STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055181	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Conv Center	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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to follow transfer/discharge procedure in accordance with the facility's policy and procedure (P&P) titled, Transfer or Discharge Notices, for one of four sampled residents (Resident 1) when Resident 1's Responsible Party (RP - an individual, often a family member who acts on the Resident's behalf) 1 was not notified of Resident 1's transfer to the hospital in writing. This failure had the potential to result in loss of continuity of care, confusion over bed hold (a resident's right to keep a bed vacant and available for seven days after their transfer to the hospital in anticipation of their return to the facility), and being unaware of plan of care.Findings: During a review of Resident 1's admission Record, (AR), the AR indicated the facility admitted Resident 1 on 5/5/2026 with diagnoses that include dementia (a progressive state of decline in mental abilities), atherosclerotic heart disease (a condition where the arteries supplying blood to the heart muscle become narrowed or blocked by a buildup of fatty plaque), and hypertension (high blood pressure). During a review of Resident 1's Minimum Data Set (MDS - resident assessment tool), dated 5/9/2026, the MDS indicated Resident 1 had mildly impaired cognition (ability to understand and make decisions) and memory. During a review of Resident 1's physician's orders on 5/9/2026 at 7:15 AM, the order indicated Resident 1 to be transferred to the hospital via 911 for chest pain. The order also indicated that a 7-day bed hold per facility protocol would be in place. During an interview on 6/5/2026 at 11:15 AM with the Registered Nurse Supervisor (RN) 1, RN1 stated during an emergency situations and a resident was transferred out of the facility, a packet are provided to the paramedics, and in the packet there was a notice of proposed transfer/discharge form and a notification of bed hold form and placed on top of the residents medical chart given to the paramedics. During a concurrent interview and record review on 6/5/2026 at 2:50 PM with Medical Records Director (MR), Resident 1's Notification of Bed Hold, dated 5/9/2026 was reviewed. The Notification of Bed Hold did not indicate RP was informed. The MR stated there was no signature from the RP showing understanding of bed hold form. During a concurrent interview and record review on 6/5/2026 at 2:50 PM with MR, Resident 1's Notice of Proposed Transfer/Discharge dated 5/9/2026 was reviewed. The Notice of Proposed Transfer/Discharge did not indicate RP was informed. MR stated, there is no signature from the resident or RP on the form. During a concurrent interview and record review on 6/5/2026 at 3:20 PM with the Director of Nursing (DON), the facility's P&P titled Transfer or Discharge Notices dated 2001 was reviewed. The P&P indicated, written information will be given to the residents and resident representatives (responsible party) that explains in detailThe rights and limitations of the resident regarding bed holdsThe reserve bed payment policy as indicated by the state planThe facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed hold periodThe details of the transfer (per the Notice of Transfer).The DON stated the facility did not follow the policy in this case regarding providing written documents for transfer and bed hold.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a scheduled toileting care plan and incontinence (the loss of bladder control) care plan was developed for one of four sampled residents (Resident 1) in accordance with the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered.This failure had the potential to leave Resident 1's toileting and incontinence needs unaddressed, increasing Resident 1's risk of skin breakdown and urinary tract infections.Findings:During a review of Resident 1's admission Record (AR), dated 6/4/2026, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including but not limited to spinal stenosis (the narrowing of the spaces within the spine), chronic kidney disease (a long-term condition where the kidneys lose their ability to filter blood properly), and dementia (a progressive state of decline in mental abilities).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 6/1/2026, the MDS indicated Resident 1's mental and cognitive functions are intact. Resident 1 is occasionally incontinent of the bladder. Resident 1 requires moderate assistance with toileting hygiene. During a review of Resident 1's Urinary Continence task flowsheet from 5/5/2026 - 5/8/2026, the flowsheet indicated Resident 1 had episodes of urinary incontinence on 5/6/2026, 5/7/2026, and 5/8/2026.During a concurrent interview and record review on 6/5/2026 at 8:45 AM with Minimum Data Set Coordinator (MDS 1), Resident 1's Bowel and Bladder Program Screener form, dated 5/6/2026, was reviewed. The screener form indicated Resident 1 is not continent of both bowel and bladder and Resident 1 is a candidate for scheduled toileting. MDS 1 stated based on the results of the screener form, Resident 1 should have been placed on a scheduled toileting program to assist with improving Resident 1's level of urinary continence. MDS 1 stated the scheduled toileting program intervention would be on Resident 1's care plan and Resident 1's task flowsheets if it were implemented.During a concurrent interview and record review on 6/5/2026 at 8:48 AM with MDS 1, Resident 1's baseline care plan, dated 5/6/2026, was reviewed. The baseline care plan did not indicate Resident 1 was incontinent of the bladder. MDS 1 stated the baseline care plan should have identified Resident 1 as incontinent of the bladder.During a concurrent interview and record review on 6/5/2026 at 8:50 AM with MDS 1, Resident 1's comprehensive care plan was reviewed. The care plan did not indicate Resident 1 was placed on a scheduled toileting program. The care plan did not indicate incontinence as an identified focus area for Resident 1. MDS 1 stated Resident 1 does not have a care plan addressing Resident 1's incontinence or for the implementation of a scheduled toileting program. MDS 1 stated there should have been a care plan created to address Resident 1's incontinence and scheduled toileting program. MDS 1 stated it is important to develop care plans because they describe what interventions staff should perform for Resident 1's care. Without a care plan, Resident 1 may have an increased risk of urinary tract infections or further incontinence.During an interview on 6/5/2026 at 3:37 PM with the Director of Nursing (DON), the DON stated it is important for the facility to develop care plans for the residents so facility staff know how to take care of the residents. If a resident is incontinent, this should be identified as early as their baseline care plan.During a review of the facility's policy and procedure (P&P) titled, Care Plans - Baseline, last revised March 2023, the P&P indicated the baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission. The baseline care plan includes instructions needed to provide effective care of the resident.During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, last revised March 2023, the P&P indicated the comprehensive care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable well-being. Assessments of residents are ongoing and care plans are revised as information about the residents' conditions change.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide skin barrier cream (a topical medical cream intended to maintain the skin's physical barrier, seal in moisture, and protect fragile skin from external irritants, friction, and bodily fluids) per physician's order for one of four sampled residents (Resident 2) in accordance with the facility's policy and procedure titled, Prevention of Pressure Injuries.This failure had the potential to delay the healing and worsen Resident 2's moisture-associated skin damage (MASD - skin damage resulting from long-term exposure of the skin to moisture).Findings:During a review of Resident 2's admission Record (AR) dated 6/4/2026, the AR indicated Resident 2 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic respiratory failure (a long-term condition where the lungs cannot get enough oxygen into the blood), ventilator dependence (a state in which a person requires a mechanical machine to breathe), and gastrostomy dependence (a state in which a person relies on a surgically placed feeding tube in their stomach to receive nutrition, hydration, or medication).During a review of Resident 2's History and Physical (H&P), dated 5/30/2026, the H&P indicated Resident 2 does not have the capacity to understand and make decisions.During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 6/1/2026, the MDS indicated Resident 2 is in a persistent vegetative state (a condition where a person appears awake but shows no sign of awareness). Resident 2 has impairment to both sides of upper and lower extremities. During a review of Resident 2's care plan titled, MASD. Resident Noted with Alteration in Skin Integrity, dated 5/28/2026, the care plan indicated nursing staff shall provide treatments as ordered.During a review of Resident 2's skin reassessment, dated 5/28/2026, the skin assessment indicated Resident 2 was readmitted to the facility on [DATE] with a peri-rectal area MASD. The peri-rectal area was reddened, macerated (the softening and breaking down of skin resulting from prolonged exposure to moisture), and had fragile skin. The skin assessment indicated to provide treatment as per physician's order.During a review of Resident 2's Oder Summary Report for June 2026, the Order Summary Report indicated a physician's order for treatment of Resident 2's peri-rectal MASD, dated 5/28/2026. The physician's order indicated to cleanse the peri-rectal MASD, pat dry, and apply skin barrier cream daily and as needed.During an observation on 6/4/2026 at 1:32 PM in Resident 2's room, Certified Nurse Assistant (CNA) 1 and CNA 2 were providing peri-rectal hygiene care to Resident 2. Resident 2's buttocks area had small pink areas of skin breakdown. Resident 2's buttocks did not have white cream on it. CNA 1 cleansed Resident 2's buttock area with a wet washcloth, then grabbed a new brief and secure it around Resident 2's buttock area. CNA 2 returned Resident 2 to a back-lying position in bed.During an interview on 6/4/2026 at 1:42 PM with CNA 1, CNA 1 stated she observed a little redness to Resident 2's buttocks during the soiled brief change. CNA 1 stated she did not apply any cream to Resident 2's buttocks because the treatment nurse applied some in the morning. CNA 1 stated she will not notify the nurse of any changes to Resident 2's buttocks because the redness is not new.During a concurrent interview and record review on 6/4/2026 at 2:13 PM with the Treatment Nurse (TN), Resident 2's physician's orders were reviewed. TN stated licensed nurses must apply skin barrier cream at least every day and as needed when the cream is wiped away and gone. TN stated the CNAs must notify him when Resident 2's briefs are being changed so he knows when to reapply the skin barrier cream. TN stated the skin barrier cream leaves an observable white colored cream on Resident 2's buttocks when applied. If the white colored cream is not observed, this indicates more skin barrier cream must be applied.During a concurrent observation and interview on 6/4/2026 at 2:45 PM with TN in Resident 2's room, Resident 2's brief was removed for a second brief change. Resident 2's buttock did not have white cream on it. TN stated Resident 2 did not have any skin barrier cream on his buttock when the brief was removed. TN stated Resident 2's CNAs should have notified him there was no more cream on Resident 2's buttocks so more cream could be applied. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	TN stated it is important to reapply the skin barrier cream because it is to protect Resident 2's skin from moisture. If the skin barrier cream is not reapplied, it could lead to further skin breakdown and redness of Resident 2's buttocks.During an interview on 6/4/2026 at 3:03 PM with CNA 1, CNA 1 stated she did not notify TN to apply more cream to Resident 2's buttocks the first time she changed Resident 2's soiled brief. CNA 1 stated she should have notified TN to reapply the skin barrier cream when she observed there was no more white cream on Resident 2's buttocks.During an interview on 6/5/2026 at 3:26 PM with the Director of Nursing (DON), the DON stated every time a CNA performs a brief change for a resident, the CNA must notify the treatment nurse to reapply the skin barrier cream because the cream may get wiped away during peri-rectal hygiene care. If the CNA does not notify the treatment nurse and the treatment nurse does not reapply the skin barrier cream, the resident's skin breakdown can worsen.During a review of the facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries, last revised April 2020, the P&P indicated facility staff will use and apply barrier products to protect the skin from moisture.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a scheduled toileting program was implemented for one of four sampled residents (Resident 1) in accordance with the facility's policy and procedure titled, Urinary Incontinence.This failure had the potential to worsen Resident 1's bladder incontinence (the loss of bladder control), increasing Resident 1's risk of skin breakdown and urinary tract infections. Findings:During a review of Resident 1's admission Record (AR) dated 6/4/2026, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including but not limited to spinal stenosis (the narrowing of the spaces within the spine), chronic kidney disease (a long-term condition where the kidneys lose their ability to filter blood properly), and dementia (a progressive state of decline in mental abilities).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 6/1/2026, the MDS indicated Resident 1's mental and cognitive functions are intact. Resident 1 is occasionally incontinent of the bladder. Resident 1 requires moderate assistance with toileting hygiene. During a review of Resident 1's Urinary Continence task flowsheet from 5/5/2026 - 5/8/2026, the flowsheet indicated Resident 1 had episodes of urinary incontinence on 5/6/2026, 5/7/2026, and 5/8/2026.During a concurrent interview and record review on 6/5/2026 at 8:45 AM with Minimum Data Set Coordinator (MDS) 1, Resident 1's Bowel and Bladder Program Screener form, dated 5/6/2026, was reviewed. The screener form indicated Resident 1 is not continent of both bowel and bladder and Resident 1 is a candidate for scheduled toileting. MDS 1 stated based on the results of the screener form, Resident 1 should have been placed on a scheduled toileting program to assist with improving Resident 1's level of urinary continence. MDS 1 stated the scheduled toileting program intervention would be on Resident 1's care plan and Resident 1's task flowsheets if it were implemented.During a concurrent interview and record review on 6/5/2026 at 8:50 AM with MDS 1, Resident 1's care plan was reviewed. The care plan did not indicate Resident 1 was placed on a scheduled toileting program. MDS 1 stated Resident 1 does not have a care plan for the implementation of a scheduled toileting program. MDS 1 stated Resident 1 was not placed on a scheduled toileting program.During a concurrent interview and record review on 6/5/2026 at 9:00 AM with MDS 1, Resident 1's task flowsheets were reviewed. The task flowsheets did not indicate MDS 1 was placed on a scheduled toileting program. MDS 1 stated Resident 1 does not have a task flowsheet for scheduled toileting. MDS 1 stated it is important to place residents on a scheduled toileting program if indicated by the bowel and bladder screener form because it helps the residents improve their level of urinary continence and level of function.During an interview on 6/5/2026 at 3:40 PM with the Director of Nursing (DON), the DON stated the purpose of the bowel and bladder program screener form is to assess a resident's level of continence and to determine if the resident is capable of bladder training. If the screener form assesses a resident as a candidate for scheduled toileting, a care plan should be created to initiate the program. The purpose of the program is to improve the resident's level of continence and improve their quality of life.During a review of the facility's policy and procedure (P&P) titled, Urinary Incontinence, last revised April 2018, the P&P indicated facility staff will provide scheduled toileting to improve the resident's continence status if indicated by assessment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program in accordance with the facility's policy and procedure (P&P) titled, Infection Control, for one of four sampled residents (Resident 2) when Certified Nurse Assistant (CNA) 1 did not perform hand hygiene after handling Resident 2's soiled brief (a disposable, highly absorbant undergarment designed to manage bladder and bowel incontinence) during activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).This failure had the potential to increase risk for infections due to cross contamination (unintentional transfer of bacteria/germs or other contaminants from one surface to another) and Resident 2 to develop infection.Findings:During a review of Resident 2's admission Record (AR), dated 6/4/2026, the AR indicated Resident 2 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including chronic respiratory failure (a long-term condition where the lungs cannot get enough oxygen into the blood), ventilator dependence (a state in which a person requires a mechanical machine to breathe), and gastrostomy dependence (a state in which a person relies on a surgically placed feeding tube in their stomach to receive nutrition, hydration, or medication).During a review of Resident 2's History and Physical (H&P), dated 5/30/2026, the H&P indicated Resident 2 does not have the capacity to understand and make decisions.During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 6/1/2026, the MDS indicated Resident 2 is in a persistent vegetative state (a condition where a person appears awake but shows no sign of awareness). Resident 2 has impairment to both sides of upper and lower extremities. During an observation on 6/4/2026 at 1:32 PM in Resident 2's room, Certified Nursing Assistant (CNA) 1 and CNA 2 were ADL care to Resident 2. CNA 1 was wearing gloves and removed Resident 2's soiled brief. CNA 1 then cleaned Resident 2's buttocks area with a wet washcloth. Continuing to wear the same gloves, CNA 1 grabbed a new brief and secured it around Resident 2's buttocks area. CNA 2 returned Resident 2 to a back-lying position in bed. Continuing to wear the same gloves, CNA 1 replaced Resident 2's pillows behind his head, under his right arm, and under his legs. Continuing to wear the same gloves, CNA 1 touched Resident 2's right arm, head, and both legs and repositioned them on top of the pillows. During an interview on 6/4/2026 at 1:42 PM with CNA 1, CNA 1 stated she did not change her gloves or perform hand hygiene after cleaning Resident 2's buttocks and before placing the new brief on Resident 2. CNA 1 stated she should have changed her gloves and performed hand hygiene for infection control.During an interview on 6/4/2026 at 1:46 PM with CNA 2, CNA 2 stated after changing a resident's brief, CNAs should change their gloves because the briefs are dirty. Changing gloves and performing hand hygiene is for infection control.During an interview on 6/5/2026 at 10:14 AM with the Infection Preventionist Nurse (IPN), the IPN stated all staff must perform hand hygiene before, in between, and after patient care. After a CNA removes a resident's soiled diaper and cleans their buttocks, the CNA should remove their soiled gloves, perform hand hygiene, then put on new gloves before proceeding with the next task. If this is not done, the CNA may contaminate the resident with germs, which could lead to infection in the resident.During an interview on 6/5/2026 at 3:20 PM with the Director of Nursing (DON), the DON stated CNAs should perform hand hygiene and change their gloves immediately after changing a resident's briefs. This is per the facility's policy and is important to prevent the spread of infections.During a review of the facility's policy and procedure (P&P) titled, Infection Control, undated, the P&P indicated staff must clean their hands after each direct resident contact. Staff should perform hand hygiene before and after assisting a resident with personal care and after handling linens.