all departments in the facility. The DON stated without developing a care plan for out on pass, it can result in miscommunication among staff on what is expected when residents go out on pass. During a review of facility's policy and procedure (P&P) titled, Comprehensive Person- Centered Care Planning, dated 11/2017, and last reviewed on 4/4/2026, the P&P indicated, It is the policy of this facility to provide person-centered, comprehensive and interdisciplinary (a collaborative approach where professionals from diverse medical and social fields unite to manage a patient's care) care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well?being. a. The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission. It should address resident-specific health and safety concerns to prevent decline or injury, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. c. Since the baseline care plan is developed before the comprehensive assessment, goals and interventions may change. If the comprehensive assessment and thecomprehensive care plan identified a change in the resident's goals, or physical, mental or psychosocial functioning, which was not previously identified on the baseline care plan, those changes must be incorporated into an updated summary provided to the resident and his or her representative, if applicable. Within seven days from the completion of the comprehensive MDS assessment, the comprehensive care plan will be developed. All goals, objectives, interventions, etc. from the current baseline care plan will be included in the resident's comprehensive care plan. b. Additional changes or updates to the residents' comprehensive care plan will be made based on the assessed needs of the residents. These subsequent changes will not need to be included in the baseline care plan. It is no longer required to revise/update the base line care plan.

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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 ensure one of three sampled residents (Resident 1) was safely assessed for the use of a cane before allowing to leave the facility on an Out on Pass (a resident is temporarily allowed to leave a hospital, long-term care facility, or rehabilitation center without being officially discharged) order on 5/11/2026. This failure had the potential for Resident 1 to fall outside of the facility that could potentially cause injury. Findings: During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 11/4/2025, with diagnoses that included unspecified (unconfirmed) fracture (break in the bone) of the left tibia shaft (between the knee and ankle), and difficulty in walking. 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 11/11/2025, 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 2/12/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 used wheelchair (a mobility device with wheels, a seat, and footrests, designed to help people move around when walking is difficult or impossible) and needed supervision with ambulating. During a review of Resident 1's Care Plan, dated 11/4/2026, on activities of daily living (ADL - activities such as bathing, dressing and toileting a person performs daily), the Care Plan indicated an intervention to provide assistance with ADL care as needed. During a review of Resident 1's Fall Risk Evaluation, dated 1/20/2026, the Fall Risk Evaluation indicated Resident 1 had one to two fall incidents in the past three months. The Fall Risk Evaluation indicated Resident 1 required use of assistive device. During a review of Resident 1's Progress Notes, dated 5/11/2026, timed at 5:32 p.m., the Progress Notes indicated Resident 1 requested to go out on pass. The Progress Notes indicated Licensed Vocational Nurse (LVN) 3 notified the Physician and the Physician approved Resident 1's out on pass for four hours. During a review of Resident 1's Physician Order, dated 5/11/2026, the Physician Order indicated Resident 1 may go out on pass today (5/11/2026) to be with family for maximum of four hours. During an interview on 5/14/2026 at 9 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 can walk but used a wheelchair all the time. During an interview on 5/14/2026 at 9:20 a.m. with Registered Nurse (RN) 1, RN 1 stated Resident 1 ambulates with assistance and uses wheelchair. During an interview on 5/14/2026 at 9:42 a.m. with LVN 2, LVN 2 stated on 5/11/2026, at 6:20 p.m., Resident 1 left the faciity on out on pass, took his (Resident 1) cane (walking stick) and left the wheelchair at the facility. LVN 2 stated she (LVN 2) informed Resident 1 where to place his (Resident 1) wheelchair. LVN 2 stated she (LVN 2) had only seen Resident 1 use the wheelchair and was not sure where he (Resident 1) got the cane. LVN 2 stated she (LVN 2) knows Resident 1 depends on his (Resident 1) wheelchair. During a concurrent interview and record review on 5/14/2026 at 10:11 a.m. with the Minimum Data Set Nurse (MDSN), Resident 1's MDS, dated [DATE], was reviewed. The MDSN stated the MDS, dated [DATE], indicated Resident 1 needed supervision to limited assistance with walking and uses front wheeled walker (FWW - a lightweight, height-adjustable metal frame with two small wheels on the front legs and stationary rubber caps or glides on the back legs) and wheelchair. The MDSN stated she (MDSN) had never seen Resident 1 use a cane before. The MDSN stated Resident 1 had a higher chance of falling using a cane. During an interview on 5/14/2026 at 10:30 a.m. with the Director of Rehabilitation (DOR), the DOR stated residents were assessed for use of durable medical equipment (DME - reusable medical devices prescribed by a doctor for long-term use in home) for safety before use. The DOR stated Resident 1 was assessed for the use of a FWW with Restorative Nursing Assistant (RNA) and the use of wheelchair on his (Resident 1) own. During an interview on 5/14/2026 at 10:37 a.m. with (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the DOR, the DOR stated there was no documentation on Resident 1's medical record for the use of cane. The DOR stated Resident 1 was able to walk 100 feet on 4/28/2026, using a FWW when he (Resident 1) was discharged from the rehab therapy on 4/28/2026. The DOR stated the FWW provides more support for balance than a cane. The DOR stated there is a higher risk for fall with using cane than FWW. During an interview on 5/14/2026 at 10:44 a.m. with the Director of Nursing (DON), the DON stated Resident 1 left the facility using a cane. The DON stated Resident 1 could have a safety issue with the use of a cane and could fall as a result. The DON stated the facility failed to assess Resident 1's safety on the use of a cane before allowing him (Resident 1) to leave out on pass on his (Resident 1) own. The DON stated LVN 2 should have advised Resident 1 to bring the FWW or wheelchair instead of the cane and educate Resident 1 that it was not safe to use cane. During a review of the facility's policy and procedure (P&P) titled, Out on Pass, dated 2/2/2026, was reviewed. The P&P indicated, Prior to the Resident leaving on pass, a Licensed Nurse will assess the resident's physical and mental status and ensure that:1. The Resident and responsible person (if applicable) has been instructed of any special needs of the Resident during the pass as applicable (special diet, needs, medications) .5. The Resident is provided with required assistive devices (walker, wheelchair, cane).

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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** Based on interview and record review, the facility failed to maintain accurate and complete medical record for four of four sampled residents (Residents 1, 4, 5, and 6) by failing to: 1. Ensure Licensed Vocational Nurse (LVN) 2 documented that Resident 1 went out on pass (a resident is temporarily allowed to leave a hospital, long-term care facility, or rehabilitation center without being officially discharged) on 5/11/2026, using a cane (walking stick) and leaving behind his (Resident 1) wheelchair (a mobilized seating device with wheels, used by individuals who have difficulty or are unable to walk due to injury, illness, disability, or age-related conditions). 2. Ensure LVN 1 and LVN 5 documented the date and time Residents 4, 5, and 6 returned to the facility after an out on pass. This failure had the potential to cause confusion in 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 admitted Resident 1 on 11/4/2025, with diagnoses that included unspecified (unconfirmed) fracture (break in the bone) of the left tibia shaft (between the knee and ankle), and difficulty in walking. During a review of Resident 1'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 11/11/2025, 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 2/12/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 used wheelchair and needed supervision with ambulating. During a review of Resident 1's Progress Notes, dated 5/11/2026, timed at 5:32 p.m., the Progress Notes indicated Resident 1 requested to go out on pass. The Progress Notes indicated LVN 3 notified the Physician and the Physician approved Resident 1's out on pass for four hours. During a review of Resident 1's Physician Order, dated 5/11/2026, the Physician Order indicated Resident 1 may go out on pass today (5/11/2026) to be with family for maximum of four hours. During an interview on 5/14/2026 at 9:42 a.m. with LVN 2 LVN 2 stated on 5/11/2026, at 6:20 p.m., Resident 1 took his (Resident 1) cane and left the wheelchair at the facility. LVN 2 stated Resident 1 left the facility unaccompanied on out on pass and was picked up by a taxi. During an interview on 5/14/2026 at 10:44 a.m. with the Director of Nursing (DON), the DON stated Resident 1 left the facility using a cane. The DON stated if she was informed that Resident 1 used the cane, she (DON) would have asked rehab to evaluate Resident 1 for the safe use of cane. The DON stated if rehab did not evaluate Resident 1 for cane it means cane was not safe for Resident 1's use. During a concurrent interview and record review on 5/15/2026 at 8:42 a.m. with LVN 4, Resident 1's Progress Notes, dated 5/11/2026, were reviewed. LVN 4 stated there was no documentation in Resident 1's medical record that Resident 1 left with a cane. LVN 4 stated the facility had a Resident Out on Pass Log where nurse's documents date and time when residents leave and when residents return to the facility and signed by nurses. 2a. During a review of Resident 4?s admission Record, the admission Record indicated the facility admitted Resident 4 on 4/23/2026, with diagnoses that included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN - high blood pressure) and unsteadiness on feet. During a review of Resident 4's H&P, dated 4/24/2026, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 4 needed moderate assistance from staff for ambulating 10 feet and used wheelchair. During a review of Resident 4's Physician Order, dated 5/11/2026, the Physician Order indicated Resident 4 may go out on pass with the Administrator (ADM) on 5/11/2026, until 11:59 p.m. During a review of facility's Resident Out on Pass Log, the Resident Out on Pass Log indicated (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 4 signed out on pass on 5/11/2026, at 9: 20 a.m. During a concurrent interview and record review on 5/14/2026 at 9:14 a.m. with LVN 4, Residents Out on Pass log was reviewed. LVN 4 stated Resident Out on Pass Log indicated Resident 4 went out on pass 5/11/2026, at 9:20 a.m. but did not indicate the following:1. License Nurse initial of when Resident 4 left the facility.2. Expected return time.3, Time Returned4. License Nurse initial of when Resident 4 returned. During a concurrent interview and record review on 5/15/2026 at 8:42 a.m. with LVN 4, Resident 4's Progress Notes, dated 5/11/2026, were reviewed. LVN 4 stated there was no documentation in Resident 4's medical record of when Resident 4 returned to the facility on 5/11/2026. LVN 4 stated LVN 5 did a late entry documentation on 5/14/2026, timed at 9:28 p.m., that Resident 4 left the faciity on 5/11/2026, at 9:20 a.m. with the Activity Director (AD), and returned at 10:10 a.m. and left again at 11:23 a.m., with the Administrator (ADM) and returned at 11:46 a.m. LVN 4 stated LVN 5 should have documented the date and time of Resident 4's return to the facility on 5/11/2026, to show Resident 4's safe return to the facility. 2b. During a review of Resident 5?s admission Record, the admission Record indicated the facility admitted Resident 5 on 3/2/2023, with diagnoses that included HTN, DM and localized edema (swelling in one specific area of your body caused by trapped fluid). During a review of Resident 5's Physician Order, dated 8/10/2025, the Physician Order indicated Resident 5 may go out on pass for four hours if not in conflict with care. During a review of Resident 5s H&P, dated 2/13/2026, the H&P indicated Resident 5 had the capacity to understand and make decisions. During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognitive skills for daily decisions were intact. During a review of facility's Resident Out on Pass Log, the Resident Out on Pass Log indicated Resident 5 signed out on pass on 4/12/2026, at 1 p.m. During a concurrent interview and record review on 5/14/2026 at 9:14 a.m. with LVN 4, Residents Out on Pass log was reviewed. LVN 4 stated Resident Out on Pass Log indicated Resident 5 went out on pass on 4/12/2026, at 1 p.m., but did not indicate the following:1. License Nurse initial of when Resident 4 left the facility.2. Expected return time.3, Time Returned4. License Nurse initial of when Resident 4 returned. During a concurrent interview and record review on 5/15/2026 at 8:42 a.m. with LVN 4, Resident 5's Progress Notes dated 5/11/2026, were reviewed. LVN 4 stated there was no documentation in Resident 5's medical record of when Resident 5 returned to the facility on 4/12/2026. LVN 4 stated LVN 1 did a late entry documentation on 5/14/2026 timed at 9:51 p.m., that Resident 5 left the faciity on 4/12/2026, with a friend and returned at 8 p.m. LVN 4 stated LVN 1 should have documented the date and time of Resident 5's return to the facility on 4/12/2026, to show Resident 5's safe return to the facility. 2c. During a review of Resident 6?s admission Record, the admission Record indicated the facility admitted Resident 6 on 12/14/2022, with diagnoses that included lymphedema (an abnormal buildup of protein-rich lymph fluid in the body's tissues that causes persistent swelling), and acute thyroiditis (the swelling or inflammation of your thyroid gland. Located in the front of your neck, thyroid is a small, butterfly-shaped organ that acts as the body's engine, producing hormones that control metabolism and energy). During a review of Resident 6's H&P, dated 12/5/2025, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive skills for daily decisions were intact. During a review of Resident 6's Physician Order, dated 9/30/2025, the Physician Order indicated Resident 6 may go out on pass for four hours. During a review of facility's Resident Out on Pass Log, the Resident Out on Pass Log indicated Resident 6 signed out on pass on 3/12/2026, at 1:30 p.m. During a concurrent interview and record review on 5/14/2026 at 9:14 a.m. with LVN 4, Residents Out on Pass log was reviewed. LVN 4 stated Resident Out on Pass Log indicated Resident 6 went out on pass on 3/12/2026, at 1:30 p.m., but did not indicate the following:1. License Nurse initial of when Resident 4 left the facility.2. Expected return time.3, Time Returned4. License Nurse initial of when Resident 4 returned. During a concurrent interview and record review on 5/15/2026 at 8:42 a.m. with LVN 4, Resident 6's Progress Notes, dated 3/12/2026, were reviewed. LVN 4 stated there was no documentation in Resident 6's medical record of when Resident 6 returned to the facility on (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	05/15/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/12/2026. LVN 4 stated LVN 5 did a late entry documentation on 5/14/2026, timed at 8:06 p.m., that Resident 6 returned to the facility on 3/12/2026 at 8:06 pm. LVN 4 stated LVN 5 should have documented the date and time of Resident 6's return to the facility on 3/12/2026, to show Resident 6's safe return to the facility. During an interview on 5/15/2026, at 9:18 a.m. with the DON, the DON stated the facility's Resident Out on Pass Log was incomplete. The DON stated there was also no documentation of the accurate time of Residents 4, 5, and 6 return to the facility. The DON stated nurses should complete the Resident Out on Pass Log and document in the Progress Notes of the time Resident 4, 5, and 6's return to the facility for residents' safety. The DON stated when residents return from out on pass, the nurses assess residents' skin for any breakdown, injury or any accidents. The DON stated all intervention provided to the residents should be documented. The DON stated if it was not documented, intervention was not done. The DON stated nurses should document timely and make sure residents medical records are complete and accurate. During a review of facility's policy and procedure (P&P) titled, Completion and Correction, dated 3/25/2026, was reviewed. The P&P indicated, Entries will be recorded in a timely manner and will be complete, legible, and accurate.IV. Documentation will reflect medically relevant information concerning the Resident and will be documented in a professional manner.During a review of facility's P&P, titled, Progress Notes, dated 1/1/2012, and last reviewed on 4/4/2026, the P&P indicated, Progress notes will reflect the resident's current status, progress or lack of progress, changes in condition, adjustment to the Facility, and other relevant information. Progress notes are to be documented in a timely manner.