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	03/10/2026

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 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. Based on interview and record review, the facility failed to notify the physician promptly (acting immediately, without delay, or exactly at a scheduled time) for one of three sampled residents (Resident 1) by:1. Failing to notify the physician promptly when Resident 1 had a change of condition with blood-tinged (a small amount of blood) urine on 2/13/2026, at 3 a.m.2. Failing to notify the physician promptly when the facility received Resident 1's urinalysis (urine test) result on 2/17/2026.These failures had the potential for a delay in the delivery of necessary care and services and had the potential for increased risk of infection to Resident 1.Findings:During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 1/15/2026, with diagnoses that included unspecified (unconfirmed) encephalopathy (a change in how your brain functions), unspecified dementia (a progressive state of decline in mental abilities), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing).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 1/15/2026, 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 1/20/2026, 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 always incontinent (unable to control) of bowel and bladder functions.During a review of Resident 1's Change of Condition (COC- a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status), dated 2/13/2026, the COC indicated on 2/13/2026, at 3 a.m. Certified Nursing Assistant 1 (CNA 1) reported to Licensed Vocational Nurse 1 (LVN 1) that Resident 1 had diaper with blood-tinged urine. LVN 1 noted Resident 1 with hematuria (bloody urine) but had no pain and no burning sensation. The COC indicated on 2/13/2026, at 6:30 a.m., CNA 1 reported to LVN 1 the second episode of blood-tinged urine in Resident 1's diaper. The COC indicated Registered Nurse 1 (RN 1) notified the physician at 7:13 a.m.During a concurrent interview and record review on 3/6/2026, at 1:48 p.m., with RN 2, Resident 1's COC, dated 2/13/2026, was reviewed. RN 2 stated LVN 1 should have informed the physician right away on the first sign of hematuria on 2/13/2026, at 3 a.m. RN 2 stated Resident 1's condition can worsen because of delay in physician notification.During an interview on 3/6/2026, at 2:34 p.m., with LVN 2, LVN 2 stated physician should be notified immediately if there was a blood-tinged urine. LVN 2 stated that delay in physician notification can delay care and worsen Resident 1's hematuria and could lead to urinary tract infection (UTI- an infection in the bladder/urinary tract).During an interview on 3/10/2026, at 8:51 a.m. with RN 1, RN 1 stated her (RN 1) work starts from 7 a.m. to 3 p.m. RN 1 stated on 2/13/2026, she (RN 1) was informed by LVN 1 that Resident 1 had hematuria at 3 a.m. and again at 6:30 a.m. and the physician was not yet notified so as soon as she (RN 1) came she (RN 1) notified the physician. RN 1 stated LVN 1 should have notified the physician on the first sign of blood-tinged urine on 2/13/2026 at 3 a.m. RN 1 stated delay in physician notification can result to infection and possible sepsis (a life-threatening blood (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection).During an interview on 3/10/2026, at 12:18 p.m. with the Director of Nursing (DON), the DON stated LVN 1 should have notified the physician on 2/13/2026, at 3 a.m., on the first sign of hematuria despite no complaints of pain. The DON stated that timely notification of physician is important to inform the physician and obtain an order for laboratory test (a medical procedure analyzing samples of blood, urine, or tissue to gather data on a patient's health). The DON stated there was a delay in Resident 1's physician notification that could worsen Resident 1's hematuria.b. During a review of Resident 1's Order Listing Report, dated 2/13/2026, the Order Listing Report indicated an order for urinalysis with culture and sensitivity (test detects bacteria or yeast in the urine and determines the most effective antibiotic for treatment).During a concurrent interview and record review on 3/10/2026, at 8:51 a.m. with RN 1, Resident 1's Laboratory Results Report, dated 2/17/2026, and Progress Notes, dated 2/17/2026, were reviewed. The Laboratory Results Report indicated the urinalysis result reported to the facility on 2/17/2026, at 7:37 p.m. RN 1 stated there was documentation in Resident 1's medical record that the physician was notified on 2/17/2026, of the urinalysis result. RN 1 stated she (RN 1) worked that day on 2/17/2026, but only until 3 p.m. RN 1 stated after 3 p.m. the assigned LVNs in Station 1 or in Station 2 should have received the fax (the telephonic transmission of scanned printed material normally to a telephone number connected to a printer or other output device) of any laboratory results and send a copy thru electronic message (text) to the physician on 2/17/2026. RN 1 stated Resident 1's urinalysis result may have indicated signs of infection, and the physician should have been notified right away.During a concurrent interview and record review on 3/10/2026, at 11:58 a.m. with the DON, the text messages from the facility phone, dated 2/17/2026, and 2/18/2026, were reviewed. The facility phone indicated a text of a picture of Resident 1's urinalysis result sent to the physician on 2/18/2026, at 3:37 p.m. The DON stated the facility phone did not indicate notification to the physician on 2/17/2026.During an interview on 3/10/2026, at 12:18 p.m. with the DON, the DON stated the LVNs should have notified the physician of the urinalysis result on 2/17/2026. The DON stated physicians should be notified of laboratory test results to proceed with appropriate plan of care to address the problem, obtain a new set of laboratory test or obtain new medication like antibiotic (medication used to treat infection) to fight the infection. The DON stated delay in physician notification can cause further complication (something that makes a situation more difficult) and lead to Resident 1's infection.During a review of facility's policy and procedure (P&P), titled, Change in Condition, dated 1/24/2017, and last reviewed on 1/14/2026, the P&P indicated, A change in condition is a sudden or marked difference in resident's.4. Output (example given low urine output, hematuria.).5. Laboratory or radiology reports.A. All changes of condition in a resident shall be handled promptly.C. Upon a Change in Condition for any reason, nursing staff members are to take the following actions: Physician shall be called promptly.-If for some reason physician cannot be reached, alternative physician shall be contacted.- If alternate cannot be reached, Medical Director is to be contacted.- All contacts or attempts to contact shall be documented and include the correct time of the activity.- If no physician is available, arrangements are to be made for physician services that may include transfer to emergency room for appropriate care.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 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 one of three sampled residents (Resident 1) who had an episode of hematuria (presence of blood in the urine) accurately.This failure had the potential for confusion and may delay in the delivery of necessary care and services to Resident 1. Findings:During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 1/15/2026, with diagnoses that included unspecified (unconfirmed) encephalopathy (a change in how your brain functions), unspecified dementia (a progressive state of decline in mental abilities), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing).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 1/15/2026, 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 1/20/2026, 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 always incontinent (unable to control) of bowel and bladder functions.During a review of Resident 1's Change of Condition (COC- a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status), dated 2/13/2026, the COC indicated on 2/13/2026, at 3 a.m. and at 6:30 a.m. Certified Nursing Assistant 1 (CNA 1) reported to Licensed Vocational Nurse 1 (LVN 1) that Resident 1 had diaper with blood-tinged (a small amount of blood) urine.During a review of Resident 1's Order Listing Report, dated 2/13/2026, the Order Listing Report indicated the following orders:-Urinalysis (urine test) with culture and sensitivity (test detects bacteria or yeast in the urine and determines the most effective antibiotic for treatment).-May do straight catheterization (a thin, flexible, single-use tube inserted temporarily through the urethra to drain urine and removed immediately after) for urine collection, if unable to obtain clean catch (a technique for collecting a sterile, midstream urine specimen).During a review of Resident 1's Care Plan, dated 2/13/2026, about episodes of hematuria, the Care Plan indicated the following interventions:Monitor indwelling catheter (a hollow tube that is inserted into your bladder to drain urine) and change catheter or bag as ordered.Foley catheter (a specific, common type of indwelling catheter) cares every shift or as ordered.Maintain proper alignment of foley catheter to promote proper drainage.During an interview on 3/10/2026, at 11:10 a.m., with LVN 2, LVN 2 stated on 2/13/2026, she (LVN 2) assisted Registered Nurse 1 (RN 1) in obtaining urine sample for urinalysis, culture and sensitivity to Resident 1's using straight catheterization. LVN 2 stated Resident 1 had no indwelling catheter.During a concurrent interview and record review on 3/10/2026, at 12:18 p.m., with the Director of Nursing (DON), Resident 1's Care Plan, dated 2/13/2026, about hematuria was reviewed. The DON stated Resident 1's Care Plan should have been individualized to reflect use of straight catheter instead of indwelling catheter. The DON stated indwelling catheter is a continuous use of catheter. The DON stated the care plan was not accurate because Resident 1 never had an indwelling catheter. The DON stated a care plan should be individualized to be consistent and accurate in providing care specific to Resident 1.During a concurrent interview and record review on 3/10/2026, at 12:45 p.m., with the DON, facility's policy and procedure (P&P) titled, The Resident Care Plan, undated and last reviewed on 1/14/2026, the P&P indicated, To provide an individualized nursing care plan and to promote continuity of resident care.Record the following: 1. Procedures directly ordered by the physician; 2. Procedures associated with specific resident teaching; 3. Care necessitated by the resident's individual needs. The DON stated Resident 1's Care plan should be individualized for Resident 1's needs.

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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. 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 failing to:1. Ensure Licensed Vocational Nurse 1 (LVN 1) document accurately the time Family Member 1 (FM 1) was notified of Resident 1's change of condition on 2/13/2026.2. Ensure Registered Nurse 1 (RN 1) and LVN 2 document obtaining of urine sample through straight catheterization (a medical procedure, also known as intermittent or in-and-out catheterization, where a flexible tube is inserted through the urethra into the bladder to drain urine, then immediately removed) of Resident 1.3. Ensure nurses document notification of the physician of Resident 1's laboratory test result on 2/17/2026 and 2/20/2026.These failures had the potential to result in confusion in care and the medical records containing inaccurate documentation.Findings:a. During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 1/15/2026, with diagnoses that included unspecified (unconfirmed) encephalopathy (a change in how your brain functions), unspecified dementia (a progressive state of decline in mental abilities), and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing).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 1/15/2026, 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 1/20/2026, 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 always incontinent (unable to control) of bowel and bladder functions.During a review of Resident 1's Change of Condition (COC- a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status), dated 2/13/2026, the COC indicated on 2/13/2026, at 3 a.m. Certified Nursing Assistant 1 (CNA 1) reported to LVN 1 that Resident 1 had diaper with blood-tinged (a small amount of blood) urine. LVN 1 noted Resident 1 with hematuria (bloody urine) but had no pain and no burning sensation. The COC indicated on 2/13/2026, at 6:30 a.m., CNA 1 reported to LVN 1 the second episode of blood-tinged urine in Resident 1's diaper. The COC indicated notification to FM 1 on 2/13/2026, at 12 midnight.During a concurrent interview, and record review on 3/10/2026, at 12:18 p.m., with the Director of Nursing (DON), Resident 1's COC, dated 2/13/2026, was reviewed. The DON stated LVN 1 documented notification of FM 1 on 2/13/2026, at 12 midnight but the blood-tinged urine did not happen until 2/13/2026, at 3 a.m. and 6:30 a.m. The DON stated 12 midnight was not the accurate time. The DON stated LVN 1 should have documented accurately the time she (LVN 1) called FM 1.b. During a review of Resident 1's Order Listing Report, dated 2/13/2026, the Order Listing Report indicated the following orders:- Urinalysis (urine test) with culture and sensitivity (test detects bacteria or yeast in the urine and determines the most effective antibiotic for treatment).- May do straight catheterization for urine collection, if unable to obtain clean catch (a technique for collecting a sterile, midstream urine specimen).During a concurrent interview, and record review on 3/6/2026, at 1:48 p.m., with RN 2, Resident 1's Physician Order, dated 2/13/2026, were reviewed. RN 2 stated the physician ordered urinalysis, culture and sensitivity to Resident 1's using straight catheterization for urine collection.During an interview on 3/10/2026, at 10:37 a.m., with RN 1, RN 1 stated on 2/13/2026, she (RN 1) with the help of LVN 2, had straight-catheterized Resident 1 and obtained urine sample for urinalysis, culture and sensitivity but there was an issue with the labelling so on 2/14/2026, LVN 2 had to straight-catheterized Resident 1 again with RN 2.During an interview on 3/10/2026, at 11:10 a.m., with LVN 2, LVN 2 stated on 2/13/2026, she (LVN 2) assisted RN 1 to straight-catheterized Resident 1 in obtaining urine sample for urinalysis, culture and sensitivity. LVN 2 stated she (LVN 2) did not document the straight catheterization of Resident 1 on 2/13/2026. LVN 2 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated RN 1 should have documented since she (RN 1) was the one who performed the procedure on 2/13/2026. LVN 2 stated she (LVN 2) placed the urine sample in a specimen cup but was informed on 2/14/2026, that it should have been in a tube. LVN 2 stated on 2/14/2026, she (LVN 2) had straight-catheterized Resident 1 again. LVN 2 stated she (LVN2) did not document that she (LVN 2) performed the straight catheterization to Resident 1 on 2/14/2026. LVN 2 stated she (LVN 2) should have documented in Resident 1's medical record because it happened and it was an invasive procedure (a medical action that enters the body by cutting, puncturing the skin, or inserting instruments [example given, catheters, scopes {thin, flexible or rigid tubes equipped with cameras and lights, used by specialists to visualize, diagnose, and treat internal organs and body cavities without major surgery}] through natural orifices [opening]) so documentation of how the Resident 1 tolerated the procedure is important and for completeness of Resident 1's medical record.During an interview on 3/10/2026 at 12:18 p.m., with the DON, the DON stated RN 1 and LVN 2 should have documented nursing procedures like straight catheterization and how well Resident 1 tolerated (how well a resident's body accepts a certain treatment or medication) the procedure. The DON stated the facility failed to document two invasive procedures in Resident 1's medical record.c. During a review of Laboratory Results Report, dated 2/17/2026, the Laboratory Results Report for urinalysis indicated on 2/17/2026, at 4:39 a.m., the laboratory received the urine specimen. The Laboratory Results Report indicated on 2/17/2026, at 7:37 p.m., the laboratory reported the urinalysis result to the facility and on 2/20/2026, at 5:45 p.m., the laboratory reported the urine culture result to the facility.During a concurrent interview, and record review on 3/10/2026, at 8:51 a.m. with RN 1, Resident 1's Laboratory Results Report, dated 2/17/2026, and Progress Notes, dated 2/17/2026 and 2/20/2026, were reviewed. The Laboratory Results Report indicated the urinalysis result reported to the facility on 2/17/2026, at 7:37 p.m. and the urine culture result reported to the facility on 2/20/2026 at 5:45 p.m. RN 1 stated there was no documentation in Resident 1's medical record that the physician was notified on 2/17/2026, of the urinalysis result and on 2/20/2026, of the urine culture result. RN 1 stated she (RN 1) worked on both days on 2/17/2026, and 2/20/2026, but only until 3 p.m. RN 1 stated after 3 p.m. the assigned LVNs in Station 1 or in Station 2 should have received the fax (the telephonic transmission of scanned printed material normally to a telephone number connected to a printer or other output device) of any laboratory results and send a copy thru electronic message (text) to the physician on 2/17/2026, and on 2/20/2026. RN 1 stated Resident 1's urinalysis and culture result may have indicated signs of urine infection. RN 1 stated the nurses should have documented that physician was notified of the urinalysis and urine culture test result on 2/17/2026, and 2/20/2026.During an interview on 3/10/2026, at 11:58 a.m. with the DON, the DON stated there was no documented evidence in Resident 1's medical record that the nurses have notified the physician on 2/17/2026, and 2/20/2026, of the urinalysis and urine culture test result. The DON stated it is important to document notification of the physician of the laboratory test result for the continuity and communication of care and to obtain physician order like medication such as antibiotics (medication used to treat infection) appropriate for the laboratory test result. The DON stated failing to document means physician notification was not done. The DON stated the facility's policy for charting was not followed and Resident 1's medical record was not complete and accurate.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, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial (the interrelation of social factors and individual thought and behavior) condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team (IDT- a coordinated group of experts from several different fields who work together) regarding the resident's condition and response to care.2. The following information is to be documented in the resident medical record: . c. Treatments or services performed;3. Documentation in the medical record will be objective (not opinionated or speculative), (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	complete, and accurate.7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided; b. the name and title of the individual(s) who provided the care; c. the assessment data and/or any unusual findings obtained during the procedure/ treatment; d. how the residents tolerated the procedure/treatment; e. whether the resident refused the procedure/treatment; f. notification of family, physician or other staff, if indicated; and g. the signature and title of the individual documenting.