STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055170	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pico Rivera Healthcare Center	9140 Verner Street Pico Rivera, CA 90660

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48778 Based on interview and record review, the facility to ensure the primary care provider (PCP) was notified for one of seven residents ' (Resident 1), when: 1. Resident 1 had missed doses of Macrobid oral capsule (a type of antibiotic) to treat Urinary Tract Infection ([UTI], an infection in the bladder/urinary tract) on 3/11/2025, 3/13/2025, and 3/15/2025. 2. Resident 1 refused the suprapubic catheter (a thin, flexible tube inserted directly into the bladder through a small incision in the lower abdomen above the pubic bone) changed as ordered by the PCP. These failures had the potential to cause unresolved UTI and can lead complications such as sepsis (a life-threatening infection), hospitalization , and death. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of pneumonitis (inflammation of lung tissue, usually caused by a virus) and acute (sudden) pulmonary edema (excess accumulation of fluid in the lungs, causing shortness of breath, difficulty breathing). During a review of Resident 1 ' s Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 1/16/2025, the MDS indicated Resident 1 had moderate cognitive (the ability to think and reason) impairment. The MDS indicated Resident 1 was dependent (helper does all the effort) for Activities of Daily Living (ADLs) such as rolling left to right and transferring from chair/bed-to-chair. 1. During a review of Resident 1 ' s Medication Administration Record (MAR) for March 2025, the MAR indicated Resident 1 had an order of Macrobid Oral Capsule 100 mg, one (1) capsule by mouth two times a day for seven (7) days for UTI. The MAR indicated Resident 1 had missed dosage of Macrobid on 3/11/2025, 3/13/2025, and 3/15/2025. During a review of Resident 1 ' s nursing progress notes, the progress notes did not indicate that Resident 1 ' s PCP was notified that Resident 1 ' s Macrobid evening doses were missed on 3/11/2025, 3/13/2025, and 3/15/2025. (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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Pico Rivera Healthcare Center	9140 Verner Street Pico Rivera, CA 90660

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/2025 at 1:55 p.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated Resident 1 did not receive the evening doses of Macrobid on 3/11/2025 and 3/13/2025 because Resident 1 was at dialysis. LVN 5 stated Resident 1 ' s PCP was not informed of the missed doses because they were busy. LVN 5 stated because of the missed antibiotic doses, Resident 1 ' s UTI would become severe. LVN 5 stated that if a resident was not available during medication pass, the medication should be offered when the resident return. During an interview on 3/26/2025 at 2:22 p.m. with LVN 3, LVN 3 stated that if a resident missed a medication, it should be documented in the resident ' s clinical record. LVN 3 stated the PCP should also be notified if a resident missed a medication dose. LVN 3 Resident 1 ' s PCP was not notified on 3/15/2025 when the resident missed the 3/15/2025 Macrobid dose, because LVN 3 did not think they had to notify the PCP. LVN 3 stated if a resident missed an antibiotic dose, the effectiveness of the antibiotic would not be as strong. During a concurrent interview and record review on 3/26/2025 at 3:53 p.m. with the Director of Nursing (DON), Resident 1 ' s 3/2025 MAR was reviewed. The DON stated, If a resident had an order for antibiotics and was unavailable, staff should give the antibiotic when the resident return and clarify with the doctor for any additional orders for the missed dose. During a review of the facility ' s P&P titled, Administering Medications, dated 3/2023, the P&P indicated if a resident is not available to receive the medication on the pass, the MAR may be flagged and the nurse should return to the missed resident to administer the medication after the medication pass. 2. During a review of Resident 1 ' s physician order dated 1/15/2025, the physician ' s order indicated Suprapubic catheter change by Skilled Nursing Facility (SNF) wound care in facility every month and as needed (PRN). During a review of Resident 1 ' s wound physician progress notes dated 2/25/2025, the progress notes indicated Resident 1 refused suprapubic catheter change. During a review of Resident 1 ' s nursing progress notes dated 2/25/2025, the progress notes did not indicate Resident 1 ' s PCP was notified of the resident ' s refusal to have the suprapubic catheter changed. During an interview on 4/1/2025 at 12:43 p.m. with Registered Nurse (RN) 1, RN 1 stated the PCP should have been notified of Resident 1 ' s refusal to have the suprapubic catheter changed and obtain additional orders for monitoring signs and symptoms of infection. During a concurrent interview and record review on 4/1/2025 at 3:28 p.m. with RN 2, the facility ' s P&P titled, Change in a Resident ' s Condition or Status, dated 3/2023 was reviewed. RN 2 stated the facility did not follow the P&P which indicated, any refusal of treatment should be reported to the PCP. RN 2 stated the PCP should have been notified when Resident 1 refused to have the suprapubic catheter changed and so the staff can obtain additional monitoring orders. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pico Rivera Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9140 Verner Street Pico Rivera, CA 90660	

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility ' s P&P titled, Change In A Resident ' s Condition or Status, dated 3/2023, the P&P indicated the nurse should notify the resident ' s attending physician or physician on call, when the resident refused treatment or medications two (2) or more consecutive times. The P&P indicated the nurse should record in the resident ' s medical records information related to changes in the resident ' s medical condition or status.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48778 Based on observation, interview and record review, the facility failed to ensure, three of seven sampled residents (Residents 1, 6, and 7), received oxygen as per physician's orders and oxygen saturations ([O2 sat], a measurement of how much oxygen the blood is carrying as a percentage, normal range is 95-100%) were checked accurately. These failures had the potential to not identify Residents 1, 6, and 7's oxygenation status and placed the residents at risk for complications related to poor oxygenation (the process of supplying blood or tissues with oxygen) such as respiratory distress (a condition where breathing is labored and inadequate), hospitalization and death. Findings: 1). During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of pneumonitis (inflammation of lung tissue, usually caused by a virus) and acute (sudden) pulmonary edema (excess accumulation of fluid in the lungs, causing shortness of breath, difficulty breathing). During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool), dated 1/16/2025, the MDS indicated Resident 1 had moderate (average) cognitive (the ability to think and reason) impairment. The MDS indicated Resident 1 was dependent (helper does all of the effort) for Activities of Daily Living (ADLs) such as rolling left to right and transferring from chair/bed-to-chair. During a review of Resident 1's Order Summary Report (a list of current doctor's orders), the Order Summary Report indicated to administer oxygen (O2) at three (3) liters (L) per minute (PM) via nasal cannula ([NC] a small plastic tube applied into the resident's nostrils for providing supplemental oxygen) and may titrate (adjust) up to five (5) L/min for O2 saturation (sat, amount of oxygen in the system (normal is 90-100%)) less than 89% every shift. During a review of Resident 1's O2 Sat Summary, the summary indicated Resident 1's O2 sats were assessed at room air (without oxygen use). 2). During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of chronic (persisting for a long time) respiratory failure (a medical condition where the lungs are unable to exchange gases, leading to insufficient oxygen in the blood) with hypercapnia (excessive carbon dioxide). During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 had moderate cognitive impairment. The MDS indicated Resident 6 was dependent to perform ADLs such as toileting hygiene and lower body dressing. (continued on next page)

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During a review of Resident 6's Order Summary Report, the Order Summary Report indicated, Resident 6 had orders for continuous O2 at 2 LPM via NC and may titrate up to 5 LPM for O2 sat less than 92% every shift for Chronic Obstructive Pulmonary Disease ([COPD], a chronic lung disease causing difficulty in breathing).

During a review of Resident 6's O2 Sats Summary, the O2 Sats Summary indicated Resident 6's O2 sats were assessed at room air.

During a concurrent interview and record review on 3/28/2025 at 12:22 p.m. with Licensed Vocational Nurse (LVN) 7, Resident 6's oxygen orders and O2 sats were reviewed. LVN 7 stated Resident 6's O2 sats should have checked while receiving oxygen via NC and not on room air.

During a concurrent observation and interview on 3/28/2025 at 12:29 p.m. with LVN 7 of Resident 6's bedside oxygen tank, LVN 7 stated Resident 6's oxygen tank was at 1 liter. LVN 7 stated Resident 6's oxygen should have been set at 2 liters. LVN 7 stated residents with oxygen orders should be assessed at the beginning of the shift to ensure that their oxygen is on and calibrated correctly. LVN 7 stated Resident 6's O2 sat needed to be accurate to assess how well the resident is tolerating oxygen along if resident is experiencing respiratory distress.

3). During a review of Resident 7's Admission Record, the Admission Record indicated Resident 7 was originally admitted to the facility on [DATE] with diagnoses of chronic (persisting for a long time) respiratory failure (a medical condition where the lungs are unable to exchange gases, leading to insufficient oxygen in the blood) with hypercapnia (excessive carbon dioxide).

During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7 was cognitively intact. The MDS indicated Resident 7 required partial/moderate assistance (helper does less than half the effort) for ADLs such as oral and personal hygiene.

During a review of Resident 7's Order Summary Report, the Order Summary Report indicated, Resident 7 had orders for O2 at 2 LPM via NC and may titrate up to 5 LPM for O2 sat less than 92% every shift for interstitial lung disease (a group of conditions that cause inflammation and scarring of the space between the air sacs and blood vessels of the lungs) continuously.

During a review of Resident 7's O2 Sats Summary, the summary indicated Resident 7's O2 sats were assessed at room air.

During a concurrent interview and record review on 3/28/2025 at 12:37 p.m. with LVN 7, Resident 7's oxygen orders and O2 sat were reviewed. LVN 7 stated he had not taken Resident 7's O2 sat on the morning of 3/28/2025.

During a concurrent observation and interview on 3/28/2025 at 12:42 p.m. with LVN 7, Resident 7's oxygen tank was observed. LVN 7 stated Resident 7's oxygen was set at 2.5 liters. LVN 7 stated if O2 sat was not assessed, Resident 7 may not receive adequate oxygenation.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/28/2025 at 1:45 p.m. with Director of Nursing (DON), Residents 1, 6, and 7's oxygen orders and O2 sats were reviewed. The DON stated, staff should check residents' oxygen order were implemented correctly and residents' O2 sats were checked with vitals. The DON stated if a resident had an order of oxygen, the documentation should reflect the amount in percentage according to the doctor's order, to ensure monitoring that residents receivedproper oxygenation or to identify any changes. During a concurrent interview and record review on 3/28/2025 at 2:19 p.m. with the DON, a photo of Resident 6 and Resident 7's oxygen tanks were reviewed. The DON stated Resident 6 and Resident 7's oxygen tanks were not accurately set according to physician's order. The DON stated if residents did not receive the ordered amount of O2 and O2 sats were not properly assessed, it could lead to a change of condition and symptoms such as shortness of breath. During a concurrent interview and record review with DON on 3/28/2025 at 2:37 p.m., the facility's policy and procedure (P&P) titled, Oxygen Administration, undated, was reviewed. The DON stated, the P&P indicated oxygen should be administered per physician's orders, document the resident's response to oxygen use. The DON stated, in order to determine if a resident needed to have their oxygen titrated, the O2 sat should have been checked with the residents' O2 orders. The P&P also indicated to check the O2 sat to ensure that oxygen use is effective. The DON stated when the residents' O2 sats were checked at room air, the facility did not follow their policy.