

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555690	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/11/2025
NAME OF PROVIDER OR SUPPLIER  Alameda Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  925 W. Alameda Ave. Burbank, CA 91506	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure a call light device (also known as a call bell or nurse call button, is a device typically found near a patient's bed or within reach, consists of a button that, when pressed, sends a signal to the nursing station or a centralized system, alerting healthcare providers that assistance is required in the room) was within reach for two of three sampled residents (Resident 2 and 3).</p> <p>This failure had the potential to result in a delay in care and not receiving assistance timely.</p> <p>Findings:</p> <p>During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted Resident 2 on 2/2/2017 with diagnoses that included unspecified (unconfirmed) Alzheimer ' s Disease (a disease characterized by a progressive decline in mental abilities), essential hypertension (HTN-high blood pressure) and cognitive communication deficit (difficulty communicating due to a disruption in cognitive processes like attention, memory, and reasoning, rather than a primary language or speech problem).</p> <p>During a review of Resident 2 ' s History and Physical (H&amp;P - a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 4/15/2023, the H&amp;P indicated Resident 2 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 2 ' s Minimum Data Set (MDS - a resident assessment tool), dated 12/1/2024, the MDS indicated Resident 2 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was severely impaired. The MDS indicated Resident 2 needed moderate assistance from staff for toileting, dressing and personal hygiene.</p> <p>During a review of Resident 2 ' s Care Plan about self-care deficit (when someone has trouble performing daily tasks related to health and well-being), created on 5/29/2018 and last revised on 3/10/2025, the Care Plan indicated an intervention that call light will be within reach and attend needs promptly.</p> <p>During a review of Resident 3 ' s Admission Record, the Admission Record indicated the facility admitted Resident 3 on 9/8/2021 with diagnoses that included chronic obstructive pulmonary disease (COPD-chronic lung disease causing difficulty in breathing), muscle weakness and Alzheimer ' s Disease.</p> <p>(continued on next page)</p>

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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NAME OF PROVIDER OR SUPPLIER  Alameda Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  925 W. Alameda Ave. Burbank, CA 91506	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 3 ' s H&amp;P, dated 1/28/2025, the H&amp;P indicated Resident 3 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 3 ' s MDS, dated [DATE], the MDS indicated Resident 3 ' s cognitive skills for daily decisions was severely impaired. The MDS indicated Resident 3 was dependent to staff for toileting, showering and transferring.</p> <p>During a review of Resident 3 ' s Care Plan about self-care deficit, created on 9/8/2021 and last revised on 2/5/2025, the Care Plan indicated an intervention that call light will be within reach and attend needs promptly.</p> <p>During an observation on 3/11/2025 at 8:54 a.m., inside Resident 2 ' s room, observed Resident 2 ' s call light on the floor by the right side of the bed above Resident 2 ' s head.</p> <p>During an observation on 3/11/2025 at 8:55 a.m., in Resident 3 ' s bedside, observed Resident 3 ' s call light on the floor by the right side of the bed tangled with Resident 4 ' s call light.</p> <p>During an observation on 3/11/2025 at 8:59 a.m., outside of Resident 3 ' s room, observed Certified Nursing Assistant 1 (CNA 1) went inside Resident 3 ' s room and came out with Resident 3 ' s food tray.</p> <p>During a concurrent observation and interview on 3/11/2025 at 9:01 a.m., with Restorative Nursing Assistant 1 (RNA 1), at Resident 3 ' s bedside, Resident 3 ' s call light was on the floor. RNA 1 stated Resident 3 and Resident 4 ' s call light were tangled with each other and was on the floor. RNA 1 stated Resident 4 was outside the room and Resident 3 ' s call light was not within Resident 3 ' s reach.</p> <p>During an interview on 3/11/2025 at 9:02 a.m., CNA 1 stated she (CNA 1) went inside Resident 3 ' s room and picked up Resident 3 ' s the food tray. CNA 1 stated she (CNA 1) did not notice that the call light was on the floor. CNA 1 stated she (CNA 1) should have looked around the bed and made sure call light was within Resident 3 ' s reach.</p> <p>During an interview on 3/11/2025 at 10:41 a.m., the Director of Nursing (DON) stated facility failed to ensure call light was within Resident 2 and Resident 3 ' s reach. The DON stated staff should make sure call light was within reach of each residents. The DON stated call light was a device to help residents call for assistance if residents need something. The DON stated if call light are not within reach, resident cannot call for assistance and residents needs would possibly be delayed.</p> <p>During a concurrent interview and record review on 3/11/2025 at 10:51 a.m., with the DON, the facility ' s policy and procedure (P&amp;P) titled, Call System, Residents, dated 9/2022 and last reviewed on 1/29/2025, was reviewed. The P&amp;P indicated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Each resident is provided with a means to call staff directly for assistance from his or her bed, from toileting or bathing facilities and from the floor. The DON stated the facility's policy was to have the call light within resident reach.</p>		