STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555165	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Skilled Nursing and Wellness Center	5125 Monte Vista St. Los Angeles, CA 90042

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 0580 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one (1) of two (2) sampled residents (Resident 1) physician was informed when Resident 1 had a change of condition (COC - a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) of upper extremities skin discoloration and swelling on 6/18/2026.This deficient practice has the potential to result in a delay in the necessary care and services for Resident 1.Findings:During a review of Resident 1's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of dementia (a progressive state of decline in mental abilities), and difficulty walking. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/22/2026, the MDS indicated the resident is moderately impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear and personal hygiene but required setup or clean up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating, oral hygiene, and upper body dressing. The MDS indicated the resident had no present skin issues. During a review of Resident 1's admission Assessment, dated 6/15/2026 at 8:56PM, the assessment indicated no skin issues were identified. During a review of Resident 1's Progress Notes, dated 6/18/2026 at 9:57 AM, the progress notes indicated Resident 1 had upper extremities discoloration and slight swelling. During a review of Resident 1's Skin Check, dated 6/18/2026 at 9:57AM, the skin check indicated Resident 1 had upper extremities discoloration and slight swelling. During a review of Resident 1's Progress Notes, dated 6/19/2026 at 9:29 AM, the progress notes indicated Resident 1 had upper extremities discoloration and slight swelling. During a review of Resident 1's Skin Check, dated 6/19/2026 at 9:29 AM, the skin check indicated Resident 1 had upper extremities discoloration and slight swelling. During an interview on 6/24/2025 at 11:35 AM, Licensed Vocational Nurse 1 (LVN 1) stated, on 6/18/2026, she observed skin discoloration and slight swelling of Resident 1's left lower arm. In addition, LVN 1 stated, on 6/19/2026 at 12:45PM, Resident 1 had skin discoloration and swelling of the left upper arm. LVN 1 also stated Resident 1 had facial grimacing as the resident's arm was touched. During an interview on 6/24/2026 at 2:08 PM, Treatment (TX) Nurse stated, on 6/18/2026, Resident 1 was observed with a hunch posture while the resident was walking. In addition, TX Nurse stated Resident 1 normally walks standing up straight. TX Nurse further stated Resident 1 also did not want to raise the resident's arm to put on his sweater. TX Nurse stated, on 6/19/2026, Resident 1 was observed with a more hunch posture than 6/18/2026. TX Nurse also stated she noticed the swelling of the upper extremities has not gone down since it was first observed. During an interview on 6/24/2026 at 3 PM, TX Nurse stated if there is a change of condition (COC) while performing a skin check on the resident, the doctor needs to be notified, a COC (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	555165	A. Building B. Wing	06/24/2026

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	form needs to be done and 72- hour monitoring of the COC needs to be completed and documented. During an interview on 6/24/2026 at 3:43 PM, the Director of Nursing (DON) stated bruising (skin discoloration) and swelling are considered COC and would require a COC form to be completed. The DON also stated the physician should be notified of the resident's COC. The DON further stated the doctor should have been informed on 6/18/2026 when the licensed nurse noted that Resident 1 had swelling and discoloration on the resident's left upper arm, but the doctor was not informed. During a review of the facility's P&P titled Change in Condition, revised 1/14/2026, the P&P indicated the licensed nurse will assess the change of condition, notify the physician and family, and document the details in the medical record. During a review of the facility's P&P titled Resident Safety, revised 1/14/2026, the P&P indicated residents will be evaluated whenever there is a change in condition to identify circumstances that pose a risk for the safety and wellbeing of the resident.

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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 - 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 interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices for one (1) of two (2) sampled residents (Resident 1) by failing to accurately document the resident's skin check form dated 6/18/2026 and 6/19/2026. This deficient practice had the potential to negatively impact on the delivery of services.Findings:During a review of Resident 1's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of dementia (a progressive state of decline in mental abilities), difficulty walking, and fracture (break of bone) of the long, middle portion of the forearm's medial bone (the bone on the pinkie side). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/22/2026, the MDS indicated the resident is moderately impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear and personal hygiene but required setup or clean up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating, oral hygiene, and upper body dressing. During a review of Resident 1's Progress Notes, dated 6/18/2026 at 9:57 AM, the progress notes indicated Resident 1 had upper extremities discoloration and slight swelling. The progress notes indicated the physician was notified. During a review of Resident 1's Skin Check, dated 6/18/2026 at 9:57AM, the skin check indicated Resident 1 had upper extremities discoloration and slight swelling. The skin check indicated the physician was notified. During a review of Resident 1's Progress Notes, dated 6/19/2026 at 9:29 AM, the progress notes indicated Resident 1 had upper extremities discoloration and slight swelling. The progress notes indicated the physician was notified. During a review of Resident 1's Skin Check, dated 6/19/2026 at 9:29AM, the skin check indicated Resident 1 had upper extremities discoloration and slight swelling. The skin check indicated the physician was notified. During an interview on 6/24/2026 at 2:08PM, Resident 1's skin check, dated 6/18/2026 and 6/19/2026, were reviewed. Treatment (TX) Nurse stated she did not notify the physician on 6/18/2026 and 6/19/2026 and she made an error in documenting in the skin check forms that the physician was notified. During an interview on 6/24/2026 at 3:43 PM, the Director of Nursing (DON) stated the TX Nurse should not be documenting she notified the physician, if she did not call the physician about Resident 1's skin discoloration and swelling on the upper extremities. The DON further stated the medical records need to maintain accuracy and integrity to ensure the resident receives the right services. During a review of the facility's Policy and Procedure (P&P) titled Completion and Correction, revised 1/19/2026, the P&P indicated the facility will work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation. The P&P also indicated entries will be complete, legible, descriptive and accurate.