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	02/03/2026

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 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. Based on interview and record review, the facility failed to report an allegation of employee to resident abuse within two hours to the State Survey Agency (SSA- the agency that inspects long-term care facilities for the purposes of survey and certification), the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and to the law enforcement agency (LLE) as per its policy on abuse for one of three sampled residents (Resident 2).This failure had the potential to place Resident 2 at further risk of abuse.Findings:During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 9/12/2025, with diagnoses that included unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), and generalized weakness.During a review of Resident 2'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 9/13/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 12/15/2025, the MDS indicated Resident 2 had the ability to sometimes understand others and make self-understood. The MDS indicated Resident 2 required supervision from staff with toileting and showering.During a review of Resident 2's Progress Notes, dated 1/6/2026, the Progress Notes indicated on 1/6/2026, Resident 2 had exhibited verbal and physical restlessness and anger outburst (a sudden, intense, and often disproportionate burst of rage, yelling, or aggression) before shower. The Progress Note indicated Resident 2 calmed down and agreed to the shower but in the middle of the shower, Resident 2 became physically aggressive, yelled and spit at Certified Nursing Assistant 1 (CNA 1).During an interview on 2/2/2026, at 11:06 a.m., with CNA 2, CNA 2 stated on 1/6/2026, CNA 1 showered Resident 2 and CNA 2 together with Student 1 showered Resident 3 in the shower room, when Resident 2 got agitated. CNA 2 stated after the shower, Student 1 reported to her (CNA 2) that CNA 1 slapped Resident 2 in the face. CNA 2 stated she (CNA 2) instructed Student 1 to report it and Student 1 stated that she (student) had already reported it. CNA 2 stated she (CNA 2) should have reported it directly to the Administrator (ADM). CNA 2 stated she (CNA 2) did not report to the ADM because the ADM already called for CNA 1.During an interview on 2/2/2026, at 11:22 a.m., with the Director of Staff Development (DSD), the DSD stated on 1/6/2026, CNA 1 reported that during Resident 2's shower, Resident 2 became combative (being eager or ready to fight), agitated (to feel very worried, upset, or nervous, showing this state through restlessness, irritability) and spit at CNA 1 inside the shower room. The DSD stated CNA 1 reported that she (CNA 1) tried to cover herself by blocking Resident 2's spit with CNA 1's two hands.During a concurrent interview, and record review on 2/3/2026, at 12:21 p.m., with the ADM, facility's policy and procedure (P&P), titled, Abuse and Mistreatment of Residents, undated but last reviewed on 1/14/2026, the P&P indicated, Reporting: Facility shall ensure reporting of all alleged and substantiated (something (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is proven true) violations to the state agency and all other agencies as required, and take all necessary corrective action based on the results of the investigation. A mandated reporter is any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that caretaker receives compensation. This includes administrators, supervisors, and any staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, or employee of a county adult protective services agency or a local law enforcement agency. It is the facility's policy for any mandated reporter working in a facility to report abuse to their supervisor as well as the California Department of Public Health (CDPH/SSA). When an incident has been determined to have satisfied the definition of an abuse:a) Facility Administrator shall be responsible for reporting of all alleged and substantiated violations to the state agency and all other agencies as required.b) Facility shall report the incident by notifying the CDPH within two hours of the knowledge of such incident; followed by a letter explaining the circumstances surrounding the incident. This letter shall be maintained in a separate file and made available to the CDPH upon request. The ADM stated allegations of abuse should be reported within two hours to SSA, Ombudsman and police. The ADM stated CNA 2 did not report the allegation on 1/6/2026. The ADM stated yesterday 2/2/2026, she (ADM) spoke to CNA 2 and CNA 2 reported that on 1/6/2026, Student 1 mentioned that CNA 1 slapped Resident 2. The ADM stated CNA 2 should have reported to her (ADM) immediately on 1/6/2026. The ADM stated not reporting allegations of abuse could cause Resident 2's psychological (related to the mental and emotional state of a person) distress and could potentially cause further abuse.

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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. Based on observation, 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 two of three sampled residents (Residents 1 and 2) by:1. Failing to develop a care plan for Resident 2's behavior of spitting.2. Failing to develop a care plan on Resident 1's use of wedge pillow (a firm, triangle-shaped foam cushion used to prop up parts of the body at an angle while sleeping, resting, or sitting in bed).3. Failing to develop a care plan for Resident 1's refusal of repositioning.These failures had the potential for delays in the delivery of necessary care and services to Resident 1. Findings:a. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 9/12/2025, with diagnoses that included unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities) and generalized weakness.During a review of Resident 2'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 9/13/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 12/15/2025, the MDS indicated Resident 2 had the ability to sometimes understand others and make self-understood. The MDS indicated Resident 2 required supervision from staff with toileting and showering.During a review of Resident 2's Progress Notes, dated 1/6/2026, the Progress Notes indicated on 1/6/2026, Resident 2 had exhibited verbal and physical restlessness and anger outburst (a sudden, intense, and often disproportionate burst of rage, yelling, or aggression) before shower. The Progress Notes indicated Resident 2 calmed down and agreed to the shower but in the middle of the shower, Resident 2 became physically aggressive, yelled and spit at Certified Nursing Assistant 1 (CNA 1).During an interview on 2/2/2026 at 11:22 a.m., with the Director of Staff Development (DSD), the DSD stated on 1/6/2026, CNA 1 reported that Resident 2 had spit on her (CNA 1).During an interview on 2/2/2026, at 11:52 a.m., with the Administrator (ADM), the ADM stated on 1/6/2026, CNA 1 reported that Resident 2 yelled and spit at her (CNA 1).During a concurrent interview, and record review on 2/2/2026, at 12:28 p.m., with Minimum Data Set Nurse (MDSN), Resident 1's Care Plans were reviewed. The MDSN stated Resident 1 had a behavior of spitting and kicking. The MDSN stated there was no care plan on Resident 1's behavior of spitting.During an interview on 2/2/2026, at 12:57 p.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated Resident 2 had a behavior of kicking, but spitting was something new.During an interview on 2/3/2026, at 10:54 a.m., with Registered Nurse 1 (RN 1), RN 1 stated care plan should have been developed for new behavior to provide utmost level of care and make sure Resident 2 received the care she (Resident 2) needed and to manage her (Resident 2)'s behavior.During a review of facility's policy and procedure (P&P), titled, Behavioral Assessment, Intervention and Monitoring, dated 3/2019, and last reviewed on 1/14/2026, the P&P indicated, The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial (the interrelation of social factors and individual thought and behavior) well-being in accordance with the comprehensive assessment and plan of care. 2. As part of the comprehensive assessment, staff will evaluate, based on input from the residents, family and caregivers, review of medical record, and general observations: a. the resident's usual patterns of cognition, mood and behavior; b. the resident's usual method of communicating things like pain, hunger, thirst, and other physical discomforts; c. the resident's typical or past responses to stress, fatigue, fear, anxiety, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	frustration and other triggers; and d. the resident's previous patterns of coping with stress, anxiety, and depression. 4. New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others. 7. Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities.b. During an observation on 2/2/2026, at 9:39 a.m., inside Resident 1's room, observed a wedge pillow on Resident 1's left side.During a concurrent interview, and record review on 2/2/2026, at 9:47 am, with the Treatment Nurse (TN), Resident 1's Care Plans were reviewed. The TN stated Resident 1 had a wedge pillow used to keep Resident 1's sacral (tailbone) area off the bed to prevent worsening of the pressure ulcer (localized damage to the skin and/or underlying tissue usually over a bony prominence). The TN stated there was no care plan for Resident 1's use of wedge pillow.During a concurrent interview and record review on 2/2/2026, at 10:50 a.m., with RN 1, Resident 1's Care Plans were reviewed. RN 1 stated there was no care plan Resident 1's use of wedge pillow.During a concurrent interview, and record review on 2/2/2026, at 12:28 p.m., with Minimum Data Set Nurse (MDSN), Resident 1's Care Plans were reviewed. MDSN stated there was no care plan for Resident 1's use of wedge pillow. The MDSN stated there should be a care plan on the use of wedge pillows. The MDSN stated care plan provides nurses with a guide on how to take care of the resident.During an interview on 2/3/2026, at 10:54 a.m., with RN 1, RN 1 stated care plan should have been developed on the use of wedge pillow. RN 1 stated care plans guide the nurses on what intervention to provide to prevent pressure ulcers.During an interview on 2/3/2026, at 12:29 p.m., with the Registered Nurse Supervisor (RNS), the RNS stated interventions provided to Resident 1 to address the current problem which is pressure ulcer should have a care plan. The RNS stated without a care plan, nurses would not be able to evaluate if intervention is effective and could possibly cause worsening of Resident 1's pressure ulcer.During a review of facility's P&P, titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol, dated 4/2018, and last reviewed on 1/14/2026, the P&P indicated, The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement (the medical process of cleaning a wound by removing dead, damaged, or infected tissue) approaches, dressings and application of topical (a medication, cream, or treatment that is applied directly to a specific, localized part of the body) agents.During a review of facility's P&P, titled, Prevention of Pressure Injuries, dated 4/2020, and last 1/14/2026, the P&P indicated, The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. 1. Review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application and ability to secure the device.c. During an interview on 2/2/2026, at 9:47 a.m., with the TN, the TN stated Resident 1 was noncompliant with repositioning.During a concurrent interview and record review on 2/2/2026, at 12:28 p.m., with the MDSN, Resident 1's Care Plan was reviewed. The MDSN stated there was no care plan developed for Resident 1s' refusal to be repositioned. The MDSN stated care plan helps minimize further decline or prevent worsening of pressure ulcers. The MDSN stated that without the care plan for refusal to be repositioned, Resident 1's wound can worsen.During an interview on 2/2/2026, at 1:13 p.m. with LVN 4, LVN 4 stated Resident 1 refused to be repositioned. LVN 4 stated CNAs had reported Resident 1's refusal and she (LVN 4) would talk to Resident 1 and Resident 1 would still refuse. LVN 4 stated she (LVN 4) did not develop a care plan for Resident 1's refusal to be repositioned. LVN 4 stated RNs develop the care plan. LVN 4 stated she (LVN 4) did not report Resident 1's noncompliance to the RN. LVN 4 stated care plan should have been developed. LVN 4 stated that without the care plan for resident 1's refusal for repositioning, Resident 1's (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wound could worsen.During an interview on 2/3/2026, at 12:29 p.m., with the RNS, the RNS stated care plan should have been developed to address Resident 1's refusal for repositioning to make sure resident rights for refusal are followed to prevent worsening of Resident 1's pressure ulcer.During a review of facility's policy and procedure (P&P), titled, Wound Care, dated 3/2023, and last reviewed on 1/14/2026, the P&P indicated, Review the resident's care plan to assess for any special needs of the resident.a. For example, the residents may have pro re nata (PRN-as needed) orders for pain medication to be administered prior to would care.Documentation:The following information should be recorded in the resident's medical record: .8. Any problems complaints made by the resident related to the procedure.9. If the resident refused the treatment and the reason(s) why.During a review of facility's policy and procedure (P&P), titled, Comprehensive Person-Centered Care Plans, dated 3/2022, and last reviewed on 1/14/2026, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (I) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; . e. reflects currently recognized standards of practice for problem areas and conditions.10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.13. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure a resident received care consistent with professional standards of practice to prevent pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence) for one of three sampled residents (Resident 1), by:1. Failing to provide wound care treatments as per physician order on 8/3/2025, 11/25/2025, 12/24/2025, 1/20/2026 and 1/27/2026.2. Failing to perform head to toe skin assessment before Resident 1's transfer to General Acute Care Hospital (GACH) on 1/14/2026.3. Failing to obtain a physician order for the use of wedge pillow (a firm, triangle-shaped foam cushion used to prop up parts of the body at an angle while sleeping, resting, or sitting in bed).These failures had the potential for the development and worsening of Resident 1's pressure ulcers.Findings:During a review of Resident 1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on 7/18/2025, with diagnoses that included metabolic encephalopathy (when the brain has trouble working because of a chemical, or metabolic, problem in the body), stage four pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) in the sacral area (tailbone) and unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities).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 7/19/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's admission Reassessment, dated 7/19/2025, the admission Reassessment indicated Resident 1 had left heel pressure ulcer and sacrococcyx (sacro-end of spine, coccyx-tailbone) pressure ulcer.During a review of Resident 1's Physician Order, dated 7/19/25, the Physician Order indicated the following:1. For left heel deep tissue injury (DTI- a serious form of pressure injury where soft tissue is damaged underneath intact skin) - cleanse with normal saline (salt in water), pat dry, paint with betadine (used to treat and prevent skin infections) and cover with foam dressing daily for wound care management for four weeks.2. For sacrococcyx DTI- cleanse with normal saline, pat dry, apply zinc oxide (a medicated cream, ointment or paste that treats or prevents skin irritation like cuts, burns or diaper rash) to affected area and cover with foam dressing daily for wound care management for four weeks.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 7/23/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent on staff for toileting, showering, dressing, and personal hygiene. The MDS indicated Resident 1 was always incontinent (unable to control) of bowel and bladder functions. The MDS indicated Resident 1 had two unstageable (a severe, full thickness wound where the base is completely covered by dead tissue, making it impossible to see how deep the damage goes) pressure ulcer present upon admission.During a review of Resident 1's Skin Issues, dated 12/11/2025, the Skin Issues indicated Resident 1 had one stage three (full-thickness loss of skin. Dead and black tissue may be visible) sacrococcyx pressure ulcer.During a review of Resident 1's Skin Issues, dated 1/6/2026, the Skin Issues indicated Resident 1 had four stage three pressure ulcers and one stage four (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) pressure ulcer.During a review of Resident 1's Treatment Administration Record (TAR), dated 8/2025, the TAR indicated on 8/3/2025, the treatment for left heel and sacrococcyx DTI was left blank.During a review of Resident 1's Physician Order, dated 11/11/25, the Physician Order indicated for sacrococcyx stage 3 pressure ulcer to be cleanse with quarter strength Dankins solution (bleach solution used as an antiseptic to clean, disinfect, and treat infected wounds), pat dry., apply Santyl ointment (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(medicine used to clean, heal, and remove dead tissue from serious wounds) 250 units per gram to wound bed and zinc oxide to peri-wound (around the wound), apply calcium alginate (a natural, gel-like material that is primarily used in advanced wound care to manage heavily draining wounds) over wound bed and cover with dry dressing every day for wound care treatment for four weeks.During a review of Resident 1's TAR, dated 11/2025, the TAR indicated on 11/25/2025, the treatment for sacrococcyx stage three pressure ulcer was left blank.During a review of Resident 1's Physician Order, dated 12/17/25, the Physician Order indicated for sacrococcyx stage three pressure injury- cleanse with normal saline, pat dry, apply Santyl external ointment 250 unit per gram to wound bed and zinc oxide to peri wound, apply calcium alginate over wound bed and cover with super absorbent dressing daily for wound care for four week.During a review of Resident 1's TAR, dated 12/2025, the TAR indicated on 12/24/2025, the treatment for sacrococcyx stage three pressure ulcer was left blank.During a review of Resident 1's Physician Order, dated 1/20/2026, the Physician Order indicated for sacrococcyx stage four pressure injury- cleanse with normal saline, pat dry, apply zinc oxide paste to peri wound, Santyl external ointment 250 unit per gram to wound bed, apply calcium alginate over wound bed and cover with dry dressing daily for wound care management for four weeks.During a review of Resident 1's TAR, dated 1/2026, the TAR on 1/2026 was reviewed. The TAR indicated on 1/20/2026 and 1/27/2026, the treatment for sacrococcyx stage four pressure ulcers was left blank.During a concurrent interview, and record review on 2/3/2026, at 9:28 a.m., with the Minimum Data Set Nurse (MDSN), Resident 1's TAR, from 8/2025, to 1/2026, were reviewed. The MDSN stated TAR were blank on 8/3/2025, 11/11/2025, 12/24/2025, 1/20/2026 and 1/27/2026. The MDSN stated blank TAR means the Treatment Nurse (TN) did not sign the TAR. The MDSN stated if TAR is not signed treatment was not done. The MDSN stated if treatment was not done, pressure ulcer could get worse.During an interview on 2/3/2026, at 10:19 a.m., with the Administrator (ADM), the ADM stated the facility had issues with wound treatments.During an interview on 2/3/2026, at 10:54 a.m., with Registered Nurse 1 (RN 1), RN 1 stated if treatment not provided Resident 1's pressure ulcer could worsen.During a concurrent interview, and record review on 2/3/2026, at 12:29 p.m., with the Registered Nurse Supervisor (RNS), facility's policy and procedure (P&P) titled, Wound Care dated 3/2023, and last reviewed on 1/14/2026, the P&P indicated, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing.1. Verify that there is a physician's order for this procedure.Documentation:The following information should be recorded in the resident's medical record1. The type of wound care given.2. The date and time of the wound care was given.3. The position in which the resident was placed.4. The name and title of the individual performing the wound care. The RNS stated if TAR was left blank means treatment not done and could result in worsening of Resident 1's pressure ulcer. The RNS stated pressure ulcer treatment should be done as per physician order. The RNS stated the facility's policy indicated to verify wound treatment order and document date and time wound care was given. The RNS stated if treatment is not done, the TN need to document reason why, if Resident 1 refused or if the TN was busy to endorse to other staff for wound care treatment.b. During a review of Resident 1's Interact Assessment Form (COC), dated 1/14/2026, the COC indicated Resident 1 had generalized weakness and pocketing of food with overall decline in activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 1's Discharge Summary Report, dated 1/14/2026, the Discharge Summary Report indicated Resident 1 was transferred to GACH on 1/14/2026, at 12:52 p.m.During a review of Resident 1's Resident Transfer Record, dated 1/14/2026, the Resident Transfer Record indicated Resident 1 was transferred with sacrococcyx stage three pressure ulcer.During an interview on 2/2/2026, at 10:50 a.m., with RN 1, RN 1 stated if the facility had to transfer a (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident whether planned or unplanned a complete head to toe skin assessment is done and documented in the Resident Transfer Record form and reported to the accepting GACH.During an interview on 2/3/2026, at 12:47 p.m., with RN 2, RN 2 stated on 1/14/2026, the Director of Nursing (DON) instructed her (RN 2) to complete the Discharge Summary Report and Resident Transfer Record, dated 1/14/2026. RN 2 stated the DON was the one who completed the COC and should be the one to do the head-to-toe skin assessment prior to transfer to GACH. RN 2 stated when she (RN 2) completed the Resident Transfer Record, she (RN 2) just looked at the sacral area and did not perform a head to toe skin assessment therefore she (RN 2) was not sure if the resident had rashes (any noticeable change in the color, texture, or feel of your skin that makes it look irritated, inflamed, or swollen) anywhere on her body. RN 2 stated RNS are also responsible for head-to-toe skin assessment prior to transfer.During a concurrent interview, and record review on 2/3/2026, at 1:18 p.m., with the RNS, facility's P&P, titled, Transfer/Discharge, undated and last review on 1/14/2026, the P&P indicated, Purpose:1. To ensure that there is continuity of care when a transfer is necessary.2. To prevent transfer trauma.3. To ensure proper information is sent with the resident.7. Complete a body check when possible and document findings. the RNS stated RNs are responsible for the complete head to toe skin assessment before Resident 1's transfer to GACH. The RNS stated that without complete head-to-toe skin assessment, the facility would not know if Resident 1 had rashes and nothing will be documented in Resident 1's medical record. The RNS stated the facility's policy before transferring residents was to perform a complete body assessment when possible and document in resident medical record.During a review of facility's P&P, titled, Prevention of Pressure Injuries, dated 4/2020, and last 1/14/2026, the P&P indicated, Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge.c. During an observation on 2/2/2026, at 9:39 a.m., inside Resident 1's room, observed a wedge pillow on Resident 1's left side.During an interview on 2/2/2026, at 9:47 am, with the TN, the TN stated Resident 1 had a wedge pillow used to keep Resident 1's sacral area off the bed to prevent worsening of the pressure ulcer.During a concurrent interview, and record review on 2/2/2026, at 10:50 a.m., with RN 1, Resident 1's Physician Orders were reviewed. RN 1 stated there was no physician order for the use of the wedge pillow.During an interview on 2/2/2026, at 1:42 p.m., with the TN, the TN stated the facility needs a physician order before wedge pillow can be used by Resident 1. The TN stated the DON or the RNS should have obtained an order.During an interview on 2/3/2026, at 10:54 a.m., with RN 1, RN 1 stated physician order should have been obtained for Resident 1's use of wedge pillow.During a review of facility's P&P, titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol, dated 4/2018, and last reviewed on 1/14/2026, the P&P indicated, The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement (the medical process of cleaning a wound by removing dead, damaged, or infected tissue) approaches, dressings and application of topical (a medication, cream, or treatment that is applied directly to a specific, localized part of the body) agents.During a review of facility's P&P, titled, Prevention of Pressure Injuries, dated 4/2020, and last 1/14/2026, the P&P indicated, The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. 1. Review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application and ability to secure the device.

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	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	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)
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. Based on interview and record review, the facility failed to maintain accurate and complete medical record for one of three sampled residents (Resident 1), by:1. Failing to accurately document number of pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence) in Resident 1's medical record.2. Failing to accurately document medication administration. Licensed Vocational Nurse 1 (LVN 1) documented administration of Mirtazapine (medication used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest]), Potassium (medication used to prevent and treat low blood potassium), Depakote (medication used to treat manic [elevated or high energy] episodes associated with bipolar disorder [mood swings that range from the lows of depression to elevated periods of emotional highs]) on 1/16/2026, and LVN 2 documented administration of Depakote on 1/15/2026, at 12 noon when Resident 1 was in General Acute Care Hospital (GACH) from 1/14/2026, to 1/19/2026.These failures had the potential to cause confusion in Resident 1's care and the medical records containing inaccurate documentation.Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 7/18/2025, with diagnoses that included metabolic encephalopathy (when the brain has trouble working because of a chemical, or metabolic, problem in the body), stage four pressure ulcer (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) in the sacral area (tailbone) and unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities).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 7/19/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's admission Reassessment, dated 7/19/2025, the admission Reassessment indicated Resident 1 had left heel pressure ulcer and sacrococcyx (sacro-end of spine, coccyx-tailbone) pressure ulcer.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 7/23/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent on staff for toileting, showering, dressing, and personal hygiene. The MDS indicated Resident 1 was always incontinent (unable to control) of bowel and bladder functions. The MDS indicated Resident 1 had two unstageable (a severe, full thickness wound where the base is completely covered by dead tissue, making it impossible to see how deep the damage goes) pressure injury present upon admission.During a review of Resident 1's Skin Issues, dated 12/11/2025, the Skin Issues indicated Resident 1 had one stage three (full-thickness loss of skin. Dead and black tissue may be visible) sacrococcyx pressure ulcer.During a review of Resident 1's Skin Issues, dated 1/6/2026, the Skin issues indicated Resident 1 had four stage three pressure ulcers and one stage four (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) pressure ulcer.During a concurrent interview, and record review on 2/3/26, at 10:30 a.m., with the Treatment Nurse (TN), Resident 1's Skin Issues, dated 1/6/2026, were reviewed. The TN stated the Skin Issues dated 1/6/2026, were not accurate. The TN stated Resident 1 had only one stage four pressure ulcer in the sacrococcyx. The TN stated inaccurate documentation could cause confusion of care and made Resident 1's medical record inaccurate.During a concurrent interview, and record review on 2/3/2026, at 10:54 a.m., with Registered Nurse 1 (RN 1), Resident 1's Skin Issues, dated 1/6/2026, was reviewed. RN 1 stated the TN was the one who documented inaccurately the number of pressure ulcers on 1/6/2026. RN 1 stated the TN should document accurately and completely. RN 1 stated inaccurate documentation can create confusion in care and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	can create gap in communication.During a concurrent interview, and record review on 2/3/2026, at12:29 p.m., with the Registered Nurse Supervisor (RNS), facility's policy and procedure (P&P) titled, Charting and Documentation, dated 7/2017, and last reviewed on 1/14/2026, the P&P indicated, The following information is to be documented in the resident medical record: a. Objective observations; . 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. The RNS stated it is the facility's policy to document accurately to prevent confusion in care.b. During a review of Resident 1's Order Summary Report, dated 7/18/2025, the Order Summary Report indicated the following orders:1. Depakote oral tablet delayed release, give 375 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount) by mouth three times a day for mood disorder manifested by extreme mood swings causing stress such as increased irritability and yelling.2. Mirtazapine oral tablet 15 mg, give one tablet by mouth at bedtime for mood disorder manifested by self-isolation by pulling bedsheet overhead.3. Potassium chloride extended release 10 milliequivalent (meq-unit of chemical measure), give one tablet by mouth daily for hypokalemia (low blood potassium level), take with food and full glass of water.During a review of Resident 1's Resident Transfer Record, dated 1/14/2026, the Resident Transfer Record indicated Resident 1 was transferred to GACH for generalized weakness and pocketing of food.During a review of Resident 1's Progress Notes, dated 1/19/2026, timed at 10:01 p.m., the Progress Notes indicated Resident 1 returned to facility on 1/19/2026, at 7:20 p.m., from GACH.During a review of Resident 1's Medication Administration Record (MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 1/2026, the MAR indicated the following:1. LVN 2 administered Depakote on 1/15/2026, at 12 noon.2. LVN 1 administered mirtazapine on 1/16/2026, at 8 p.m.3. LVN 1 administered potassium on 1/16/2026, at 5 p.m.4. LVN 1 administered Depakote on 1/16/2026, at 4 p.m.During a concurrent interview, and record review on 2/3/2026, at 9:28 a.m., with the Minimum Data Set Nurse (MDSN), Resident 1's MAR, dated 1/2026, was reviewed. The MDSN stated Resident 1 was in GACH from 1/14/2026, to 1/19/2026. The MDSN stated check mark in MAR indicated medication administered. The MDSN stated the documentation was incorrect because Resident 1 was in GACH. The MDSN stated the nurses are supposed to sign the MAR after medication administration. The MDSN stated LVN 1 and LVN 2 should verify that Resident 1 was in the facility before medication administration documentation.During an interview on 2/3/2026, at 10:54 a.m., with Registered Nurse 1 (RN 1), RN 1 stated nurses should verify the residents' name and date of birth and make sure residents are actively in the facility. RN 1 stated inaccurate documentation can cause confusion in care.During an interview on 2/3/2026, at 12:29 p.m., with the Registered Nurse Supervisor (RNS), RNS stated the nurse should verify residents' identity, check the electronic MAR for correct medication, correct resident, correct time and correct documentation. RNS stated nurses should also check documentation after medication administration. RNS stated inaccurate documentation can cause confusion in care. During a review of facility's policy and procedure (P&P), titled, Charting and Documentation, dated 7/2017, and last reviewed on 1/14/2026, the P&P indicated, The following information is to be documented in the resident medical record: .b. Medications administered;During a review of facility's P&P, titled, Administering Medications, dated 3/2023, and last reviewed on 1/14/2026, the P&P indicated, Medications are administered in a safe and timely manner and as prescribed.9. The individual administering medications verify the resident's identity before giving the resident his/her medication. Methods of identifying the residents include: a. checking identification band; b. checking photograph attached to medical record; and c. if necessary, verifying resident identification with other facility personnel.20. The individual administering the medication initials the resident's MAR on the appropriate line after giving (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	each medication and before administering the next ones.21. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered; b. the dosage; c. the route of administration; d. the injection site (the act of administering a liquid-like medicine into the body using a needle); e. any adverse (harmful, unintended, and unexpected reactions to medications or treatments that occur at normal doses) or undesired result; f. any results achieved and when those results were observed; and g. the signature and title of the person administering the drug.