

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Montebello Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1035 W Beverly Blvd Montebello, CA 90640	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919</p> <p>Based an observation, interview, and record review, the facility staff failed to ensure one of four sampled residents (Resident 4) was free of accident hazards by leaving an unattended bottle of cleaning solution in the shower and failing to supervise Resident 4 who had a history of wandering (when a resident roams around and becomes lost or confused about his/her location).</p> <p>This deficient practice resulted in Resident 4 to gain access to the bottle of cleaning solution on 5/2/24 and was observed holding the bottle tilted towards the resident's mouth. This failure also had the potential for other residents to have access to the bottle of cleaning solution and risk for ingesting the cleaning solution, which could lead to harm and hospitalization .</p> <p>Findings:</p> <p>A review of Resident 4's Admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included hypercalcemia (a condition in which the calcium level in the blood becomes too high), dementia (a brain disorder that results in memory loss, poor judgment, and confusion), and dysphagia (difficulty or discomfort in swallowing).</p> <p>A review of Resident 4's History and Physical Examination (H&P), dated 3/14/2024 indicated Resident 4 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 4's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/7/2024, indicated Resident 4 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making and required partial moderate assistance (helper does less than half the effort) with toileting hygiene, shower/bathe self, sit to lying, sit to stand, wheel 50 feet (ft- unit of measurement) with two turns (the ability to wheel at least 50 feet and make two turns once seated in wheelchair/scooter), and wheel 150 feet (the ability to wheel at least 150 feet in a corridor or similar space once seated in wheelchair/scooter).</p> <p>A review of Resident 4's Care Plan, revised on 2/6/2024, indicated Resident 4 was observed at risk for physical behaviors: wandering. The care plan indicated Resident 4's risk factors included impaired cognition secondary to dementia and impaired safety awareness/safety judgement. Resident 4's care plan interventions indicated to redirect resident to resident care areas when indicated.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 4's Change in Condition Evaluation form, dated 5/2/2024, indicated Resident 4 was witnessed by Certified Nursing Assistant (CNA) holding a bottle of cleaning solution in Station 2 shower room. The COC also indicated; Resident 4 was also witnessed spitting something out. The COC further indicated, Registered Nurse (RN) did the assessment and called Poison Control Center. The COC indicated RN was directed by the Poison Control Center to provide resident with water or milk and Resident 4 refused water did drink the milk.</p> <p>During an interview with Housekeeping Supervisor (HKS), on 5/15/2024, at 11:19 AM, HKS stated cleaning solutions are stored and locked in the housekeeping carts after use. HKS stated housekeeping staff are not allowed to leave any cleaning solutions or chemicals in the bathrooms or showers and/ or other areas that can be accessed by the residents. HKS stated on 5/2/2024 Housekeeper (HK 1) left a bottle of cleaning solution in Shower 2. HKS stated in the evening of 5/2/2024, Resident 4 was found by CNA 1 and CNA 2 inside Shower 2 holding a bottle of Toilet Bowl Cleaner (cleaning solution). HKS stated she was told that Resident 4 drank and spit out the cleaning solution. HKS stated Resident 4 likes to wander around Station 2.</p> <p>During an observation in Resident 4's room on 5/15/2024 at 12:14 PM, Resident 4 was observed seated on the wheelchair about to be assisted for lunch by the facility staff. Resident mumbled and was not able respond to any questions asked.</p> <p>During an interview with Licensed Vocational Nurse (LVN 1), on 5/15/2024, at 12:38 PM, LVN 1 stated CNA 2 found Resident 4 in Shower 2 on 5/2/2024 at around 8:30 PM holding a bottle of cleaning solution. LVN 1 stated she was informed by CNA 2 that Resident 4 had a bottle of cleaning solution tilted towards Resident 4's mouth when she found her. LVN 1 stated CNA 2 saw Resident 4 spit something out of her mouth after Resident 4 was found. LVN 1 stated Resident 4 gets restless and wanders around the facility and needs to be redirected when the resident wanders. LVN 1 stated the Shower 2 door is usually left open. LVN 1 stated housekeeping staff store bottles of cleaning solutions in the housekeeping cart of in the locked closet. LVN 1 stated housekeeping staff is not allowed to leave any bottles of cleaning solution in the bathrooms or showers. LVN 1 stated residents can have a bad reaction and get sick from ingesting cleaning solution.</p> <p>During an interview with CNA 1, on 5/15/2024, at 1:08 PM, CNA 1 stated, on 5/2/2024, at approximately 8:45 PM, CNA 1 and CNA 2 were getting ready to prepare Resident 4 for bed and found Resident 4 inside Shower 2. CNA 1 stated she was walking behind CNA 2 when CNA 2 found Resident 4 inside Shower 2 holding a bottle of cleaning solution tilted and pointing towards the resident's mouth. CNA 1 stated CNA 2 pulled Resident 4's wheelchair back and immediately checked Resident 4's mouth for any cleaning solution. CNA 1 stated the bottle of cleaning solution was left inside Shower 2. CNA 1 stated Resident 4 can get sick from drinking cleaning solution. CNA 1 stated Resident 4 needs to be supervised for her safety because she tends to wander into different rooms in the facility.</p> <p>During an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), on 5/15/2024, at 1:32 PM, the DON stated she was notified on 5/2/2024 at approximately 10 PM the Resident 4 was seen holding a bottle of cleaning solution inside Shower 2. The DON stated CNA 2 saw Resident 4 spitting after Resident 4 was found. The DON stated Resident 4 possibly wheeled herself into Shower 2 which is located across Resident 4's room. The DON stated Shower 2 door did not have a lock. The DON stated that based on the facility's investigation, a housekeeping staff left the bottle of cleaning solution in Shower 2.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the same interview with the DON and ADON, on 5/15/2024, at 1:32 PM, the DON stated housekeeping staff is not allowed to leave any cleaning solution around the facility. The DON stated cleaning solutions should be placed in the locked closet or inside the locked housekeeping cart to prevent residents having and access to the cleaning solutions and from accidentally ingesting the cleaning solution. The DON stated if the cleaning solution is ingested it can cause accidental poisoning, potential harm, a change in condition, and possible hospitalization for the resident. The DON stated, on 5/2/2024, the facility staff did not monitor Resident 4's location in the facility and provide redirection when the resident wheeled herself inside Shower 2.</p> <p>A review of the facility's P&P, titled, Storage Areas, Maintenance, revised on 12/2009, indicated, Maintenance storage areas shall be maintained in a clean and safe manner.</p> <p>A review of the facility's P&P, titled, Safety and Supervision of Residents, revised on 7/2017, indicated the following:</p> <p>Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.</p> <p>Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents.</p> <p>The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents.</p> <p>The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.</p>		