STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **056113**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/07/2026**
NAME OF PROVIDER OR SUPPLIER **ALEXANDRIA CARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP CODE **1515 N ALEXANDRIA AVE. , LOS ANGELES, California, 90027**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following Reflects the Findings of the California Department of Public Health during investigation of two Facility Reported Incidents. Facility Reported Incidents numbers: 2966348 and 2969277. The inspection was limited to the specific Facility Reported Incidents investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for Facility Reported Incident numbers: 2966348 and 2969277.	F0000		04/08/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to follow professional standards of nursing practice for one of four sampled residents (Resident 1) by failing to ensure licensed nurses appropriately assessed and monitored Resident 1’s medical status following the resident’s Change of Condition (COC) on 3/26/2026 related to the resident’s reported facial trauma. This deficient practice had the potential to result in	F0684	Facility Response Submission of the Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusion set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State laws. This Plan of Correction constitutes the facility’s credible allegation of compliance Corrective Action On 4/7/2026 Resident 1 was reassessed by LVN 3 and no skin issue was identified. On 4/7/2026 LVN 3 received one-on-one in-service by DON regarding importance of documenting details about resident’s change of condition and monitoring every shift for 72 hours. Identification of other residents and corrective action On 4/8/2026 DON and/or designee reviewed audits	04/08/2026

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 reverse for further 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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F0684 SS = D	Continued from page 1 the failure to identify continued or worsening clinical deterioration, thereby placing Resident 1 at risk for adverse health outcomes and compromised safety. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted the resident on 8/7/2024 with diagnoses including Parkinson's disease (a progressive brain disorder that causes problems with movement, balance, and muscle control), age-related osteoporosis (a disease that makes bones thin, weak, and brittle, increasing the risk of fractures [broken bones]), and osteoarthritis (occurs when the cartilage that cushions the ends of bones in the joints gradually wears away). During a review of Resident 1's Minimum Data Set (MDS – a resident assessment tool), dated 2/13/2026, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making was intact. During a review of Resident 1's Change in Condition Evaluation, dated 3/26/2026, the Change in Condition Evaluation indicated on 3/26/2026 at 7:30 p.m., another resident hit Resident 1 on the nose and both cheeks. The Provider Notification and Feedback section indicated Resident 1's Attending Physician (MD) 1 was notified on 3/27/2026 at 10 p.m., 26 hours and 30 minutes after the resident's reported COC. The Change in Condition Evaluation indicated MD 1's recommendation was to monitor Resident 1's nose and both cheeks for any changes and pain. During a review of Resident 1's Care Plan, initiated on 3/26/2026, the Care Plan indicated the resident reported another resident hit him on the nose and both cheeks. The Care Plan Interventions indicated the licensed nurses to check and assess Resident 1's body. During an interview on 4/7/2026 at 11:05 a.m. with Resident 1, Resident 1 stated Resident 2 (Resident 1's previous roommate) came into the room, stood on Resident 1's left side of the bed, and punched him on the face. A picture of Resident 1's face was taken two days after Resident 2 allegedly punched	F0684	Continued from page 1 provided by medical records for all change of condition in month of April to ensure proper documentation and monitoring are in place. No other deficient practice noted. Measures to prevent recurrence On 4/7/2026 LVN 3 received one-on-one in-service by DON regarding importance of documenting details about resident's change of condition and monitoring every shift for 72 hours. On 4/8/2026 Licensed nurses received in-service by DON regarding importance of documenting details about resident's change of condition and monitoring every shift for 72 hours. Monitoring and incorporation into the QA system HID will audit change of conditions using Change of Condition Audit form daily Monday-Friday and will report any finding during daily stand-up meeting Monday-Friday on-going. DON or designee will review change of conditions from prior day during daily clinical meetings (Monday -Friday) on going to ensure the nurse notified the attending physician regarding resident's significant change of condition and documented. Any deficient finding will be reported to DON and/or Administrator for further corrective action/recommendation. Any trend of deficient finding(s) will be documented on Change of Condition Audit Form and will be reviewed during the monthly QA meeting for further review and/or recommendation(s). Administrator who will then report to the Quality Assurance (QA) team during monthly Quality Assurance (QA)/Quality Assurance and Performance Improvement (QAPI) for further evaluation/recommendation and to provide feedback and program modification if needed x3 months or until compliant. Date Corrective action to be completed:	04/08/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056113	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026
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F0684 SS = D	Continued from page 2 Resident 1. The picture of Resident 1’s face indicated a purplish-blue colored bruise on the right lower orbital area (a bony socket in the skull that includes the eye socket, eye lids, eyebrow, and surrounding skin). Resident 1 refused to provide a copy of the picture. During an interview on 4/7/2026 at 1:09 p.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated on 3/27/2026, Resident 1’s right lower eyelid had a purple bruise from the inner lower eyelid extending to the middle lower eyelid. CNA 3 stated Resident 1’s bruise was the size of the tip of her (CNA3) fifth digit (pinky or little finger). During a concurrent interview and record review on 4/7/2026 at 1:26 p.m. with Licensed Vocation Nurse (LVN) 3, Resident 1’s Progress Notes, dated 3/26/2026 to 3/29/2026, were reviewed. LVN 3 stated on 3/27/2026, Resident 1’s right lower eyelid was observed with a dime-sized, purplish colored bruise. LVN 3 stated there was no documented evidence of Resident 1’s right lower eyelid bruise. LVN 3 stated Resident 1 should be monitored every shift for 72 hours after a change of condition. LVN 3 stated Resident 1’s Progress Notes indicated there was no documented evidence that the resident was monitored on the following shifts: a. On 3/27/2026 (7 a.m. to 3 p.m. shift), b. On 3/28/2026 (7 a.m. to 3 p.m. shift), and c. On 3/29/2026 (7 a.m. to 3 p.m. shift). LVN 3 stated that failure to document Resident 1’s right lower eyelid bruise and the monitoring provided after the resident’s change of condition could cause the resident discomfort and pain. During an interview on 4/7/2026 at 3:19 p.m. with the Director of Nursing (DON), the DON stated she (DON) was not made aware of Resident 1’s right eyelid bruise. The DON stated Resident 1 should be monitored every shift for at least 72 hours following COC. The DON stated there was no confirmed documented evidence of monitoring on the identified shifts. The DON stated failure to monitor Resident 1 every shift after a COC could result in worsening of the resident’s condition. The DON stated that care not documented was considered not provided. The DON acknowledged and stated the facility failed to identify, document, and monitor Resident 1’s change	F0684	Continued from page 2 4/8/2026	04/08/2026

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F0684 SS = D	Continued from page 3 of condition. During a review of the facility’s policy and procedure (PnP) titled, “Change in Condition: Notification of,” last reviewed on 1/14/2026, the PnP indicated “a facility must immediately inform the resident, consult with the resident’s physician and/or NP …where there is a significant change in the resident’s physical, mental, or psychosocial status… a need to alter treatment significantly.” During a review of the facility’s PnP titled, “Charting and Documentation,” last reviewed on 1/14/2026, the PnP 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 condition, shall be documented in the resident’s medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident’s condition and response to care.” The PnP indicated “the following information is to be documented in the resident’s medical record…changes in the resident’s condition… progress toward or changes in the care plan goals and objectives. Documentation in the medical record will be objective, complete, and accurate.”	F0684		04/08/2026