STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	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)
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. (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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(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	Based on interview and record review the facility failed to inform the Medical Doctor (MD) and the Resident Representative (RR) for one of four sampled resident (Resident 1) when on 11/6/2025 at 3 p.m. Resident 1 had a fall. This deficient practice had the potential to negatively affect the care and services provided to Resident 1. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 9/12/2025 with diagnoses including dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), muscle weakness (general), and difficulty in walking. During a review of Resident 1's Fall Risk Evaluation (a process used by healthcare providers to determine a person's likelihood of falling), dated 9/12/2025, the Fall Risk Evaluation indicated Resident 1's fall risk score was 16 (a total score of 10 or greater, the resident should be considered at high risk for potential falls). During a review of Resident 1's Physician History and Physical (H&P- a process used by doctors to understand a resident's health by combining medical history and physical examination), dated 9/13/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 9/17/2025, the MDS indicated Resident 1 sometimes understood and was sometimes understood. The MDS indicated Resident 1 was dependent (helper does all the effort) for showering, required substantial assistance (helper does more than half the effort) with upper body dressing, and required partial assistance (helper does less than half the effort) with eating, oral hygiene, toileting, lower body dressing, putting on and taking off footwear, and personal hygiene. During a review of Resident 1's Electronic Medical Record (EMR- digital collection of medical information about a person that is stored on a computer) as of 11/13/2025 at 10:27 a.m., the EMR indicated Resident 1 did not have a Change in Condition (COC- when there is a sudden change in a resident's condition) Assessment for 11/6/2025, and no Fall Risk Evaluation dated 11/6/2025. During an interview on 11/13/2025 at 12:08 p.m. with Activity Assistant (AA 1), AA 1 stated on 11/6/2025 at 3p.m. in the dining room AA 1 stated she heard a commotion and saw Resident 1's wheelchair moving slowly without Resident 1 on it. AA 1 stated Resident 1's wheelchair was moving on its own and Resident 1 was sitting on the floor in the entrance of the dining room closest to Resident 1's room. AA 1 stated not aware of how Resident 1 ended up on the floor. During an interview on 11/13/2025 at 12:47 p.m. with AA 2, AA 2 stated on 11/6/2025 at 3 p.m. AA 2 was in the dining room by the entrance closest to Room A and AA 2 was facing the opposite entrance near Resident 1's room (Room B) and Resident 1 was by the entrance near Resident 1's room. AA 2 stated she (AA 2) saw when Certified Nursing Assistant (CNA) 1 brought Resident 1 into the dining room, Resident 1 then got up and turned quickly on her own and fell on Resident 1's left side. During an interview on 11/13/2025 at 3:03 p.m. with CNA 1, CNA 1 stated on 11/6/2025 at 3 p.m. she (CNA 1) was already leaving and saw Resident 1 going into a room that was not hers (Resident 1) then CNA 1 took Resident 1 into the dining room. CNA 1 stated she (CNA 1) left Resident 1 in the entrance of the dining room and did not take Resident 1 all the way to the dining room table. CNA 1 stated she (CNA 1) then clocked out and on her (CNA 1) way out CNA 1 saw Resident 1. During an interview on 11/13/2025 at 3:40 p.m. with the Director of Staff Development (DSD), the DSD stated Resident 1 had a fall in the dining room. The DSD stated CNA 1 was going to clock out and saw Resident 1 in the hallway and placed Resident 1 into the dining room for activities and left Resident 1 in the dining room by doorway then CNA 1 clocked out and while clocking out and passed by dining room saw Resident 1 on the floor. During a concurrent interview and record review on 11/13/2025 at 4:38 p.m., Resident 1's EMR was reviewed with the Director of Nursing (DON). The DON stated on 11/6/2025 at 3 p.m. she (DON) was leaving her office which is located across the dining room when she (DON) saw Resident 1 on the floor on her right side in a fetal position. The DON stated when a fall occurs, staff should create a COC. The DON stated the COC for Resident 1's fall was created only today (11/13/2025). The DON reviewed COC Assessment Form, dated 11/6/2025, and the DON stated it indicated it was created on 11/13/2025 at 10:56 a.m. The DON stated Resident 1's COC should have been done on the same day or it can be an hour later but should be done during the shift and care plan and the rest of the forms can be done the following day. The DON was not able to provide documented evidence the MD and the RR were notified on 11/6/2025. The DON stated not documenting the COC can result to not providing the appropriate interventions and/or not following the plan of care. The DON stated monitoring should be specific to the COC. The DON stated there was no 72 hours monitoring for the fall. The DON stated COC monitoring

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of an employee-to-resident physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) to the State Survey Agency (SSA), the ombudsman (advocates for residents of nursing homes), and local law enforcement for one of three sampled residents (Resident 1) in accordance with the facility's policy and procedure (P&P) titled, Abuse & Mistreatment of Residents, when on 11/6/2025 at 3 p.m. Activities Assistant (AA) 1 alleged Certified Nursing Assistant (CNA) 1 pushed Resident 1.This deficient practice increased Resident 1's risk for further abuse, which could have led to additional unreported incidents and failure to protect other residents from potential harm. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 9/12/2025 with diagnoses including dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), muscle weakness (general), and difficulty in walking. During a review of Resident 1's Fall Risk Evaluation (a process used by healthcare providers to determine a person's likelihood of falling), dated 9/12/2025, the Fall Risk Evaluation indicated Resident 1's fall risk score was 16 (a total score of 10 or greater, the resident should be considered at high risk for potential falls). During a review of Resident 1's Physician History and Physical (H&P- a process used by doctors to understand a resident's health by combining medical history and physical examination), dated 9/13/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 9/17/2025, the MDS indicated Resident 1 sometimes understood and was sometimes understood. The MDS indicated Resident 1 was dependent (helper does all the effort) for showering, required substantial assistance (helper does more than half the effort) with upper body dressing, and required partial assistance (helper does less than half the effort) with eating, oral hygiene, toileting, lower body dressing, putting on and taking off footwear, and personal hygiene. During a review of Resident 1's Change in Condition (COC- when there is a sudden change in a resident's condition) assessment dated [DATE] at 4:27 p.m., the COC Assessment indicated Resident 1 had a fall from the wheelchair at around 3 p. m., after CNA 1 brought Resident 1, in a wheelchair, to the big dining room and placed Resident 1 by the area near the TV. The COC Assessment indicated CNA 1 quickly went to clock out and when CNA 1 returned she saw Resident 1 on the floor. The COC Assessment indicated that within two to three seconds after CNA 1 placed Resident 1 in the dining room, Resident 1 quickly stood up from the wheelchair and landed on her (Resident 1) right side without hitting her (Resident 1) head. During an interview on 11/13/2025 at 12:08 p.m. with AA 1, AA 1 stated on 11/6/2025 at around 3 p.m. she (AA 1) was in the dining room and heard a commotion then observed Resident 1's wheelchair moving slowly without Resident 1 on it. AA 1 stated Resident 1's wheelchair was moving on its own and Resident 1 was found sitting on the floor in the entrance of the dining room closest to Resident 1's room. AA 1 stated she was not aware of how Resident 1 ended up on the floor.During an interview on 11/13/2025 at 3:03 p.m. with CNA 1, CNA 1 stated on 11/6/2025 at 3 p.m. she (CNA 1) was already leaving and saw Resident 1 going into a room that was not hers (Resident 1). CNA 1 stated she (CNA 1) took Resident 1 into the dining room. CNA 1 stated she (CNA 1) left Resident 1 in the entrance of the dining room and did not take Resident 1 all the way to the dining room table. CNA 1 stated she (CNA 1) then clocked out and on her (CNA 1) way out CNA 1 saw Resident 1 on the floor. CNA 1 stated she (CNA 1) then went home. CNA 1 stated she heard from other staff that AA 1 was going around telling everyone that CNA 1 pushed Resident 1 and that was why Resident 1 fell on the floor. CNA 1 stated she (CNA 1) did not push Resident 1 but was told on 11/7/2025 by the Administrator (Adm) that she (CNA 1) was suspended pending investigation because the facility thought it was an alleged abuse. CNA 1 stated she informed the facility that AA 1 was going around telling everyone that she (CNA 1) pushed Resident 1. CNA 1 stated on 11/12/2025 she (CNA 1) was terminated and was told this is what is best. During an interview on 11/13/2025 at 3:40 p.m. with the Director of Staff Development (DSD), the DSD stated CNA 1 was suspended by the Adm because CNA 1 placed Resident 1 into the dining room and left Resident 1 in the dining room by the doorway. DSD stated CNA 1 then clocked out and when passing by the dining room saw Resident 1 on the floor. The DSD stated the Adm informed CNA 1 she would be suspended pending investigation because staff were saying CNA 1 had basically pushed Resident 1 into the dining room causing Resident 1 to fall. The DSD stated because it was alleged that Resident 1 was pushed that was why

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility failed to ensure interventions to prevent falls were in place for one of four sampled residents (Resident 1) when Resident 1 had a fall on 11/6/2025, by failing to: 1. Ensure interventions were developed through a care plan after Resident 1's fall on 11/6/2025. 2. Update Resident 1's Fall Risk Evaluation (a process used by healthcare providers to determine a person's likelihood of falling).3. Ensure monitoring was provided after Resident 1's fall. These deficient practices had the potential to place Resident 1 at risk for more falls in the facility. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 9/12/2025 with diagnoses including dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), muscle weakness (general), and difficulty in walking. During a review of Resident 1's Fall Risk Evaluation (a process used by healthcare providers to determine a person's likelihood of falling), dated 9/12/2025, the Fall Risk Evaluation indicated Resident 1's fall risk score was 16 (a total score of 10 or greater, the resident should be considered at high risk for potential falls).During a review of Resident 1's Physician History and Physical (H&P- a process used by doctors to understand resident's health combining medical history and physical examination), dated 9/13/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 9/17/2025, the MDS indicated Resident 1 sometimes understood and was sometimes understood. The MDS indicated Resident 1 was dependent (helper does all the effort) for showering, required substantial assistance (helper does more than half the effort) with upper body dressing, and required partial assistance (helper does less than half the effort) with eating, oral hygiene, toileting, lower body dressing, putting on and taking off footwear, and personal hygiene. During a review of Resident 1's Electronic Medical Record (EMR- digital collection of medical information about a person that is stored on a computer) on 11/13/2025 at 10:27 a.m., the EMR indicated Resident 1 did not have a Fall Risk Evaluation dated 11/6/2025. During an interview on 11/13/2025 at 12:08 p.m. with Activity Assistant (AA 1), AA 1 stated on 11/6/2025 at 3 p.m. in the dining room she (AA 1) heard a commotion and saw Resident 1's wheelchair moving slowly without Resident 1 on it. AA 1 stated Resident 1's wheelchair was moving on its own and Resident 1 was sitting on the floor in the entrance of the dining room closest to Resident 1's room. AA 1 stated she was not aware of how Resident 1 ended up on the floor. During an interview on 11/13/2025 at 12:47 p.m. with AA 2, AA 2 stated on 11/6/2025 at 3 p.m. AA 2 was in the dining room by the entrance closest to Room A. AA 2 stated she (AA 2) was facing the opposite entrance near Resident 1's room (Room B) and Resident 1 was by the entrance near Resident 1's room. AA 2 stated she (AA 2) saw Certified Nursing Assistant (CNA) 1 brought Resident 1 into the dining room. AA 2 stated Resident 1 got up and turned quickly on her own and fell on Resident 1's left side. During an interview on 11/13/2025 at 3:03 p.m. with CNA 1, CNA 1 stated on 11/6/2025 at 3 p.m. she (CNA 1) was already about to leave the facility and saw Resident 1 going into a room that was not hers (Resident 1). CNA 1 stated she (CNA 1) took Resident 1 into the dining room. CNA 1 stated she (CNA 1) left Resident 1 at the entrance of the dining room and did not take Resident 1 all the way to the dining room table. CNA 1 stated she (CNA 1) then clocked out and on her (CNA 1) way out CNA 1 saw Resident 1. During an interview on 11/13/2025 at 3:40 p.m. with the Director of Staff Development (DSD), the DSD stated Resident 1 had a fall in the dining room. The DSD stated CNA 1 was going to clock out and saw Resident 1 in the hallway and placed Resident 1 in the dining room to join any activities. The DSD stated CNA 1 left Resident 1 in the dining room by doorway then CNA 1 clocked out and while clocking out and passed by dining room saw Resident 1 on the floor. During a concurrent interview and record review on 11/13/2025 at 4:38 p.m., Resident 1's EMR was reviewed with the Director of Nursing (DON). The DON stated on 11/6/2025 at 3 p.m. she (DON) was leaving her office which is located across the dining room when she (DON) saw Resident 1 on the floor on her right side in a fetal position. During a concurrent interview and record review on 11/13/2025 at 4:38 p.m., Resident 1's EMR was reviewed with the Director of Nursing (DON). The DON stated on 11/6/2025 at 3 p.m. she (DON) was leaving her office which is located across the dining room when she (DON) saw Resident 1 on the floor on her right side in a fetal position. The DON stated when a fall occurs, staff should create a COC. The DON stated the COC for Resident 1's fall was created only today (11/13/2025). The DON reviewed COC Assessment Form, dated 11/6/2025, and the DON stated it indicated it was created on 11/13/2025 at 10:56 a.m. The DON stated Resident 1's COC should have been done on