

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER San Gabriel Conv Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8035 E Hill Drive Rosemead, CA 91770	

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** 48481</p> <p>Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Resident 1 and 3) were free from accident hazards as possible by failing to provide monitoring, supervision, identifying hazards and assistance for two of three sampled residents (Resident 1 and 3) who were at risk for fall in accordance with the facility's policy and procedure. In addition for Resident 3 the facility failed to ensure the bed alarm (an alarm that turns on to alert the staff when the resident attempts to get off the bed) was in functioning condition.</p> <p>This deficient practice resulted in Resident 3's fall that caused facial contusion (bruise on your face that caused by fall or being hit on the face resulting in small blood vessels leak blood under the skin) and skin tear on the upper lip and for Resident 1 to have repeat falls that could result in injury and pain.</p> <p>Findings:</p> <p>1. During a reviewed of Resident 1 ' s Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), difficulty in walking, and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage).</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment tool) dated 12/5/24 indicated that Resident 1 was severely cognitively impaired (significant problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS also indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity) on sit to stand, chair to chair/bed-to-chair transfer, and toilet transfer.</p> <p>During a review of Resident 1 ' s Care Plan revised on 6/22/24 indicated that Resident 1 was at risk for falls because of severe cognitive impairment, arthritis, difficulty walking, poor safety awareness, and unsteady gait (abnormal walking pattern by a lack of stability and balance) The interventions included the resident will be frequently visualized monitored, place frequently used items within reach, place call light within reach.</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>During a review of Resident 1's SBAR (Situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 1/5/25, indicated that Resident 1 was found on the floor by CNA 1 and sustained no acute injury.</p> <p>A review of the Fall Risk assessment dated [DATE] indicated Resident 1 was on high risk for fall due to intermittent (occasional) confusion, poor safety awareness, history of falls and elimination (bowel and bladder) status incontinent (no control) and unsteady gait (unable to balance self when walking).</p> <p>During an interview on 3/12/25 at 12:10 pm with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 1/5/25 around 3:30 am, Certified Nurse Assistant (CNA)1 walked to the nursing station and informed her that Resident 1 fell on the floor. LVN 1 stated as she went to Resident 1 ' s room and Resident 1 was already in bed. LVN 1 stated, CNA 1 told her that she put Resident 1 back in bed first because she (CNA1) needed to take her break. LVN 1 stated CNA1 should have called me first and did not assist Resident 1 up from the floor prior to calling the nurse.</p> <p>During an interview on 3/12/25 at 2:15pm CNA 2 stated Resident 1 was impulsive (acting or done suddenly without any planning or consideration of the results), getting up multiple times during the day and would not call for help, CNA 2 stated she was not made aware by the charge nurses that Resident 1 was at risk for fall, and she was not aware of any intervention to implement to prevent the resident from falling.</p> <p>During an interview on 3/14/25 at 12:30pm with CNA1, CNA1 stated on 1/5/25 when Resident 1 fell , Resident 1 was sitting on the side edge of the bed and she observed Resident 1 fall with head leading to the floor. CNA1 stated she was sitting in the chair at the end of bed and but was not able to stop Resident 1 from falling and did not move her from the edge of the bed to prevent the fall. CNA1 stated after Resident 1 fell she assisted Resident 1 back to bed prior to calling the charge nurse to assess Resident 1's condition and for possible injuries.</p> <p>2. During a reviewed of Resident 3 ' s Admission Record, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control), difficulty in walking, and muscle weakness.</p> <p>During a review of Resident 3 ' s Minimum Data Set (MDS- a resident assessment tool) dated 1/16/25 indicated that Resident 3 had severe cognitive impairment (significant problems with a person's ability to think, learn, remember, use judgement, and make decisions), The MDS also indicated that Resident 3 was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the resident to complete the activity) on rolling left and right, sitting to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, and tub/shower transfer.</p> <p>During a review of Resident 3 ' s SBAR (Situation, Background, Assessment, and Recommendation, a structured communication tool used to facilitate clear and efficient communication, especially in healthcare) dated 3/10/25 timed at 6:30 pm, Resident 3 was found lying on the floor in the room with an injury noted at the inner part of the upper lip.</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>Fall Risk assessment dated [DATE] indicated Resident 3 was on high risk for fall due to intermittent (occasional) confusion/poor safety awareness, history of fall, and unable to stand without assistance/unsteady gait/ poor sitting or standing balance.</p> <p>During an interview on 3/12/25 at 3:39 pm, with LVN 3, LVN 3 stated on 3/10/25 approximately 6:30 pm she was looking for CNA1 to assist Resident 3 back in bed, LVN 3 stated didn ' t see CNA 1 anywhere but when she saw CNA1 and to tell her Resident 3. LVN 3 stated when she entered Resident 3's room the resident was on the floor. LVN 3 stated sometimes she had hard time looking for CNA1 and she reported to the RN Supervisor that day.</p> <p>During an interview on 3/14/25 at 12:30 pm, with CNA1, CNA1 stated she remembered Resident 3 fell on [DATE], CNA1 stated she saw Resident 3 was on the floor near the commode, CNA1 stated she pulled commode to around 3 feet away from the bed because the resident kept getting up to try to use the commode which was 3 feet from bed. CNA 1 stated, Apparently she tried to use bathroom but the bed alarm was not working. I left the room and when I walked back by the room and I saw her on the floor,</p> <p>During an interview on 3/14/25 at 10:40 am with the Director of Staff Development (DSD), DSD stated she was responsible for new staffs training, ensuring CNAs job performance competency, and in-service to the staffs. CNA1 need more training on resident care and better understanding of her job. DSD stated she believed CNA1 needed more follow ups and deserved to be given an opportunity to improve that was why she continued to hire her to work overtime when there is a need for staffing.</p> <p>During an interview on 3/12/25 at 4:05 pm with the Administrator (ADM), the ADM stated many CNAs were fresh off school, the facility were giving more trainings to the new staffs. The ADM stated CNA1 was given last and final warning and anymore violation would result in termination at the moment. ADM stated was not aware of the fall incident of Resident 3 but will ask the DON for report and investigation right away. The ADM stated Resident 3's fall incident was not thoroughly invetigated to determine the cause and the interventions to implement to prevent a repeat fall.</p> <p>During a review of the facility ' s Policy and Procedure (P&P) titled Fall Risk assessment dated [DATE], indicated the following:</p> <p>All residents will be assessed using the Fall risk assessment tool within 72 hours from admission and re-admission, then re-assessed quarterly or as needed. The assessment tool is found in the Point Click Care (PCC). If the total score is 10 or greater, the resident should be considered as High Risk for potential fall.</p> <p>A review of the facility's undated policy and procedure, titled Accident/Incident Prevention indicated the facility strives to prevent accidents by providing an environment that is free from accident hazards over which the facility has control, as well as identificaion of each resident at risk for accidents and incidents and the provision of adequate care plans which procedures to prevent accidents.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>48481</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of three Certified Nurse Assistant (CNA 1) demonstrate necessary competency skills necessary to care for residents assigned to CNA 1 as indicated in the residents plan of care. CNA 1 was assigned to work double shifts when the facility was aware that CNA1 ' s job performance demonstrated incompetency and received written warnings due to sleeping during work hours, taking long breaks than scheduled, leaves work without telling anyone in the facility and did not changed residents who found soiled or reposition in bed.</p> <p>This deficient practice had resulted in the residents not to received quality of care necessary to achieve their highest potential and result in a decline in the residents well-being.</p> <p>Cross reference F689</p> <p>Findings:</p> <p>During a review of CNA1 ' s Employee File on 3/12/25 at 11:15 am with the Director of Staff Development (DSD), indicated CNA 1 ' s date of hire was 12/23/25. A Performance Correction Notice dated 3/3/25 indicated CNA1 was reported by a Registered Nurse (RN) Supervisor on 2/27/25 about not providing necessary care to her residents assigned to CNA1, who were found completely soiled. In addition, CNA1 was reported by charge nurse that CNA1 slept throughout the shift and had to awaken CNA1 to provide care. Additionally, CNA1 was found taking longer breaks than set schedule.</p> <p>During a review of CNA1 ' s Time Card for month of March 2025 and Staff Assignment Sheets, revealed on 3/8/25 CNA1 punched in to work the evening shift at 2:47 pm and punched out at 0:00 (midnight) and continued to work the night shift, then punched out on 3/9/25 at 7:01am. On the same day 3/9/25 at 2:46 pm, CNA1 punched in to work evening shift, then punched out at 0:00 (midnight) and continue to work the night shift, then punched out on 3/10/25 at 7:03am. On the same day 3/10/25 at 2:40 pm CNA1 punched in to work pm shift, then punched out at midnight, and continue to work the night shift, then punched out on 3/11/25 at 7:02 am. On the same day 3/11/25 at 3:01pm CNA1 punched in to work evening shift, then punched out at 11:02 pm (a total of seven shifts in 4 days).</p> <p>During a review of the Nursing Staffing Assignment and Sign-in Sheet on 3/14/25 at 10:40 am with the DSD, indicated 3/8/25, 3/9/25, and 3/10/25 night shift one CNA called off. The DSD confirmed there was one CNA staffing shortage for the night shift. and CNA1 worked to cover the shortage.</p> <p>During an interview on 3/12/25 at 12:10 pm with LVN 1, LVN1 stated she filed a grievance on 1/5/25 she saw CNA1 was sleeping during work hours on many occasions and did not provide necessary care to her assigned residents that were found with soiled briefs and were not repositioned in bed, improperly responding to a resident ' s fall, and taking extended breaks than set schedule, and she was away from assigned unit during work. LVN 1 stated she did not remember how many times she told the supervisors about issues with CNA1. LVN 1 stated CNA1 hasn ' t improved in any way, which is really dangerous to the residents.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/14/25 at 12:30pm with CNA1, CNA1 stated she informed the charge nurse or relief CNA by saying I ' m going to break. CNA1 stated They (CN) didn ' t listen to me sometimes. They can ignore but I still had to go. I don ' t know about what residents ' safety can be affected but they should listen and understand that I need to take my break. Regarding working double shifts CNA1 stated she was not certain if the facility was short staffing but when there ' s someone called off, they asked everyone if someone would stay over. CNA1 stated she spontaneously offered herself, she felt she could do the job, and the facility did not say no.</p> <p>During an interview on 3/14/25 at 10:40am, the DSD stated they are in the process of hiring and they hire new staff every month. DSD stated the facility was not using staffs from the nursing agency (a service provider agency which provides nurses and healthcare assistants) anymore, and because the facility needed nursing staff on the floor to cover staffing shortage. DSD stated, the facility did not reject when CNA1 offered to help work extra shift. The DSD stated she monitors CNA1 ' s performance by inquiring feedback from charge nurses. The DSD thought CNA1 deserves an opportunity to improve. The DSD did not respond to the surveyor ' s questions when asked if the facility allows staff who already received warning about their poor performance to continued work residents.</p> <p>During a review of the facility ' s Policy and Procedure (P&P) titled Staffing: Sufficient, Competent Nursing dated Year 2001, the P&P indicated the facility will provide sufficient number of nursing staff with the appropriate skills and competency necessary to provide nursing and related care services for all residents in accordance with resident care plans and the facility assessment. The facility defines a Competent Staff:</p> <ol style="list-style-type: none"> 1. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. 2. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. 		