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	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Conv Center	8035 E Hill Drive Rosemead, CA 91770

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure two of five sampled residents' (Resident 81 and 99) Physician Orders for Life Sustaining Treatment (POLST forms that tell medical staff what to do if you have a medical emergency and are unable to speak for yourself) and Advance Directive (living will, legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity) Acknowledgment Form correctly indicated Resident 81 ' s and 99 ' s Advance Directive. This deficient practice had the potential to result in misinformation of medical care and treatment and not honoring resident ' s wishes in cases where the resident and/or responsible party was unable to participate in making healthcare decisions. Findings: 1. During a review of Resident 81 ' s admission Record (AR), the AR indicated a readmission to the facility on 3/31/2025 with diagnoses that included chronic systolic heart failure (when the heart muscle doesn't pump blood as well as it should), type 2 diabetes mellitus with hyperglycemia (condition in which the level of glucose in the blood is higher than normal). During a review of Resident 81 ' s History and Physical (H&P), dated 4/06/2025, the H&P indicated the resident did not have the capacity was not able to make his own decisions. During a review of Resident 81 ' s POLST, dated 1/23/2024, the POLST indicated the resident had an Advance Directive, dated 1/23/2024. During a review of Resident 81 ' s Advance Directive Acknowledgement form, dated 3/03/2025, the form indicated Resident 81 did not have an Advance Directive. During a review of Resident 81 ' s medical chart on 5/22/2025 at 1:46 PM, no Advance Directive was found. (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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of Resident 81 ' s medical chart with the Social Services Director (SSA) on 5/22/2025 at 1:47 PM, the SSD stated she assists with resident admissions with the admission Coordinator and licensed nurses. The SSD stated she would explain the forms to residents and the families on admission and would follow up on the forms during the interdisciplinary team (IDT) admission meetings. The SSD confirmed Resident 81 ' s POLST and Advance Directive Acknowledgment form did not match. The SSD stated it was important to make sure all the dates and documents indicate Resident 81 ' s wishes, in the cases of a medical emergency, facility staff would know what medical interventions to perform. The SSD stated since the advance directive acknowledgment form and the POLST did not match and indicated different information, the SSD stated she should have clarified the information with the family and updated Resident 81 ' s chart. 2. During a review of Resident 99 ' s AR, the AR indicated a readmission to the facility on 7/15/2024 with diagnoses that included Chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood),hypersensitive heart disease with out heart failure(damage to the heart caused by chronic high blood pressure, but without the specific condition of heart failure) During a review of Resident 99 ' s H&P, dated 7/17/2024, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 99 ' s POLST, dated 7/17/2024, the POLST indicated the resident did not have an advance directive. During a review of Resident 99 ' s Advance Directive Acknowledgement form, dated 7/16/2024, the form indicated Resident 99 had an Advance Directive. During a concurrent interview and record review of Resident 99 ' s medical chart with the Social Services Director (SSD) on 5/22/2025 at 1:59 PM, the SSD stated she did not know which facility staff completed Resident 99 ' s from upon admission to the facility. The SSD confirmed Resident 99 ' s POLST and Advance Directive Acknowledgment form did not match. During a concurrent interview and record review of Resident 81 ' s and Resident 99 ' s POLST and Advanced Directive Acknowledgement form with SSD 5/22/2025 at 2:10 PM, SSD stated both forms for Resident 81 ' s and 99 ' s should have been clarified since the information on the forms did not match. SSD stated it was important to obtain correct information, so facility staff know what the resident ' s or families wishes were, in cases of a medical emergency. A review of the facility ' s policy and procedure titled Advanced Directives, revised in September 2022, indicated The resident has the right to formulate and advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify the physician for one of three sampled residents (Resident 371), who had developed edema (swelling caused by a collection of fluid in the spaces that surround the body's tissues) on the left elbow, in accordance with the facility ' s Policy and Procedure (P&P) for Change in Condition. This deficient practice had the potential to result in delayed care and treatment and could lead to tissue damage for Resident 371. Findings: During a review of Resident 371 ' s admission Record (AR), the AR indicated that Resident 371 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including chronic respiratory failure (a long-term condition in which the breathing system is unable to adequately exchange oxygen and carbon dioxide in the body) with hypoxia (low levels of oxygen in your body tissues), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of right elbow and right hand, and heart failure (a long-term condition when the heart muscle doesn't pump blood as well as it should). During a review of Resident 371 ' s Minimal Data Sheet (MDS- a resident assessment tool), dated 5/15/2025, the MDS indicated Resident 371 had severely impaired cognition (never/rarely made decisions). The MDS indicated that Resident 371 ' s range of motion on the upper and lower extremities (shoulder, elbow, wrist, hand, hip, knee, ankle, and foot) were impaired. The MDS also indicated that Resident 76 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. During a review of Resident 371 ' s admission Assessment, dated 5/8/2025, the AR indicated Resident 371 ' s upper extremities were paralyzed, and the resident ' s general skin condition was dry and warm with no edema documented. During a review of Resident 371 ' s Skin & Wound Evaluation, dated 5/9/2025, the Evaluation indicated there was no documentation that Resident 371 ' s left elbow was red and swollen when the resident was readmitted to the facility on [DATE]. During a review of Resident 371 ' s Care Plan, dated 5/18/2025, the Care Plan indicated Resident 371 was at risk for fluid retention secondary to congestive heart failure (CHF- a chronic condition where the heart can't pump enough blood to meet the body's needs). The Care Plan goal indicated to reduce the risk of fluid alteration daily, with interventions to observe for signs of excess fluid such as edema and to notify the physician. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/20/2025 at 10:10 AM with the treatment nurse (TXN) in the resident ' s room, Resident 371 ' s left elbow was red, swollen, and warm to touch. The TXN stated Resident 371 could not state what happened to Resident 371 ' s left elbow and TXN he was not sure if the condition was already reported to the physician. The TXN stated, there was no active treatment orders for Resident 371 ' s swollen left elbow. During a concurrent observation and interview on 5/20/2025 at 10:25 AM with Licensed Vocational Nurse (LVN) 2, LVN 2 assessed Resident 371 and stated the resident ' s left elbow appeared swollen, red, and warm to touch. LVN 2 stated she did not notice Resident 371 ' s left elbow was swollen when she performed an assessment on Resident 371 at the beginning of her shift (7 AM). LVN 2 stated she should have assessed Resident 371 more thoroughly. LVN 2 stated that she thought the redness and swelling of Resident 371 was reported to the physician since Resident 371 was on furosemide (a medication to help treat fluid retention and swelling that is caused by congestive heart failure, liver disease, kidney disease, or other medical conditions.) During a concurrent record review and interview on 5/20/2025 at 10:25 AM with LVN 2, Resident 371 ' s physician orders dated 5/8/2025 was reviewed. Resident 371 ' s physician order indicated on 5/8/2025, Resident 371 had a physician order for Lasix (furosemide) via gastrostomy tube (G-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) one time a day for CHF. During a concurrent record review and interview on 5/20/2025 at 10:35 AM with LVN 2, Resident 371 ' s Change of Condition (COC) since admission dated 5/8/2025, Resident 371 ' s Nursing Progress Notes since admission dated 5/8/2025, and Resident 371 ' s admission assessment dated [DATE] were reviewed. LVN 2 stated, she could not find any documented evidence that Resident 371 ' s physician was notified about Resident 371 ' s left elbow edema and any interventions or treatment orders were received. During an interview on 5/21/2025 at 11:20 AM with Registered Nurse (RN) 1, RN 1 stated Resident 371 had CHF and was currently on Lasix. RN 1 stated, he was not sure when Resident 371 ' s left elbow swelling developed but LVN 2 and Resident 371 ' s assigned CNA should have assessed the resident thoroughly and immediately reported to the physician. During an interview on 5/22/2025 at 3:50 PM with the Director of Nursing (DON), DON stated the expectation for licensed nurse was to assess the resident thoroughly to recognize a change in Resident 371 ' s condition. The DON stated Resident 371 ' s of swollen left elbow should have been reported promptly to the physician to ensure there was no delay in interventions and treatments. During a review of the facility ' s Policy and Procedures (P&P) titled Change of Condition undated, the P&P indicated that a change of condition is a sudden or marked difference in resident including Vital signs, open or red areas, skin condition (e.g. swelling or discoloration). All changes of condition in a resident shall be handled promptly. Upon a change of condition for any reason, nursing staff members are to take the following actions: a. Nursing 24-hour report form shall be completed. b. Physician shall be called promptly. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Daily assessment of condition change shall be handled by Nurse Supervisor under the direction of the DON. d. Documentation of change in condition shall be performed by the Licensed Nurse accordingly. e. Identification by Certified Nursing Assistant. CNAs will report change in condition of residents to the charge nurse as soon as possible.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect three of three sampled residents' (Residents 29, 5, and 112) privacy to ensure the unauthorized personnels did not have the access to view and obtain the baby monitors for Residents 29, 5, and 112. The deficient practices had potential to violate the residents' right for privacy. Findings: 1. During a review of Resident 29's admission Record (AR), the AR indicated the facility originally admitted Resident 29 on 11/22/2018 and readmitted her on 9/10/2022 with diagnoses that included dementia (a group of thinking and social symptoms that interferes with daily functioning) and hyperlipidemia (a condition in which there are high levels of fat particles in the blood). During a review of Resident 29's Minimum Data Set (MDS, a resident assessment tool), dated 3/4/2025, the MDS indicated Resident 29 had intact memory and cognition (ability to think and reason). The MDS indicated Resident 29 required setup or clean-up assistance with eating, supervision or touching assistance with oral hygiene, personal hygiene and chair/bed-to-chair transfer, and partial/moderate assistance with toileting hygiene and shower/bathe self. During a review of Resident 29 ' s At Risk for Falls Care Plan, dated 3/15/2025, the Care Plan indicated interventions that included to place a baby monitor (an electronic device that enables a person to see or hear a child who is in another room) at the nurses ' station with staff to monitor resident ' s activity in her room and digital screen monitor while in bed to monitor her whereabouts. During an observation on 5/19/2025 at 9:38 AM, in Resident 29 ' s room, a camera was observed in Resident 29 ' s bed, placed in a built-in wall cabinet, facing Resident 29 ' s bed. During a concurrent observation and interview on 5/19/2025 at 11:48 AM with Certified Nursing Assistant (CNA) 5, in Resident 29 ' s room, CNA 5 stated she saw the camera in Resident 29 ' s room, but did not know what the purpose of the camera was for and who had placed the camera in Resident 29 ' s room. During an observation on 5/19/2025 at 4:09 PM, in the lobby outside Nursing Station 1, Resident 29 ' s baby monitor was observed placed on top of Medication Cart 1, visible to people who passed Medication Cart 1. The baby monitor display screen was turned on, and the people who passed by Medication Cart 1 had a direct view of the monitor display screen. Resident 29 ' s bed was visible on the baby monitor display screen, but Resident 29 was not in the room at the moment. During an interview on 5/19/2025 at 4:10 PM with Licensed Vocational Nurse (LVN) 5, LVN 5 stated she placed Resident 29 ' s baby monitor on top of Medication Cart 1 and kept it on, so she could check on Resident 29 any time while she was away from the nursing station to pass medications to other residents. LVN 5 stated the monitor should be turned off when Resident 29 was not in the room and when other staff were in the room with Resident 29. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/19/2025 at 4:30 PM with the Administrator (ADM), the ADM stated the nurses should only use the baby monitor system when the residents were by themselves, without the presence of staff in the room. During an interview on 5/20/2025 at 10:40 AM with Registered Nurse (RN) 3, RN 3 stated Resident 29 ' s baby monitor should be turned on only when the resident was alone, and without the presence of staff in the room, so the nurses could keep an eye on Resident 29 at all times to prevent falls and injuries. RN 3 stated she usually worked night shift and Resident 29 was asleep by herself in the room at night, so she would keep the baby monitor on during the whole night shift. RN 3 stated she would keep the baby monitor on the nurses ' desk behind the nursing station counter. RN 3 stated the baby monitor should be kept in the nursing station at all times, but RN 3 stated she was not aware of other nurses placing the baby camera onto the medication cart while away from the nursing station. 2. During a review of Resident 112's AR, the AR indicated the facility originally admitted Resident 112 on 10/14/2024 and readmitted her on 3/11/2025 with diagnoses that included diabetes mellitus (a disease that result in too much sugar in the blood) and heart failure (a chronic condition in which the heart doesn't pump blood as well as it should). During a review of Resident 112's MDS, dated [DATE], indicated Resident 112 had severely impaired memory and cognition The MDS indicated Resident 112 was dependent with eating, oral hygiene, personal hygiene, chair/bed-to-chair transfer, toileting hygiene and shower/bathe self. 3. During a review of Resident 5's AR, the AR indicated the facility admitted Resident 5/17/2025 with diagnoses that included dementia and hyperlipidemia. During a review of Resident 5's MDS, dated [DATE], indicated Resident 5 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 5 required supervision or touching assistance with eating, partial/moderate assistance with oral hygiene, personal hygiene, chair/bed-to-chair transfer, and toileting hygiene. During an observation on 5/20/2025 at 4:05 PM, in Resident 112 ' s and Resident 5 ' s room, a camera was observed in the resident's room and placed in a built-in wall cabinet facing Resident 112 and Resident 5 ' s bed. During an observation on 5/20/2025 at 4:08 PM, Resident 112 ' s baby monitor was in Nursing Station 2 on the nurses ' desk, behind the nursing station counter. There was no staff in Nursing Sation 2. Resident 112 ' s baby monitor display screen was on and Resident 112 ' s bed and Resident 5 ' s face and head were visible through the display screen. Resident 112 was not in room. During an interview on 5/20/2025 at 4:09 PM with LVN 6, LVN 6 stated the nurses kept Resident 112 ' s baby monitor on at all times so the nurses could see where and what Resident 112 was doing to prevent falls and injuries. LVN 6 stated the nurses kept the baby monitor on the desk in the nursing station. During an interview on 5/20/2025 at 4:15 PM with LVN 5, LVN 5 stated when the baby monitor was on and the nurses would place it on the desk in the nursing station, which was visible to any passerby's passing by or going into the nursing station, could see the baby monitor display screen which displayed Resident 112 and Resident 5 ' s room. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/22/2025 at 11:23 AM, Resident 112 ' s baby monitor was turned on and was on the desk in Nursing Station 2. Resident 112 was lying on the bed with Resident 5 ' s head visible on the monitor display screen. People passing by the nursing station could have direct view of Resident 112 and Resident 5. There was no staff in the nursing station. During an interview on 5/22/2025 at 11:46 AM with Family Member (FM) 1, FM 1 stated she was not aware that Resident 5 could be seen on the baby monitor display. During an interview on 5/22/2025 at 1:43 PM with the Director of Nursing (DON), the DON stated the nurses kept the baby monitor system on at all times, left the display screen open for authorized people to see, and removed the monitor from the nursing station could potentially violate the residents ' privacy. The DON stated the camera should only capture the resident who the monitoring device was intended to be used on and should not capture other residents ' activities. The DON stated the responsible party should be informed and must agree with the use of monitoring devices to ensure residents ' right to privacy was respected. During a review of the undated facility ' s policies and procedures (P&P) titled, Monitoring Devices, the P&P indicated The monitoring device will be solely used as an intervention to maximize resident ' s safety based on the interdisciplinary team and responsible party ' s decision and included in the resident ' s care plan, Devices must be used in a way that respects the resident's dignity and privacy, and Access to monitor feeds is restricted to authorized staff only.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Identify and define specific problematic behaviors related to the use of quetiapine (a medication used to treat mental illness) in one of five residents sampled for unnecessary medications (Resident 16.) 2. Perform a gradual dosage reduction (GDR - a periodic attempt to lower the dosage of a medication or discontinue a medication to control a resident ' s symptoms with lower doses or fewer medications) related to the use of quetiapine in one of five residents sampled for unnecessary medications (Resident 16.) The deficient practices of failing to identify and define specific problematic behaviors and perform a GDR related to the use of psychotropic medications (medications that affect brain activities associated with mental processes and behavior) increased the risk that Resident 16 could have experienced adverse effects (unwanted or dangerous medication-related side effects) related to psychotropic medication therapy, such as drowsiness, dizziness, constipation, or increased risk of fall, possibly leading to impairment or decline in her mental or physical condition or functional or psychosocial status. Cross referenced to F756. Findings: During a review of Resident 16 ' s admission Record (a document containing a resident ' s diagnostic and demographic information), dated 5/21/25, indicated she was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including: dementia (the loss of cognitive function, including memory, thinking, and reasoning, that interferes with daily life) and psychosis (a mental disorder characterized by a disconnection from reality which may occur as a result of psychiatric illness, a health condition, medication, or other drug use.) During a review of Resident 16 ' s History and Physical (H&P - a record of a comprehensive physician ' s assessment), dated 8/18/24, indicated she did not have the capacity to understand and make decisions. During a review of Resident 16 ' s Physician Order Summary (a monthly summary of all active physician orders), dated 3/24/25, indicated she was prescribed quetiapine (an antipsychotic medication) 25 milligrams (mg - a unit of measure for mass) by mouth on 2/21/25 for psychosis manifested by constant physical movement to exhaustion. During a review of Resident 16 ' s Order Audit Reports (a report with information about a previous medication order), dated 5/21/25, indicated, between 8/12/24 and 2/21/25, the orders for the use of quetiapine changed as follows: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/12/24 to 8/13/24 - Quetiapine 25 mg once daily for schizophrenia (a mental illness characterized by hearing or seeing things that are not there or believing things that are untrue.) 8/13/24 to 11/5/24 - Quetiapine 25 mg once daily for psychosis. 11/5/24 to 2/21/25 - Quetiapine 25 mg once daily for psychosis manifested by inability to eat and participate in daily living activities causing sadness. 2/21/25 to 5/21/25 - Quetiapine 25 mg once daily for psychosis manifested by constant physical movement to exhaustion. During a review of the Resident 16 ' s care plan for quetiapine, dated 8/22/24, indicated quetiapine was being used for psychosis manifested by inability to cope with daily living activities causing anger. During a review of Resident 16 ' s Informed Consent (a documentation verifying a resident or their representative have opted into treatment after education about a psychotropic medication ' s potential risks and benefits), dated 2/21/25, indicated Resident 16 was receiving quetiapine 25 mg once daily for psychosis manifested by constant physical movement to exhaustion. During a review of Resident 16 ' s Medication Administration Record (MAR - a document containing a record of all medications administered and monitoring performed for a resident), between August 2024 and May 2025, indicated Resident 16 was being monitored for behaviors of psychosis manifested by inability to cope with daily living activities causing anger related to the use of quetiapine. During a review of the consultant pharmacist ' s (a medical professional responsible for a monthly review of all residents ' medication regimens) recommendations, dated 2/5/25, indicated the pharmacist recommend a GDR for Resident 16 ' s quetiapine. Further review of the pharmacist ' s recommendation indicated the facility left a message with the psychiatrist on 2/9/25 concerning the request but contained no response from the physician or documentation of any additional attempts to follow up. During a review of Resident 16 ' s clinical record indicated there was no record of Resident 16 receiving psychiatric care and no documentation that a physician considered a GDR request for quetiapine and either approved a lower dose or documented that an attempt would be contraindicated (should not be performed due to potential harm) with an accompanying resident-specific clinical rationale. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/25 at 9:32 AM with the Director of Nursing (DON), the DON stated the facility failed to identify a specific behavioral issue related to Resident 16's use of quetiapine. The DON stated the problematic behaviors identified in the physician ' s order and the informed consent documentation are different than the problematic behaviors identified in the resident's care plan and MAR. The DON stated this makes the reason for the use of quetiapine and the need for its continued use unclear for Resident 16. The DON stated the facility is required to perform GDRs on psychotropic medications, including quetiapine, twice a year in the first year and then once a year thereafter. The DON stated the pharmacist requested a GDR on 2/5/25 for Resident 16's quetiapine, but a GDR was not done. The DON stated the dose of quetiapine for Resident 16 has not changed since it was initially prescribed in August 2024. The DON stated there was no documentation available concerning a response to the pharmacist's request indicating that a GDR attempt would be clinically contraindicated. The DON stated failing to define specific problematic behaviors, perform a GDR on psychotropic medications, or respond to the pharmacist's recommendations related to psychotropic medications could have increased this resident's drowsiness and fall risk, negatively affecting her quality of life and increasing her risk of medical complications from falls. During a review of the facility ' s undated policy Psychotherapeutic Medications, indicated The use pf psychotherapeutic medication shall be kept to a minimum in this facility. These medications are to be used only for specific behaviors by a resident, quantitatively and qualitatively documented by the facility that cause: A. Danger to self. B. Danger to other residents or staff. C. Psychotic symptoms (hallucinations, paranoia, delusion) that create frightful distress in the resident . A specific diagnosis, and a specific behavior or thought process justifying the need for psychotherapeutic medications are to be identified in the resident ' s health record . Drug holidays and gradual dose reductions will be attempted as follows: A. GDR will be attempted during at least two quarters during the first year unless clinically contraindicated and B. GDR will be attempted at least once a year during following years unless clinically contraindicated .

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. Based on interview and record review, the facility failed to ensure Resident 86 was assessed using the standardized Quarterly Review assessment tool (Minimum Data Set [MDS], a resident assessment tool) no less than once every 3 months between comprehensive assessments and transmitted to Center of Medicare and Medicaid Services (CMS) in accordance with current federal and state submission timeframes for one of two sampled residents (Resident 86). This deficient practice failed to provide CMS specific resident information for quality care measure and tracking purposes. Findings: During a review of Resident 86 ' s admission Record (AR), the AR indicated a readmission to the facility on 4/29/2024 with diagnoses that included anxiety (a group of mental health conditions that cause fear, dread and other symptoms) , hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone). During a review of Resident 86 ' s History and Physical [H&P] dated 5/10/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a concurrent interview and record review on 5/21/2025 at 9:05 AM of Resident 86 ' s electronic health records with MDS coordinator, the MDS coordinator stated the most recent quarterly MDS for resident 86 was due on 3/20/2025. MDS assistant stated the MDS was completed on 5/18/2025 but was not transmitted. MDS coordinator stated Resident 86 ' s MDS was late. MDS Coordinator stated MDS should be completed upon a resident's admission, quarterly, upon change of condition During a review of the Centers for Medicare & Medicaid Services (CMS) submission report provided by facility dated 5/21/2025, timed at 11:32 AM, the Report indicated Resident 86 ' s quarterly MDS target date was 3/20/2025, and the MDS was submitted and accepted on 5/21/2025 at 11:32 AM. During an interview on 5/22/2025 at 1:38 PM with Director of Nursing (DON), the DON stated all resident MDS ' s must be completed and submitted on time to CMS to ensure the facility was providing accurate and correct information. During a review of the facility ' s policy and procedure titled Advanced Directives revised on March 2022, indicated A comprehensive assessment of every resident ' s needs is made at intervals designated by OBRA and PPS requirements.

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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 observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for two of four sampled residents (Resident 67 and 9) by failing to: 1. Ensure Resident 67's primary language was indicated in the care plan. 2. Ensure Resident 9' s hard of hearing (HOH) and hearing aids (HA, a device worn in or behind the ear designed to amplify sound for individuals who have difficulty hearing) use were indicated in the care plan. These deficient practices had the potential to result in a delay of nursing care and medical interventions for Resident 67 due to language barrier and the potential for Resident 9's specific needs to not be met, and for facility staff to not monitor and evaluate the effectiveness for resident-centered care. Findings: 1. During a review of Resident 67's admission Record (AR), the AR indicated the facility originally admitted Resident 67 on 11/10/2021 and readmitted him on 11/27/2024 with diagnoses that included dementia (a group of thinking and social symptoms that interferes with daily functioning) and diabetes mellitus (a disease that result in too much sugar in the blood). The AR indicated Resident 67 ' s primary language was Korean. During a review of Resident 67's Minimum Data Set (MDS, a resident assessment tool), dated 5/1/2025, the MDS indicated Resident 67 ' s preferred language was Korean and needed or wanted an interpreter to communicate with a doctor or health care staff. The MDS indicated Resident 67 had severely impaired memory and cognition (ability to think and reason). The MDS indicated Resident 67 required supervision or touching assistance with eating, oral hygiene and chair/bed-to-chair transfer, partial/moderate assistance with shower/bathe self and personal hygiene, and substantial/maximal assistance with toileting hygiene. During an observation on 5/19/2025 at 11:52 PM, Resident 67 was observed in the facility lobby, sitting in his wheelchair. Resident 67 did not response when spoken to in English. During a concurrent interview and record review on 5/20/2025 at 11:35 PM with Registered Nurse (RN) 3, Resident 67 ' s Comprehensive Care Plan (CCP) was reviewed. RN 3 stated Resident 67 mainly spoke Korean and there was no CCP developed to address the language barrier of Resident 67. During an observation on 5/20/2025 at 2:00 PM, Resident 67 was sitting in the activity room. Resident 67 did not response when spoken to in English, however when the same question was asked to Resident 67 in Korean by the Social Services Director, Resident 67 responded. During an interview on 5/20/2025 at 2:21 PM with Family Member (FM) 1, FM 1 stated Resident 67 ' s primary language was Korean, and to avoid any confusion or misunderstanding, Resident 67 ' s preferred language was Korean. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/21/2025 at 8:58 AM with RN 2, Resident 67 ' s CCP was reviewed. RN 2 stated Resident 67 ' s preferred language was Korean and there was no CCP developed to indicate Resident 67 ' s language barrier. RN 2 stated a CCP should have been developed to address Resident 67 ' s language barrier to ensure better communication and to meet Resident 67 ' s specific needs. During an interview on 5/22/2025 at 1:41 PM with the Director of Nursing (DON), the DON stated a person-centered CCP should be developed and updated after a comprehensive assessment to address each resident's specific needs. The DON stated Resident 67 ' s language barrier should be included in the CCP to ensure good communication and smooth delivery of care to the resident. During a review of the facility ' s policies and procedures (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2023, the P&P indicated The comprehensive, person-centered care plan is developed within seven days of the completion of the required MDS assessment .and no more than 21 days after admission. The P&P also indicated The comprehensive, person-centered care plan .describes the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being and Services provided for or arranged by the facility and outlined in the comprehensive care plan are culturally competent. 2. During a review of Resident 9 ' s admission Record (AR), the AR indicated that Resident 9 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including end stage renal disease (ESRD-irreversible kidney failure), legal blindness (a status of severe vision loss granted by United States government), acquired absence of right leg below knee, and acquired absence of left leg above knee. During a review of Resident 9 ' s Order Summary Report, the Report indicated Resident 9 had a physician order on 10/5/2023 for audiology consult as needed for hearing problems. During a review of Resident 9 ' s Minimum Data Set (MDS - a resident assessment tool) dated 3/7/2025, the MDS indicated the following: 1. Resident 9 had difficulty in hearing and used a pair of HA, and Resident 9 ' s vision was severely impaired (no vision or sees only light, colors or shapes; eyes do not appear to follow objects). 2. Resident 9 was cognitively intact (a person has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the environment). 3. Resident 9 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) on eating and oral hygiene. 4. Resident 9 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 toileting hygiene, shower/ bathe self, and lower body dressing. During a review of Resident 9 ' s active Care Plan dated from 10/5/2023 to 5/19/2025, there was no comprehensive care plan developed for Resident 9 ' s impaired hearing and the utilization of HA. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 9 ' s Licensed Nurses Weekly Notes (LNN), dated from 3/8/2025 to 5/10/2025, the LNN indicated that Resident 9 ' s hearing was severely impaired and required the use of HA. During a concurrent observation and interview on 5/20/2025 at 12:45 PM with Resident 9 and CNA 2 in the resident ' s room, Resident 9 was alert, lying in bed, and had to raise his voice when speaking to CNA 2, who also had to raise her voice to communicate with Resident 9. Resident 9 stated he was not using his HA. Resident 9 stated, when he received his HA by Provider 2 on 3/6/2025, the background noise was disturbing him, so did not like to use his HA. Resident 9 stated, he was told to give the new HA a try for a few more days. Resident 9 stated, he tried his HA but two days later, he requested to return his HA because it did not work properly for him, and he also requested for an appointment with Provider 1. Resident 9 stated, he requested updates for his HA and appointments with Provider 1, however had not had any updates regarding his HA or appointment scheduled with Provider 1 to obtain a new HA. During the same concurrent observation and interview, on 5/20/2025 at 12:45 PM, CNA 2 stated Resident 9 was hard of hearing with impaired vision. CNA 2 stated, when speaking with Resident 9, facility staff needed to speak close and raiser their voice, so that Resident 9 could hear. During a concurrent interview and record review on 5/20/2025 at 3:20 PM with licensed vocational nurse (LVN) 4, Resident 9 ' s active care plan was reviewed. LVN 4 stated, Resident 9 was HOH and required the use of HA to communicate with the facility ' s staffs. LVN 4 stated, she could not find any care plan for Resident 9 ' s impaired hearing or for the use of his HA. LVN 4 stated, Resident 9 should have a care plan indicating Resident 9 ' s HOH and for the use a HA. During an interview on 5/21/2025 at 3:15 PM with the SSD, the SSD stated Resident 9 was HOH and legally blind. SSD stated, Resident 9 could not hear adequately without his HA. SSD stated, she did not know there was no comprehensive care plan developed for Resident 9 ' s impaired hearing. SSD stated, it was part of her responsibilities to participate in the interdisciplinary team (IDT) to ensure the facility develops and implements residents ' care plan. SSD stated Resident 9 should have had a Care Plan initiated indicating Resident 9 ' s use of a HA and for his impaired hearing. During an interview on 5/22/2025 at 3:50 PM with the Director of Nursing (DON), the DON stated that the licensed nurse or anyone in IDT should have developed a person-centered care plan for Resident 9 ' s impaired hearing, to ensure the problem was identified. The DON stated interventions should be specific to Resident 9 ' s hearing impairment and use of the HA to ensure Resident 9 ' s specific needs were met. During a review of the facility ' s Policy and Procedures (P&P) titled Care Plans, Comprehensive Person-Centered revised in 03/2023, the P&P indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed within seven days of the required MDS assessment, and implemented for each resident. The IDT, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan is derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, a person-centered care plan describes the services that are to be furnished to attain or maintain the highest practicable physical, mental, and psychosocial well-being, including which professional services are responsible for each element of care.

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F 0678 Level of Harm - Actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide immediate, effective and uninterrupted basic life support (BLS - a set of emergency medical procedures designed to maintain life in individuals experiencing cardiac arrest, respiratory failure, or other life-threatening conditions) and cardiopulmonary resuscitation (CPR) on [DATE] for one of three closed record sampled residents (Resident 119), who was identified full code in the facility and found unresponsive and not breathing, in accordance with the facility ' s P&P, by failing to: 1. Implement Resident 119 ' s Physician Orders for Life Sustaining Treatment (POLST, a written medical order from a physician, nurse practitioner, or a physician assistant which specifies what a patient ' s lifesaving treatment wishes are) according to the resident ' s preferences for life sustaining treatment. 2. Ensure LVN 8, LVN 9 and RN 4 activated the facility ' s emergency response system (code blue) and implemented BLS sequence of events (airway, breathing, chest compressions) and 911 emergency services (EMS) when Resident 119 was found unresponsive, not breathing, and oxygen saturation (a measure of how much oxygen the blood is carrying) fluctuating between 50% to 80 % on [DATE] between the hours of 7:45 PM to 8:11 PM. RN 4 called 911 EMS at 8:11 PM, 26 to 31 minutes after Resident 119 was reported unresponsive by FM 1 to LVN 9 on [DATE], in accordance with the facility ' s policy and procedure (P&P) on CPR. 3. Ensure RN 4, LVN 8, and LVN 9 performed effective and continuous CPR. RN 4 stated she performed CPR by rubbing Resident 119 ' s chest gently in a circular motion rather than performing chest compressions and mouth to mouth [rescue breaths - by breathing into another person's lungs [rescue breathing], to supply enough oxygen to preserve life] breathing at a ratio of 30:2 compressions-to-breaths or chest compressions at a rate of 100 to 120 per minute and to a depth of at least 2 inches (5 cm) until 911 EMS arrive and take over, in accordance with professional standard of practice specified by the American Heart Association, on [DATE], during the code blue. As a result of these deficient practices, 911 EMS arrived at the facility on [DATE] at 8:18 PM and found the resident Dead prior to Arrival (DOA) of the EMS. The EMS Report indicated DOA/Obvious Death and No care or support services required. The EMS Report further indicated Resident 119 was found by 911 EMS personnel on [DATE] as unresponsive, both eyes dilated, absent breath sounds to both lungs, skin was clammy and showed signs of lividity (a process where blood pools in the lowest parts of the body after the heart stops pumping that typically begins to appear within 30 minutes to an hour after death. Lividity is noticeable by the human eye within 1 to 2 hours after death). Cross referenced to F695 and F842. Findings: (continued on next page)

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F 0678 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 119 ' s admission Record (AR), the AR indicated Resident 119 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), acute respiratory failure with hypoxia, and chronic obstructive pulmonary disease (COPD, lung disease causing restricted airflow and breathing problems) with (acute) exacerbation (worsening of a disease or an increase in its symptoms). During a review of Resident 119 ' s care plan titled Oxygen, Resident is receiving Oxygen Therapy due to Acute Respiratory failure and COPD Exacerbation dated [DATE] indicated to monitor oxygen saturation as ordered, notify physician for any significant change, and to provide oxygen as ordered. During a review of a care plan initiated for Resident 119 on [DATE] and revised on [DATE], the care plan titled Resident [119] was transferred to the acute hospital secondary to desaturation and altered mental status, indicated a goal with a target date of [DATE] of reducing the risk of further complications until the next assessment. The care plan interventions indicated applying oxygen as needed, assess the resident ' s level of consciousness, call 911 as needed, monitor oxygen saturations, monitor vital signs and initiate CPR if indicated During a review of Resident 119 ' s care plan dated [DATE] and revised on [DATE], titled Resident is at risk for respiratory distress (shortness of breath (SOB), irregular respiration, wheezing/crackles, rhonchi, activity intolerance, edema) related to COPD, the care plan indicated goals that resident would have no unrecognized signs and/or symptoms of respiratory distress and would reduce episodes and symptoms of respiratory distress thru appropriate interventions daily through the next assessment. The care plan indicated to assess the resident for shortness of breath (SOB), irregular respiration, wheezing, crackles, rhonchi, coughing, weakness, activity intolerance, excessive secretions, and to inform physician promptly. During a review of Resident 119 ' s POLST, dated [DATE] indicated Resident 119 was full code (resident ' s heart stopped beating and/or the resident stopped breathing, the resident or their representative wishes for all lifesaving procedures to be provided to keep them alive). During a review of Resident 119 ' s previous admission to a General Acute Care Hospital (GACH) 1 from the facility, the GACH 1 History and Physical (H&P) dated [DATE] indicated the resident presented to the emergency room from the facility for symptoms of respiratory distress. The GACH 1 H&P indicated in the emergency room Resident 119 was hypoxic at 88% with blood pressure of 54/32 and was also febrile with a temperature of 101 degrees. The GACH 1 H&P indicated Resident 119 was subsequently intubated for hypoxic respiratory failure and had lactic acidosis as well as leukocytosis and initial chest x-ray was unremarkable. The GACH 1 H&P indicated Resident 119 was started on broad-spectrum intravenous (IV) antibiotics for presumed healthcare associated pneumonia. The GACH 1 H&P indicated Resident 119 was septic on admission. During a review of GACH 1 Discharge Summary (undated), the GACH 1 Discharge Summary indicated Resident 119 was admitted to GACH 1 on [DATE] and discharged from GACH 1 on [DATE] with discharge primary diagnoses that included but not limited to acute hypoxic respiratory failure status post [s/p] intubation, suspected healthcare associated pneumonia, severe sepsis with shock, acute COPD exacerbation, NSTEMI and left pleural effusion s/p thoracentesis. The Discharge Summary indicated that pulmonary and cardiology GACH 1 physician had cleared Resident 119 for discharge from GACH 1 back to the facility. (continued on next page)

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F 0678 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 119 ' s physician orders, the order indicated Resident 119 was readmitted back to the facility from GACH 1 on [DATE]. The physician admission orders included Attempt Resuscitation (CPR). During a review of Resident 119 ' s Order Summary Report dated [DATE], the report indicated a physician order to administer Oxygen at 2L per minute via nasal cannula, may titrate up to 4L per minute for oxygen saturation less than 90% every shift. During a review of Resident 119 ' s History and Physical (H&P), dated [DATE], the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 119 ' s Change of Condition (COC)/Interact Assessment Form dated [DATE] timed at 8:23 PM, the COC indicated during rounds at 8 PM, Resident 119 ' s oxygen saturation level was found to be 90% while on 2L of oxygen with no respiratory distress. The COC indicated Resident 119 ' s oxygen was titrated up to 5L per physician order and the oxygen level came up to 97%. During a review of the Fire Department (FD) Paramedics (911 EMS) Report dated [DATE], the report indicated the facility called 911 EMS on [DATE] timed at 8:11 PM and dispatch complaint of cardiac arrest. The FD Report further indicated FD paramedics arrived at the facility at 8:18 PM (9 minutes) and at Resident 119 ' s room at 8:20 PM (2 minutes). The FD Report under Disposition indicated Resident 119 was dead prior to arrival (DOA). The FD Report indicated Resident 119 was evaluated by the FD paramedics and further indicated No care or support services required. the FD Report indicated no transport was made to the acute hospital due to the resident being DOA. The FD Report under Patient Assessment further indicated Resident 119 ' s Distress Level as Severe. The FD Report under Primary Impression indicated as DOA/Obvious death. The FD Report indicated on [DATE] timed at 8:22 PM, further physical assessment was performed by the paramedics and showed Resident 119 as unresponsive, both eyes dilated, absent breath sounds to both lungs, skin was clammy and showed signs of lividity. The FD Report Narrative indicated Patient determined to be dead (pronounced dead) at 8:23 PM. Patient found by staff in bed unresponsive. Compressions only CPR provided by staff, no BVM. Patient found pulseless, non-breathing, unresponsive at FD arrival, no lung sounds or heart tones, no response to painful stimuli, pupils fixed and dilated, lividity to lower back and legs, no obvious trauma. Per staff patient last seen alive 2-3 hours ago. No complaints prior, per staff patient bedridden. During a review of Resident 119 ' s Certificate of Death (COD) signed by the physician on [DATE], the COD indicated Resident 119 ' s date of death was [DATE]. The COD indicated Resident 119 ' s immediate cause of death (final disease or condition resulting in death) was cardiopulmonary arrest. The COD indicated Resident 119 ' s underlying cause of death (disease or injury that initiated the event resulting in death) was COPD. During a review of RN 4, LVN 8 and LVN 9 ' s CPR cards, the cards indicated RN 4, LVN 8 and LVN 9 had up to date and successful completion of CPR/Basic Life Support training. (continued on next page)

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F 0678 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 11:48 AM, Licensed Vocational Nurse (LVN) 8 stated she was the charge nurse assigned to Resident 119 on [DATE]. LVN 8 stated she made her resident rounds (regular visits made by nurses to check on their patients and assess their progress, well-being and safety) before she took her break at 7:30 to 8:00 PM and observed Resident 119 was stable. LVN 8 stated before she left for her lunch break at 7:30 PM, Resident 119 ' s oxygen saturation was fluctuating between 90 to 93% with continuous oxygen at 2 liters via nasal cannula. LVN 8 stated before she left for her break, Resident 119 was able to open eyes when called by name and mouth breathing was shallow. LVN 8 stated she could not recall the color of Resident 119 ' s skin, but appeared weak and tired. LVN 8 stated when she came back from her break at around 8:06 PM, she observed LVN 9 rushing to Resident 119 ' s room and Registered Nurse (RN) 4 was at the Nursing Station calling 911 EMS preparing paperwork for Resident 119 ' s possible transfer to GACH. LVN 8 stated she was informed by LVN 9 that there was an emergency going on with Resident 119. LVN 8 stated Resident 119's blood pressure was fluctuating two days ago and was on the low side with a systolic blood pressure reading about 80 mm/hg. LVN 8 stated Resident 119 appeared weaker during this current readmission to the facility ([DATE]). During the same interview on [DATE] at 12:04 PM, LVN 8 stated Resident 119's usual blood pressure from readmission was as low as 80/40 mm/hg and as high as 90 mm/hg. LVN 8 stated she would only document the good number in Resident 119 ' s electronic records, because if she wrote the bad number she would be questioned (by facility leadership). LVN 8 stated she thought the physician was aware of Resident 119 ' s fluctuating blood pressure. LVN 8 stated when she arrived on her shift on [DATE] at around 3 PM to 3:30 PM, Resident 119 ' s blood pressure was around 80/40 mm/hg and on the low side. LVN 8 stated she could not recall the other blood pressure readings Resident 119 had, but she reported to RN 4 the fluctuating blood pressures results of Resident 119. LVN 8 stated RN 4 informed her to monitor Resident 119 ' s blood pressure because the resident was just readmitted back from GACH 1 recently. LVN 8 stated she did not document Resident 119's fluctuating blood pressure. LVN 8 stated before she left for break, she endorsed to LVN 9 that at the time she did not see any sudden change of condition resident was at baseline. During the same interview on [DATE] at 12:44 PM, LVN 8 stated when she returned from her break at 8:06 PM, she did not hear any overhead page of Code Blue (the facility ' s emergency response system that signifies a medical emergency, specifically a cardiac or respiratory arrest, requiring immediate resuscitation efforts) being called. LVN 8 stated she followed LVN 9 to Resident 119 ' s room and checked Resident 119 ' s vital signs (essential physiological measurements that indicate a person's basic bodily functions and overall health). LVN 8 stated LVN 9 left Resident 119 ' s room. LVN 8 stated Resident 119 ' s oxygen saturation was fluctuating between 70 % to 80%, blood pressure was lower around 70/40 mm/hg more or less. LVN 8 stated she could not recall Resident 119 ' s heart rate. LVN 8 stated she did not know what Resident 119 ' s code status and she (LVN 8) stood by Resident 119 ' s door to ask RN 4 (who was at the Nursing Station) if Resident 119 was a full code or DNR. LVN 8 stated she could not recall exactly what time or what RN 4 brought into Resident 119 ' s room when RN 4 came back to the room. LVN 8 stated Resident 119 was on nasal cannula, and she increased Resident 119 ' s oxygen to 6 to 8 liters via nonrebreather mask (a device that gives you oxygen, usually in an emergency). LVN 8 could not recall who put the mask on Resident 119. LVN 8 stated she could not recall any staff performing CPR on Resident 119. LVN 8 stated RN 4 wanted to do CPR but could not recall if RN 4 started CPR. LVN 8 stated 911 EMS took care over shortly after RN 4 came into the room. (continued on next page)

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	055181	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Conv Center	8035 E Hill Drive Rosemead, CA 91770

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F 0678 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview with Resident 119 ' s family member (FM) 1 on [DATE] at 8:43 AM, FM 1 stated he and a friend arrived at the facility on [DATE] at around 7:40 PM and noticed there was something strange with Resident 119. FM 1 stated he comes to the facility every day, at least twice a day and Resident 119 was usually awake with eyes opened and would look at him but was nonverbal. FM 1 stated on [DATE], Resident 119 was not awake despite being called and not responding. FM 1 stated Resident 119 was not breathing through his mouth, and his eyes were closed. FM 1 stated after waiting for about 5 minutes (7:45 PM) trying to wake up Resident 119, FM 1 stated they call the nurse into the room. FM 1 stated he came out to the Nursing Station to call the nurse; the licensed nurse came in and checked the vital signs and told him Everything was low including the blood pressure. FM 1 stated he believed the nurse told him Resident 119 ' s oxygen level was below 50%. FM 1 stated he could not recall if the vital signs machine showed any numbers because he was so worried and focused on Resident 119. FM 1 stated he only recalled that the nurse told him everything was low, and oxygen level (oxygen saturation) was below 50%. FM 1 stated he could not recall who the nurse was, but he witnessed the nurse help Resident 119 with breathing using a mask, but it was not effective. FM 1 stated he could not recall if the nurses ' provided CPR because he was only focused on Resident 119. FM 1 stated he saw about 2 nurses in and out of the room, before 911 arrived. During a telephone interview with LVN 9 on [DATE] at 9:37 AM, LVN 9 stated Resident 119 ' s family member (FM) 1 came to him and said [Resident 119] did not seem right. LVN 9 stated he went over to Resident 119 ' s room to check and the resident ' s blood pressure was 100/50 mm/hg. LVN 9 stated he could not recall Resident 119 ' s oxygen saturation level, but it was within normal range between 90 to 93%. LVN 9 stated he could not recall if he told FM 1 about Resident 119 ' s blood pressure and oxygen levels. LVN 9 stated at the time, Resident 119 did not respond to verbal stimuli but was breathing. LVN 9 stated Resident 119 ' s mouth was closed and appeared to be sleeping but was difficult to arouse. LVN 9 stated he called RN 4. LVN 9 stated RN 4 went into the room and about the same time, LVN 8 returned from her break. LVN 9 stated LVN 8 took over and brought a new blood pressure cuff and pulse oximeter machine (an electronic device that measures the saturation of oxygen carried in your red blood cells). LVN 9 stated Resident 119 was still unresponsive. LVN 9 stated he could not recall the resident ' s vital signs. LVN 9 stated RN 4 left the room to call 911 and to check Resident 119's documented code status. LVN 9 stated he could not recall if the crash cart was brought inside the room or if a code blue was called. LVN 9 stated he told RN 4 about Resident 119 ' s oxygen saturation was low because anything below 95% should be reported especially because Resident 119 had COPD. LVN 9 stated Resident 119 was wearing a nasal cannula at the time and could not recall how many liters of oxygen was given. LVN 9 stated he could not find Resident 119's POLST at that time so they treated it as a full code. LVN 9 stated he saw RN 4 doing compressions, but did not stay in Resident 119 ' s room the whole time. LVN 9 stated he could not recall if RN 4 used the backboard while doing compressions. LVN 9 stated he left Resident 119 ' s room to clear the hallway because the EMS arrived a few minutes after RN 4 called 911. LVN 9 stated Resident 119 ' s family members were at the bedside. During a telephone interview with LVN 9 on [DATE] at 10:09 AM, LVN 9 stated when he returned to Resident 119's room after checking resident's code status he saw RN 4 performing CPR on Resident 119. LVN 9 stated he stood by Resident 119 ' s door and RN 4 was on one side of the bed because the other side of resident's bed was next to a wall. LVN 9 stated he saw both of RN 4's hands on Resident 119 ' s chest. LVN 9 stated he could not recall when CPR was initiated to Resident 119 by RN 4. LVN 9 stated LVN 8 was standing next to Resident 119 ' s bed with RN 4. LVN 9 could not recall if LVN 8 was assisting RN 4 with CPR. (continued on next page)

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F 0678 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview with Physician 1 on [DATE] at 12:55 PM, Physician 1 stated he could not recall specifically if he was notified of Resident 119 ' s change of condition on [DATE]. Physician 1 stated usually nurses would notify the physician if a resident ' s blood pressure went below expected or if there was a change in a resident's status. Physician 1 stated if resident's blood pressure was unstable I would send him [Resident 119] to emergency room and according to family wishes. During another interview on [DATE] at 9:42 AM, RN 4 stated on [DATE] at 8 PM, she had already left Resident 119 ' s room and was going to other rooms when LVN 8 grabbed her to go back to Resident 119 ' s room. RN 4 stated when she conducted her 8 PM rounds, Resident 119 looked okay and blood pressure and heart rate were within normal limits at 100/53. RN 4 stated she did not document the vital signs on the facility ' s online charting system. RN 4 stated in the presence of LVN 8, Resident 119 ' s oxygen saturation was 90%. RN 4 stated she titrated the oxygen to 5 liters to keep the oxygen level above 97%. RN 4 stated everything happened within a twinkle of an eye. RN 4 stated when LVN 8 showed her Resident 119 ' s oxygen saturation at 90%, RN 4 rushed out of the room to get her own pulse oximeter. RN 4 stated Resident 119 ' s oxygen saturation level was not steady at 90% and desatting. RN 4 was asked what desatting means and RN 4 stated desatting meant Resident 119 ' s oxygen saturation level was fluctuating and was going below 90%. RN 4 stated everything happened fast and before increasing Resident 119 ' s oxygen rate, Resident 119 ' s oxygen saturation level was around 86 % to 88% which raised a concern. RN 4 stated she rushed out of the room and called 911 and Physician 1. RN 4 stated when she returned to Resident 119 ' s room she started to perform a chest maneuver with Resident 119. RN 4 stated a chest maneuver was like a scrub. RN 4 stated when the 911 EMS arrived Resident 119 ' s oxygen saturation level was at 97%. RN 4 stated when she called 911 EMS, she also called an overhead page Code CPR or Code Blue. RN 4 stated she called the Code Blue at the time Resident 119 ' s oxygen saturation level was 86 to 88%. RN 4 stated Resident 119 ' s oxygen saturation was fluctuating and at that time the heart rate was also fluctuating it was not one value, 110 to 115 and 97 to 99 [beats/minute] and was just fluctuating in the high-low. RN 4 stated she could not recall if Resident 119 ' s heart rate went lower than 97 beats/minute. (continued on next page)

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F 0678 Level of Harm - Actual harm Residents Affected - Few	During the same interview on [DATE] at 9:42 AM, RN 4 stated Resident 119 ' s appearance was Still the same, open eyes and open mouth, he [Resident 119] does not talk. RN 4 stated she performed the chest rub to Resident 119 because the heart rate and oxygen was going up and down. RN 4 stated she changed Resident 119 ' s nasal cannula to a mask. RN 4 stated the crash cart was always there, in front of Resident 119 ' s room and she just grabbed the mask and went inside resident ' s room. RN 4 stated she grabbed the mask with the bag (non-rebreather mask). RN 4 stated when she returned to Resident 119 ' s room she and LVN 8 tried moving and repositioning Resident 119. RN 4 stated that after placing the resident at 5liters of oxygen, she performed the Valsalva maneuver (a breathing technique that involves pinching your nose and breathing out forcefully with the mouth closed) because Resident 119 ' s Heart rate, blood pressure was getting low, and heart rate was going up, both fluctuating. The resident ' s oxygen was up and down. RN 4 stated that together with LVN 8, they were doing the Chest maneuver/compression. RN 4 demonstrated with her one hand how she performed the chest maneuver/compression in circulation motion to Resident 119 ' s chest area and further stated she was rubbing in a circular, gentle pressing around the [resident ' s] chest area. RN 4 stated she did not know what the exact medical term was with the procedure she performed. RN 4 stated when the 911 EMS arrived, the EMS performed their own care. RN 4 stated the 911 EMS pronounced Resident 119 dead at 8:23 PM. RN 4 stated RN 4, LVN 8, and Resident 119 ' s family were at bedside during that time. RN 4 stated she thought the other licensed nurses working that day were in Resident 119 ' s room when she was performing CPR but could not recall exactly who was in the room, but they were helping. RN 4 stated none of the other licensed nurses were involved during the code blue the whole time because they had their own residents. RN 4 stated she could not recall what everyone was doing during the CPR because it was crazy. During the same interview on [DATE] at 10:37 AM, RN 4 stated she was sure LVN 8 was in Resident 119 ' s room and a certified nursing assistant (CNA) was outside the door. RN 4 stated the CNA provided resident ' s belongings during that time. RN 4 stated it did not take long for the 911 EMS to arrive from the time she called 911. RN 4 stated Resident 119 was still breathing before and when the 911 EMS arrived. RN 4 stated she took Resident 119 ' s vital signs and it was the last one she entered in Resident 1 ' s electronic records. RN 4 stated before the paramedics arrived, Resident 119 had a blood pressure and a pulse. RN 4 stated when the 911 EMS arrived Resident 119 was still alive. RN 4 stated the 911 EMS brought their equipment. RN 4 stated she stepped aside when the EMS came. RN 4 stated she did not see what the EMS did. During the same interview on [DATE] at 10:45 AM, RN 4 stated she could not recall if LVN 8 notified her of Resident 119 ' s fluctuating blood pressure. RN 4 stated around 3 to 3:30 PM on [DATE], Resident 119 ' s blood pressure was not fluctuating. RN 4 stated LVN 8 only notified her about Resident 119 ' s oxygen saturation at 90% around 8 PM. RN 4 stated there was nothing alarming between 3 PM to 8 PM. RN 4 stated if Resident 119 had a change of condition like blood pressure going high or going low, she would assess the resident first, if assessment was abnormal she would call 911 immediately and notify physician before calling the family. At 8 PM, RN 4 stated LVN 8 grabbed her and said, come and see the oxygen. RN 4 stated when she came to Resident 119 ' s room, that was when she saw Resident 119 ' s oxygen was 90%, so she went to grab her own pulse oximeter, and Resident 119 ' s oxygen saturation was even lower than 90 % and was 85 to 86 %. RN 4 stated that was when she rushed to the Nurses Station then went back to the resident ' s room and started performing the chest maneuver to Resident 119. (continued on next page)

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F 0678 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 119 ' s Change of Condition on [DATE] at 10:52 AM, RN 4 stated CPR was initiated because she saw Resident 119 ' s oxygen and blood pressure was getting low. RN 4 stated she had already called 911. RN 4 stated CPR was cardiopulmonary resuscitation. RN 4 stated the nurse have to check if resident was full code, then check the pulse, you can start CPR if there is still a pulse. RN 4 demonstrated CPR and stated you interlock hands make sure you press 1 to 2 inches deep about 100 to 120 times per minute, on the chest around the apex of the heart and if you are comfortable you can give mouth to mouth and I did not give breaths. RN 4 stated Resident 119 was breathing, He [Resident 119] was breathing all through until the last minute. RN 4 stated she started chest compressions when the resident ' s oxygen was low at 85 to 86%. RN 4 stated She was doing both chest rub and chest compressions at the same time. RN 4 stated she and LVN 8 were doing both at the same time, alternating chest rub and chest compressions. RN 4 stated the chest rub worked better. RN 4 stated she checked Resident 119 ' s wrist for pulse and it was present. RN 4 stated Resident 119 was desatting [short term for desaturate [oxygen levels are dropping]) which was why she started chest compressions. RN 4 stated Resident 119 ' s pulse was very low, and she still performed chest compressions. RN 4 stated she did not give Resident 119 rescue breaths and that no one did rescue breaths because i was focusing on chest more. RN 4 stated after calling 911 everything was going down. RN 4 stated the paramedics arrived already. RN 4 stated the vital signs were not going low at that time like 90 something, that was the last thing i wrote down. RN 4 confirmed she did not document the abnormal findings and details about what happened when Resident 119 was found unresponsive. RN 4 stated there was no reason why she did not include Resident 119 ' s abnormal vital signs. RN 4stated she did not document of PCC the abnormal vitals, it was important to include the abnormal findings on the note, for reference to compare. RN 4 stated the abnormal findings should be documented. During an interview on [DATE] at 3:32 PM, the Director of Nursing (DON) stated if staff find a resident unresponsive, they must take vital signs right away, call for help (emergency) call code, and 911. The DON stated there should be a team around and the nurse should start delegating tasks to each staff member like checking resident ' s chart for POLST, notifying family, calling 911, and overhead page the code. The DON stated if staff should check if resident has a pulse and should palpate for a pulse. The DON stated there should be a Crash Cart as soon as the code is called, anyone like the CNAs could bring the crash cart to the resident's room. The DON stated the backboard should be ready to place underneath the resident and if resident has a low air loss mattress staff should deflate it. The DON stated someone should bring oxygen tank and Ambu bag. The DON stated staff should continue CPR if no pulse is found and should administer breaths as well. The DON stated giving breaths is not an option, the Ambu bag should be used. The DON stated staff should not stop CPR until paramedics are in the building. The DON stated chest sternal rub was not compressions. The DON stated the purpose of compressions was to have the heart pump the blood to get to the brain and organs, to stimulate the heart by manually pumping the heart. The DON stated an interruption or stop in compressions would interrupt blood flow to the heart and staff should continue CPR as long as resident has no pulse. During a review of the facility ' s undated policy and procedure (P&P) titled CPR, the P&P indicated prior to the arrival of EMS, the facility would provide CPR as indicated/needed when a resident suffers a cardiopulmonary arrest, unless this is contraindicated by advance directives. The P&P indicated if there are no signs of life that include lack of respirations, apical pulse, blood pressure and/or pupillary accommodation to light, the CPR-certified licensed nurse will initiate CPR and call the paramedics. (continued on next page)

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F 0678 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility ' s undated P&P titled Emergency Procedure-Cardiopulmonary Resuscitation indicated if an individual is found unresponsive, briefly assess for abnormal or absence of breathing, if sudden cardiac arrest is likely begin CPR: (1) instruct a staff member to activate the emergency response system (code blue) and call 911; (2) verify or instruct a staff member to verify the DNR (do no resuscitate) or code status of the individual; (3) initiate the basic life support (BLS) sequence of events; (4) The BLS sequence of events is referred to as C-A-B (chest compressions, airway, breathing). The P&P indicated when performing chest compressions: push hard to a depth of at least 2 inches (5 cm) at a rate of at least 100 compressions per minute; allow full chest recoil after each compression; and minimize interruptions in chest compressions. The P&P indicated to tilt resident ' s head back and lift chin to clear the airway. The P&P indicated after 30 chest compressions provide 2 breaths via ambu bag or manually (with CPR shield). The P&P indicated all rescuers, trained or not, should provide compressions to victims of cardiac arrest and trained rescuers should also provide ventilations with a compression-ventilation ratio of 30:2. The P&P indicated to continue with CPR/BLS until emergency medical personnel arrive. During a review of a resource reference published at the American Heart Association website titled CPR: Cardiopulmonary Resuscitation - Science Based Guidelines, the resource indicated how CPR is performed and indicated For healthcare providers and those trained: conventional CPR using chest compressions and mouth-to-mouth breathing at a ratio of 30:2 compressions-to-breaths. In adult victims of cardiac arrest, it is reasonable for rescuers to perform chest compressions at a rate of 100 to 120/min and to a depth of at least 2 inches (5 cm) for an average adult, while avoiding excessive chest compression depths (greater than 2.4 inches [6 cm]). The resource further indicated for Hands-Only CPR, it consists of two easy steps and indicated to Call 9-1-1 (or send someone to do that) and push hard and fast in the center of the chest.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of seven sampled residents (Resident 3), received restorative nursing treatment (nursing interventions that help people maintain or regain their ability to perform daily activities after an illness, injury, or surgery) that included application of left ankle-foot orthosis [AFO - a device worn on the foot and ankle to support and control movement, often used to help with walking, improve stability, or correct foot drop (a condition where it's difficult to lift the front part of the foot and toes, often causing them to drag during walking)] from 5/16/2025 to 5/22/2025 (total of 7 days) and application of left resting hand splint from 5/20/2025 to 5/22/2025 (total of 3 days) as ordered by Resident 3 ' s physician on 3/5/2025. This failure had the potential to result in Resident 3 further decline in range of motion (ROM, movement of the joints) and foot drop. Findings: During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 1/18/2016 and readmitted on [DATE] with diagnoses that included hemiplegia (paralysis of one side of the body), affecting left nondominant side, left hand contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints), and left ankle contracture. During a review of Resident 3 ' s Minimal Data Set (MDS-resident assessment tool), dated 4/29/2025, the MDS indicated Resident 3 ' s cognition (ability to think, remember, and reason) was moderately impaired and needed maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) in personal hygiene. During a review of Resident 3 ' s Order Summary Report (OSR), the OSR indicated on 3/5/2025, Resident 3 had a physician order for restorative nursing assistant (RNA) assisted exercises that included PROM exercises (passive range of motion - moving a joint through its full range of motion by someone or something else, without the individual actively using their muscles) on LLE (left lower extremity) followed by application of left AFO for 4 hours a day, 7 times per week as tolerated. The OSR also indicated Resident 3 had a physician order for PROM exercises on LUE (left upper extremity) followed by application of the left resting hand splint for 4 hours daily 7 times per week as tolerated. During a review of Resident 3 ' s Care plan, dated 3/5/2025, the Care Plan indicated Resident 3 was at risk for further development of contractures due to sequela (a condition which is the consequence of a previous disease or injury) of CVA (cerebrovascular accident, or stroke - damage to the brain from interruption of its blood supply) with left hemiparesis (weakness or the inability to move on one side of the body) and decrease mobility with the interventions that included to provide restorative nursing treatment as ordered by the physician: RNA for PROM exercises on LLE followed by application of left AFO for 4 hours a day, 7 days per week as tolerated, and RNA for PROM exercises on LUE followed by application of left resting hand splint for 4 hours a day, 7 days per week as tolerated. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3 ' s Documentation Survey Report V2 for the month of May 2025, the Report indicated for no RNA to the right lower extremity (RLE) and application for left AFO provided from 5/16/2025 to 5/22/2025. During a concurrent observation and interview on 5/20/2025 at 9:32 AM with Resident 3 in her room, Resident 3 stated her left side was weak and was not able to move her LUE and LLE. Resident 3 did not have a splint placed on her LUE and no AFO on her LLE. Resident 3 stated, she usually had a splint on her left hand and an AFO on her left foot but had not have them on in the last few days. During a concurrent observation and interview on 5/22/2025 at 11:15 AM with Resident 3 in her room, Resident 3 did not have a splint placed on her LUE and no AFO to her LLE. Resident 3 stated, she still did not have any splint on her left hand and any AFO on her left foot. Resident 3 stated, the last time she had a splint on her LUE and an AFO on her LLE was a few days ago. During a concurrent observation and interview on 5/22/2025 at 12:45 PM with RNA 1 in Resident 3 ' s room, Resident 3 had no splint on her LUE and no application of AFO on her LLE. RNA 1 stated, she usually placed the splint and the AFO on Resident 3 around 10-10:30 AM daily. RNA 1 could not state why Resident 3 ' s splint and AFO was not placed on Resident 3. During an interview on 5/22/2025 at 1 PM with CNA 5, CNA 5 stated, Resident 3 did not have any splint on her LUE or any AFO on her LLE since she started her shift at 7 AM. CNA 5 stated, she could not recall the last time Resident 3 had the splint on her LUE and the AFO on LLE. During an interview on 5/23/2025 at 2:20 PM with the Director of Physical Therapy (DPT), the DPT stated, it was important that RNA followed the physician ' s order to apply the splint onto Resident 3 ' s LUE and AFO on the LLE because to prevent further decline in ROM and foot drop. During a review of the facility ' s policy and procedure (P&P) titled, Restorative Nursing Services, revised July 2017, the P&P indicated, residents will receive restorative nursing care as needed to help promote optimal safety and independence. Restorative goals and objectives are individualized and resident-centered and are outlined in the resident ' s plan of care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an environment free of hazard for one of four sampled residents (Resident 107), who was at risk for fall due to dementia [the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities] and had a history of recent fall on 3/14/2025, by failing to: 1. Ensure that CNA 1 placed a call light within Resident 107 ' s reach as indicated in the resident ' s care plan, when CNA 1 took Resident 107 back to the resident ' s room and left the resident alone in the wheelchair. 2. Ensure LVN 3 and LVN 4 placed a floor mat in accordance with Resident 107's physician's orders dated 3/11/2025 after the room was deep cleaned prior to the resident returned to bed. This failure had the potential to result in serious physical injury and compromise both the resident ' s safety and quality of care. Findings: During a reviewed of Resident 107's admission Record (AR), the AR indicated that Resident 107 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 107's Physician Order, dated 3/11/2025, the order indicated to keep low bed with floor mat to decrease potential injury every shift. During a review of Resident 107's History and Physical (H&P), dated 3/13/2025, indicated Resident 107 did not have the capacity to understand and make decisions. During a review of Resident 107's Care Plan dated 3/13/2025, the care plan indicated Falling Star Program due to at risk for fall, and the interventions included to attach call light to within access of resident. During a review of Resident 107's SBAR (Situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 3/14/2025, the SBAR the SBAR indicated that Resident 107 slid off the bed, found on the floor on the right side and was unwitnessed with no injury noted. During a review of Resident 107's Fall Risk Assessment (FRA), dated 3/14/2025, the FRA indicated that Resident 107 was at high risk for fall due to intermittent (occasional) confusion, poor safety awareness, current fall, elimination (bowel and bladder) status incontinent (no control), and unable to stand without assistance/ unsteady gait. (continued on next page)

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San Gabriel Conv Center	8035 E Hill Drive Rosemead, CA 91770

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 107's Minimum Data Set (MDS- a resident assessment tool), dated 4/11/2025, the MDS indicated that Resident 107 was cognitively severely impaired (never/rarely made decisions). The MDS indicated that Resident 107 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) on rolling left and right. The MDS indicated Resident 107 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 sit to lying and lying to sitting on the side of bed. During an observation on 5/19/2025 at 12:15 PM, CNA 1 took Resident 107 back into the resident's room, and stepped out to assist other residents, leaving Resident 107 alone in the room. A star sign was noted on the wall of Resident 107's head of bed. During an observation and concurrent interview on 5/19/2025 at 12:55 PM with LVN 4 in the room with Resident 107, Resident 107 was observed sitting in wheelchair finishing lunch. LVN 4 stated the call light was not within access to the resident. LVN 4 stated Resident 107 should be provided with a call light within reach at all times for the resident to call for help if needed. LVN 4 also stated the staff that took Resident 107 back to room should have made sure call light was provided to the resident before leaving. During an observation and concurrent interview on 5/19/2025 at 3:15 PM with LVN 3 in the room with Resident 107, LVN 3 stated that Resident 107 was at fall risk due to dementia and history of fall, currently was in the Falling star program. LVN 3 stated there was no floor mat placed next to Resident 107, but it should have been there to prevent serious injury for the resident as ordered by the physician. During an interview on 5/22/2025 at 3:40 PM with the Director of Nursing (DON), DON stated that Resident 107 was on Falling Star Program or Super Star Program due to Parkinson's Disease and history of fall. DON stated nursing staffs are responsible to ensure fall precaution interventions were implemented such as to keep call light within resident's reach when the resident was in the bed or sitting down in the chair at bedside, to keep low bed position, and make sure floor mat(s) is in place as ordered. During a review During a review of the facility's Policy and Procedure (P&P) titled Super Star Program undated, indicated the following: 1. Policy: The Super Star Program is for residents who are severely high risk for falls and injuries. 2. Background: This special program is for residents who have a score of 8 (eight) or above on the Fall Risk Assessment and any of the following: a. History of falls b. History of neurological conditions; e.g. Parkinsonism c. New admission (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Procedure: a. Low bed with mat and padding. b. Thin floor mats at key locations, e.g. around bed, as appropriate. c. In-service to staff on both Falling Star and Super Star Program.

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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 observation, interview, and record review, the facility failed to provide necessary care and services to one of three residents (Resident 76) with an indwelling catheter (a device that drains urine [pee] from urinary bladder into a collection bag outside of body) by failing to: 1. Follow the facility ' s Policy and Procedure (P&P) titled Fluid Intake& Output (I&O) to evaluate Resident 76 for the need of continue monitoring and documenting the resident ' s I&O at the completion of the 30-day period. 2. Monitor and document findings of Resident 76 ' s bladder distention (swelling or enlargement of the bladder due to an inability to empty it completely or a buildup of urine) as indicated in Resident 76 ' s physician ' s orders and care plan. The deficient practices had the potential to increase risk for recurring Urinary Tract Infection (UTI- an infection in the bladder/urinary tract) that could lead to a decline in the resident ' s well-being. Findings: During a review of Resident 76 ' s admission Record (AR), the AR indicated that Resident 76 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses including UTI, obstructive and reflux uropathy (a condition in which the flow of urine is blocked and backward from the bladder into a ureter and toward a kidney), benign prostatic hyperplasia [BPH, a benign (not cancer) condition in which the prostate gland (a gland in the male reproductive system) is larger than normal] with lower urinary tract symptoms, retention of urine, and chronic respiratory failure (a long-term condition in which the breathing system is unable to adequately exchange oxygen and carbon dioxide in the body) with hypoxia (low levels of oxygen in your body tissues). During a review of Resident 76 ' s Care Plan (CP), revised 11/14/2024, the CP indicated Resident 76 was at risk for alteration in urinary elimination and at risk for UTI secondary to use of indwelling catheter due to obstructive uropathy. The CP indicated the goal was Resident 76 ' s bladder will be adequately emptied without complication as evidenced by no bladder distention. The CP indicated interventions that included to monitor Resident 76 ' s urine for sediment (solid substance in the urine), cloudiness, odor, blood, and amount of output, to notify MD if decreased or no urine output, and to observe abdomen for distention to rule out urinary retention. During a review of Resident 76 ' s General Acute Care Hospital (GACH)1 ' s Discharge Summary Notes, dated 3/28/2025, indicated Resident 76 was admitted on [DATE] with severe sepsis (a life-threatening blood infection) including UTI and bacteremia (bacteria in the bloodstream) with multiple organisms growing in the cultures. The DS also indicated Resident 76 was discharged with sulfamethoxazole-trimethoprim (medication used to treat infection) 800mg-160mg (milligram, unit of weight) tablet two times daily until 3/31/2025, and levofloxacin (medication used to treat infection) 500 mg tablet once daily until 3/31/2025. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 76 ' s Order Summary Report (OSR), indicated on 3/28/2025 Resident 76 had physician orders as listed: 1. An indwelling catheter attached to bedside drainage bag due to urinary retention related to BPH 2. Monitor the indwelling catheter ' s urinary drainage bag and document the following: Color, consistency, odor, hematuria (presence of blood in the urine), bladder distention, burning sensation for the presence of S/S (signs and symptoms) of UTI [(+) meaning presence of S/S of UTI, (0) meaning absence of S/S of UTI]. And, to notify the physician and document in nurse ' s progress notes if monitored and any of the S/S above observed. During a review of Resident 76 ' s Minimal Data Sheet (MDS- a resident assessment tool) dated 4/1/2025, the MDS indicated that Resident 76 was cognitively severely impaired (never/rarely made decisions). The MDS also indicated that Resident 76 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) in toileting hygiene, shower/bathe self, and personal hygiene. During a review of Resident 76 ' s Evaluations of Intake/Output (EIO), dated from 4/6/2025 to 4/20/2025, the EIO indicated weekly evaluations of lows and highs volume of Resident 76 ' s I&O. The EIO indicated there was no records of Resident 76 ' s I&O after 4/27/2025. The EIO indicated the evaluation was not reported and discussed with Resident 76 ' s physician to obtain order for continuing or discontinuing recording of Resident 76 ' s I&O. During a review of Resident 76 ' s Treatment Administration Record (TAR) dated 5/15/2025 and 5/16/2025, Resident 76 ' s Licensed Nurses Notes (LNN), dated 5/15/2025 and 5/16/2025, and Resident 76 ' s progress notes were reviewed. The TAR indicated Resident 76 had presence S/S of UTI with no documented for specific S/S on 5/15/2025 and 5/16/2025 during the evening shift (3-11PM). The LNN indicated no documented evidence that Resident 76 ' s bladder distention was assessed and what S/S of UTI were present. During a review of Resident 76 ' s COC/Interact Assessment Form (SBAR), dated 5/17/2025, indicated on 5/17/2025 around 12:30 AM, blood was noted on Resident 76 ' s urethral meatus (the opening of the urethra, the tube that carries urine from the bladder out of the body), nurse (unidentified) attempted to flush the indwelling catheter with no return. Registered Nurse (RN, unidentified) was notified and Resident 76 ' s indwelling catheter was replaced and excreted 1700 bloody urine with blood clots. Resident 76 was sent to GACH 1 around 7:15 AM on 5/17/2025. During a review of Resident 76 ' s GACH 1 Discharge Summary (DS) dated 5/17/2025, the DS indicated that Resident 76 was diagnosed with Gross Hematuria (visible blood in the urine). During a review of Resident 76 ' s OSR, dated 5/19/2025, indicated to flush indwelling catheter with 60cc (cubic centimeters) to 200cc of NS (normal saline- a saltwater solution). During an observation on 5/20/2025 at 10:45 AM with Resident 76 in the room, observed Resident 76 ' s foley catheter urinary bag with pinkish and clear urine output. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2025 at 9:19 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that Resident 76 used to have Intake and Output Record for 30 days when readmitted back to the facility. LVN 1 stated, after 30 days, she monitored Resident 76 ' s output by visualizing urine output in the drainage bag and would not be able to verify the actual output amount if the Certified Nurse Assistant (CNA) did not measure and verbally report it to her. LVN 1 stated she would not know Resident 76 ' s urine output volume if the CNAs did not measure and report it to her. During a concurrent interview and record review on 5/22/2025 at 9:30 AM with RN 1, Resident 76 ' s TAR and GACH 1 ' s laboratory report dated 3/22/2025 were reviewed. The laboratory report indicated Resident 76 ' s urine character was cloudy while the resident ' s TAR indicated no S/S of UTI. RN 1 stated he could not explain the discrepancy. RN 1 stated, Resident 76 ' s urine output was only recorded for the first 30 days of readmission. RN 1 stated not sure whether evaluation was done at completion of 30-Day EIO. RN 1 also stated that Resident 76 ' s urine output would not be monitored if CNAs did not report the measurement to charge nurses and/or if charge nurses were not competent in nursing judgment to identify urinary retention and decreased urine output. During a concurrent interview and record review on 5/22/2025 at 11:30 AM with the Treatment Nurse (TXN), Resident 76 ' s TAR for May 2025 was reviewed. The TXN stated, he observed Resident 76 ' s pinkish urine and documented (+) as indication for S/S of UTI in Resident 76 ' s TAR on 5/15/2025, and 5/16/2025 but did not document Resident 76 ' s pinkish urine in any progress note. The TXN stated the physician was notified on 5/16/2025 during the night shift and was sent to GACH 1. During an interview on 5/23/2025 at 2:00 PM with the Director of Nursing (DON), the DON stated that it was nursing staff ' s responsibility to identify S/S of UTI, urinary retention, and document any findings as ordered by the physician. The DON stated, to assess for bladder distention as ordered by the physician, the nurses were supposed to palpate the resident's bladder to ensure no distention, determine sufficient urine output by visualizing the indwelling catheter's drainage bag, assessed for intact and patent indwelling catheter with urine presented, and document their findings in their nursing notes. During a review of the facility ' s Policy and Procedure (P&P) titled, Fluid Intake& Output, undated, the P&P indicated that at the completion of the 30-day period, a licensed nurse shall evaluate the resident to determine further need for documentation of intake and output. The evaluation shall be recorded on the Intake and Output Assessment Form. During a review of the facility ' s P&P titled, Foley Catheter (indwelling catheter) Maintenance, undated, the P&P indicated to measure urine drainage at the end of each eight-hour shift, unless it is needed or ordered more often, and maintain (record of) intake and output on those residents requiring it. The P&P also indicated to irrigate catheter (only when ordered by a physician) through appropriate portal and record the amount of irrigating solution used.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility to failed to promote resident safety in administering oxygen for three (3) of 3 sampled residents (Resident 71, 119 who were receiving oxygen therapy, in accordance with the facility ' s policy and procedure by failing to: 1. Ensure the oxygen tubing (flexible plastic tubing used to deliver oxygen through nostrils and the tubing is fitted over the patient ' s ears) was labeled with date opened and not touching the floor for Resident 71 2a. Ensure physician order for oxygen administration was followed for Resident 119 to titrate up to 4L per minute for oxygen saturation less than 90% every shift 2b. Ensure that PM shift licensed nurses (LVN 8 and 9), and Registered Nurse (RN) 4 assessed and monitored Resident 119 for signs and symptoms of acute respiratory failure, abnormal vital signs and document in the resident ' s records, when Resident 119 was observed with low and fluctuating BP and oxygen saturations on 3/17/25, to provide immediate respiratory interventions as indicated in the resident ' s care plan. 2c. Ensure LVN 8 and RN 1 assessed, monitored, and documented Resident 119 ' s abnormal vital signs (HR, Oxygen saturation, respiratory rate [RR], body temperature) taken on 3/17/2025 that included abnormal blood pressure (BP) of 80 ' s (systolic BP) and 40 ' s (diastolic BP) on 3/17/25 at the start of the evening shift, around 3:30 PM. 2c. Ensure LVN 8 and RN 1 notified Physician 1 immediately when Resident 119 was observed with abnormal BP of 80 ' s (systolic BP) and 40 ' s (diastolic BP) on 3/17/25 at the start of the evening shift (3 PM to 11 PM) and before LVN 8 go on meal break on 3/17/25 prior to 8 PM, to provide necessary interventions for the abnormal BP and monitored/reported measurement of other vital signs that included abnormal oxygen saturations. 2d. Ensure LVN 8, LVN 9 and RN 4 activated the facility ' s emergency response system (code blue) and implemented BLS sequence of events (airway, breathing, chest compressions) and 911 emergency services (EMS) when Resident 119 was found unresponsive, not breathing, and oxygen saturation (a measure of how much oxygen the blood is carrying) fluctuating between 50% to 80 % on 3/17/25 between the hours of 7:45 PM to 8:11 PM. RN 4 called 911 EMS at 8:11 PM, 26 to 31 minutes after Resident 119 was reported unresponsive by FM 1 to LVN 9 on 3/17/25, in accordance with the facility ' s policy and procedure (P&P) on CPR. 3. Ensure Resident 107 ' s nasal cannula (a flexible tube that provides oxygen through the nose) was dated with an open date and stored in a clean bag when not in use. These deficient practices placed Residents 71, and Resident 107 at risk to harbor bacteria and other contaminants, potentially leading to respiratory infections. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	These deficient practices resulted in Resident 119 was found dead upon EMS arrival at the facility on 3/17/2025 at 8:18 PM. The EMS Report indicated Resident 119 was found by 911 EMS personnel on 3/17/2025 as unresponsive, both eyes dilated, absent breath sounds to both lungs, skin was clammy and showed signs of lividity (a process where blood pools in the lowest parts of the body after the heart stops pumping that typically begins to appear within 30 minutes to an hour after death. Lividity is noticeable by the human eye within 1 to 2 hours after death). Cross referenced to F678 and F842. Findings: 1. During a review of Resident 71 ' s admission Record (AR), the AR indicated the resident was admitted on [DATE] with diagnoses that included acute respiratory failure with hypoxia (a state in which oxygen is not available in sufficient amounts at the tissue level to maintain adequate homeostasis), pneumonitis (inflammation [swelling and irritation] of lung tissue) due to inhalation of food and vomit, and encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support or gastric decompression). During a review of Resident 71 ' s History and Physical (H&P), dated 4/15/2025, indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 71 ' s Order Summary Report dated 4/16/2025, indicated a physician order to administer Oxygen at 2 liters (L, unit of measure) per minute via nasal cannula (medical device to provide supplemental oxygen therapy), may titrate up to 5L per minute for oxygen saturation less than 90% every shift. During an observation in Resident 71 ' s room on 5/19/2025 at 8:47 AM, Resident 71 ' s nasal oxygen tubing was observed on the floor and not labeled with date opened. During a concurrent observation and interview in Resident 71 ' s room on 5/19/2025 at 11:28 AM, verified with certified nursing assistant (CNA) 7 of Resident 71 ' s oxygen tubing on the floor. CNA 7 stated the oxygen tubing should not be touching the floor because it was an infection control issue. During an interview with the Director of Nursing (DON) on 5/23/2025 at 4:05 PM, the DON stated oxygen tubing should be labeled with the date opened to make sure the tubing was good for 7 days. The DON stated oxygen tubing should not touch the floor to avoid accumulation of bacteria. The DON stated once the oxygen tubing touches the floor, the nurse should change the oxygen tubing. 2. During a review of Resident 119 ' s admission Record (AR), the AR indicated Resident 119 was readmitted to the facility on [DATE] with diagnoses that included pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), acute respiratory failure with hypoxia, and chronic obstructive pulmonary disease (COPD, lung disease causing restricted airflow and breathing problems) with (acute) exacerbation (worsening of a disease or an increase in its symptoms). During a review of Resident 119 ' s History and Physical (H&P), dated 3/16/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 119 ' s Order Summary Report dated 3/13/2025, indicated a physician order to administer Oxygen at 2L per minute via nasal cannula, may titrate up to 4L per minute for oxygen saturation less than 90% every shift. During a review of Resident 119 ' s care plan titled Oxygen, Resident is receiving Oxygen Therapy due to Acute Respiratory failure and COPD Exacerbation dated 2/5/2025 indicated to monitor oxygen saturation as ordered, notify physician for any significant change, and to provide oxygen as ordered. During a review of Resident 119 ' s care plan titled Resident is at risk for respiratory distress (shortness of breath (SOB), irregular respiration, wheezing/crackles, rhonchi, activity intolerance, edema) related to COPD dated 2/14/2025 indicated resident would have no unrecognized signs and/or symptoms of respiratory distress daily through the next assessment and would reduce episodes and symptoms of respiratory distress thru appropriate interventions daily through the next assessment. The care plan indicated to assess resident for SOB, irregular respiration, wheezing, crackles, rhonchi, coughing, weakness, activity intolerance, excessive secretions, and to inform physician promptly. During a review of Resident 119 ' s previous admission to a General Acute Care Hospital (GACH) 1 from the facility, the GACH 1 History and Physical (H&P) dated 3/5/2025 indicated the resident presented to the emergency room from the facility for symptoms of respiratory distress. The GACH 1 H&P indicated in the emergency room Resident 119 was hypoxic at 88% with blood pressure of 54/32 and was also febrile with a temperature of 101 degrees. The GACH 1 H&P indicated Resident 119 was subsequently intubated for hypoxic respiratory failure and had lactic acidosis as well as leukocytosis and initial chest x-ray was unremarkable. The GACH 1 H&P indicated Resident 119 was started on broad-spectrum intravenous (IV) antibiotics for presumed healthcare associated pneumonia. The GACH 1 H&P indicated Resident 119 was septic on admission. During a review of GACH 1 Discharge Summary (undated), the GACH 1 Discharge Summary indicated Resident 119 was admitted to GACH 1 on 3/5/2025 and discharged from GACH 1 on 3/12/2025 with discharge primary diagnoses that included but not limited to acute hypoxic respiratory failure status post [s/p] intubation, suspected healthcare associated pneumonia, severe sepsis with shock, acute COPD exacerbation, NSTEMI and left pleural effusion s/p thoracentesis. The Discharge Summary indicated that pulmonary and cardiology GACH 1 physician had cleared Resident 119 for discharge from GACH 1 back to the facility. During a review of Resident 119 ' s Change of Condition (COC)/Interact Assessment Form dated 3/17/2025 timed at 8:23 PM, the COC indicated during rounds at 8 PM, Resident 119 ' s oxygen saturation level was found to be 90% while on 2L of oxygen with no respiratory distress. The COC indicated Resident 119 ' s oxygen was titrated up to 5L per physician order and the oxygen level came up to 97%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Fire Department (FD) Paramedics (911 EMS) Report dated 3/17/2025, the report indicated the facility called 911 EMS on 3/17/2025 timed at 8:11 PM and dispatch complaint of cardiac arrest. The FD Report further indicated FD paramedics arrived at the facility at 8:18 PM (9 minutes) and at Resident 119 ' s room at 8:20 PM (2 minutes). The FD Report under Disposition indicated Resident 119 was dead prior to arrival (DOA). The FD Report indicated Resident 119 was evaluated by the FD paramedics and further indicated No care or support services required. the FD Report indicated no transport was made to the acute hospital due to the resident being DOA. The FD Report under Patient Assessment further indicated Resident 119 ' s Distress Level as Severe. The FD Report under Primary Impression indicated as DOA/Obvious death. The FD Report indicated on 3/17/2025 timed at 8:22 PM, further physical assessment was performed by the paramedics and showed Resident 119 as unresponsive, both eyes dilated, absent breath sounds to both lungs, skin was clammy and showed signs of lividity (a process where blood pools in the lowest parts of the body after the heart stops pumping that typically begins to appear within 30 minutes to an hour after death. Lividity is noticeable by the human eye within 1 to 2 hours after death). The FD Report Narrative indicated Patient determined to be dead (pronounced dead) at 8:23 PM. Patient found by staff in bed unresponsive. Compressions only CPR provided by staff, no BVM. Patient found pulseless, non-breathing, unresponsive at FD arrival, no lung sounds or heart tones, no response to painful stimuli, pupils fixed and dilated, lividity to lower back and legs, no obvious trauma. Per staff patient last seen alive 2-3 hours ago. No complaints prior, per staff patient bedridden. During a review of Resident 119 ' s Certificate of Death (COD) signed by the physician on 3/20/2025, the COD indicated Resident 119 ' s date of death was 3/17/2025. The COD indicated Resident 119 ' s immediate cause of death (final disease or condition resulting in death) was cardiopulmonary arrest. The COD indicated Resident 119 ' s underlying cause of death (disease or injury that initiated the event resulting in death) was COPD. During an interview on 5/21/2025 at 11:48 AM, Licensed Vocational Nurse (LVN) 8 stated she was the charge nurse assigned to Resident 119 on 3/17/2025. LVN 8 stated she made her resident rounds (regular visits made by nurses to check on their patients and assess their progress, well-being and safety) before she took her break at 7:30 to 8:00 PM and observed Resident 119 was stable. LVN 8 stated before she left for her lunch break at 7:30 PM, Resident 119 ' s oxygen saturation was fluctuating between 90 to 93% with continuous oxygen at 2 liters via nasal cannula. LVN 8 stated before she left for her break, Resident 119 was able to open eyes when called by name and mouth breathing was shallow. LVN 8 stated she could not recall the color of Resident 119 ' s skin, but appeared weak and tired. LVN 8 stated when she came back from her break at around 8:06 PM, she observed LVN 9 rushing to Resident 119 ' s room and Registered Nurse (RN) 4 was at the Nursing Station calling 911 EMS preparing paperwork for Resident 119 ' s possible transfer to GACH. LVN 8 stated she was informed by LVN 9 that there was an emergency going on with Resident 119. LVN 8 stated Resident 119's blood pressure was fluctuating two days ago and was on the low side with a systolic blood pressure reading about 80 mm/hg. LVN 8 stated Resident 119 appeared weaker during this current readmission to the facility (3/12/25). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Conv Center	8035 E Hill Drive Rosemead, CA 91770

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same interview on 5/21/2025 at 12:04 PM, LVN 8 stated Resident 119's usual blood pressure from readmission was as low as 80/40 mm/hg and as high as 90 mm/hg. LVN 8 stated she would only document the good number in Resident 119 ' s electronic records, because if she wrote the bad number she would be questioned (by facility leadership). LVN 8 stated she thought the physician was aware of Resident 119 ' s fluctuating blood pressure. LVN 8 stated when she arrived on her shift on 3/17/2025 at around 3 PM to 3:30 PM, Resident 119 ' s blood pressure was around 80/40 mm/hg and on the low side. LVN 8 stated she could not recall the other blood pressure readings Resident 119 had, but she reported to RN 4 the fluctuating blood pressures results of Resident 119. LVN 8 stated RN 4 informed her to monitor Resident 119 ' s blood pressure because the resident was just readmitted back from GACH 1 recently. LVN 8 stated she did not document Resident 119's fluctuating blood pressure. LVN 8 stated before she left for break, she endorsed to LVN 9 that at the time she did not see any sudden change of condition resident was at baseline. During the same interview on 5/21/2025 at 12:44 PM, LVN 8 stated when she returned from her break at 8:06 PM, she did not hear any overhead page of Code Blue (the facility ' s emergency response system that signifies a medical emergency, specifically a cardiac or respiratory arrest, requiring immediate resuscitation efforts) being called. LVN 8 stated she followed LVN 9 to Resident 119 ' s room and checked Resident 119 ' s vital signs (essential physiological measurements that indicate a person's basic bodily functions and overall health). LVN 8 stated LVN 9 left Resident 119 ' s room. LVN 8 stated Resident 119 ' s oxygen saturation was fluctuating between 70 % to 80%, blood pressure was lower around 70/40 mm/hg more or less. LVN 8 stated she could not recall Resident 119 ' s heart rate. LVN 8 stated she did not know what Resident 119 ' s code status and she (LVN 8) stood by Resident 119 ' s door to ask RN 4 (who was at the Nursing Station) if Resident 119 was a full code or DNR. LVN 8 stated she could not recall exactly what time or what RN 4 brought into Resident 119 ' s room when RN 4 came back to the room. LVN 8 stated Resident 119 was on nasal cannula, and she increased Resident 119 ' s oxygen to 6 to 8 liters via nonrebreather mask (a device that gives you oxygen, usually in an emergency). LVN 8 could not recall who put the mask on Resident 119. LVN 8 stated she could not recall any staff performing CPR on Resident 119. LVN 8 stated RN 4 wanted to do CPR but could not recall if RN 4 started CPR. LVN 8 stated 911 EMS took care over shortly after RN 4 came into the room. During a telephone interview with Resident 119 ' s family member (FM) 1 on 5/22/2025 at 8:43 AM, FM 1 stated he and a friend arrived at the facility on 3/17/2025 at around 7:40 PM and noticed there was something strange with Resident 119. FM 1 stated he comes to the facility every day, at least twice a day and Resident 119 was usually awake with eyes opened and would look at him but was nonverbal. FM 1 stated on 3/17/2025, Resident 119 was not awake despite being called and not responding. FM 1 stated Resident 119 was not breathing through his mouth, and his eyes were closed. FM 1 stated after waiting for about 5 minutes (7:45 PM) trying to wake up Resident 119, FM 1 stated they call the nurse into the room. FM 1 stated he came out to the Nursing Station to call the nurse; the licensed nurse came in and checked the vital signs and told him Everything was low including the blood pressure. FM 1 stated he believed the nurse told him Resident 119 ' s oxygen level was below 50%. FM 1 stated he could not recall if the vital signs machine showed any numbers because he was so worried and focused on Resident 119. FM 1 stated he only recalled that the nurse told him everything was low, and oxygen level (oxygen saturation) was below 50%. FM 1 stated he could not recall who the nurse was, but he witnessed the nurse help Resident 119 with breathing using a mask, but it was not effective. FM 1 stated he could not recall if the nurses ' provided CPR because he was only focused on Resident 119. FM 1 stated he saw about 2 nurses in and out of the room, before 911 arrived. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview with LVN 9 on 5/22/2025 at 9:37 AM, LVN 9 stated Resident 119 ' s family member (FM) 1 came to him and said [Resident 119] did not seem right. LVN 9 stated he went over to Resident 119 ' s room to check and the resident ' s blood pressure was 100/50 mm/hg. LVN 9 stated he could not recall Resident 119 ' s oxygen saturation level, but it was within normal range between 90 to 93%. LVN 9 stated he could not recall if he told FM 1 about Resident 119 ' s blood pressure and oxygen levels. LVN 9 stated at the time, Resident 119 did not respond to verbal stimuli but was breathing. LVN 9 stated Resident 119 ' s mouth was closed and appeared to be sleeping but was difficult to arouse. LVN 9 stated he called RN 4. LVN 9 stated RN 4 went into the room and about the same time, LVN 8 returned from her break. LVN 9 stated LVN 8 took over and brought a new blood pressure cuff and pulse oximeter machine (an electronic device that measures the saturation of oxygen carried in your red blood cells). LVN 9 stated Resident 119 was still unresponsive. LVN 9 stated he could not recall the resident ' s vital signs. LVN 9 stated RN 4 left the room to call 911 and to check Resident 119's documented code status. LVN 9 stated he could not recall if the crash cart was brought inside the room or if a code blue was called. LVN 9 stated he told RN 4 about Resident 119 ' s oxygen saturation was low because anything below 95% should be reported especially because Resident 119 had COPD. LVN 9 stated Resident 119 was wearing a nasal cannula at the time and could not recall how many liters of oxygen was given. LVN 9 stated he could not find Resident 119's POLST at that time so they treated it as a full code. LVN 9 stated he saw RN 4 doing compressions, but did not stay in Resident 119 ' s room the whole time. LVN 9 stated he could not recall if RN 4 used the backboard while doing compressions. LVN 9 stated he left Resident 119 ' s room to clear the hallway because the EMS arrived a few minutes after RN 4 called 911. LVN 9 stated Resident 119 ' s family members were at the bedside. During a telephone interview with LVN 9 on 5/22/2025 at 10:09 AM, LVN 9 stated when he returned to Resident 119's room after checking resident's code status he saw RN 4 performing CPR on Resident 119. LVN 9 stated he stood by Resident 119 ' s door and RN 4 was on one side of the bed because the other side of resident's bed was next to a wall. LVN 9 stated he saw both of RN 4's hands on Resident 119 ' s chest. LVN 9 stated he could not recall when CPR was initiated to Resident 119 by RN 4. LVN 9 stated LVN 8 was standing next to Resident 119 ' s bed with RN 4. LVN 9 could not recall if LVN 8 was assisting RN 4 with CPR. During a telephone interview with Physician 1 on 5/22/2025 at 12:55 PM, Physician 1 stated he could not recall specifically if he was notified of Resident 119 ' s change of condition on 3/17/2025. Physician 1 stated usually nurses would notify the physician if a resident ' s blood pressure went below expected or if there was a change in a resident's status. Physician 1 stated if resident's blood pressure was unstable I would send him [Resident 119] to emergency room and according to family wishes. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During another interview on 5/23/2025 at 9:42 AM, RN 4 stated on 3/17/2025 at 8 PM, she had already left Resident 119 ' s room and was going to other rooms when LVN 8 grabbed her to go back to Resident 119 ' s room. RN 4 stated when she conducted her 8 PM rounds, Resident 119 looked okay and blood pressure and heart rate were within normal limits at 100/53. RN 4 stated she did not document the vital signs on the facility ' s online charting system. RN 4 stated in the presence of LVN 8, Resident 119 ' s oxygen saturation was 90%. RN 4 stated she titrated the oxygen to 5 liters to keep the oxygen level above 97%. RN 4 stated everything happened within a twinkle of an eye. RN 4 stated when LVN 8 showed her Resident 119 ' s oxygen saturation at 90%, RN 4 rushed out of the room to get her own pulse oximeter. RN 4 stated Resident 119 ' s oxygen saturation level was not steady at 90% and desatting. RN 4 was asked what desatting means and RN 4 stated desatting meant Resident 119 ' s oxygen saturation level was fluctuating and was going below 90%. RN 4 stated everything happened fast and before increasing Resident 119 ' s oxygen rate, Resident 119 ' s oxygen saturation level was around 86 % to 88% which raised a concern. RN 4 stated she rushed out of the room and called 911 and Physician 1. RN 4 stated when she returned to Resident 119 ' s room she started to perform a chest maneuver with Resident 119. RN 4 stated a chest maneuver was like a scrub. RN 4 stated when the 911 EMS arrived Resident 119 ' s oxygen saturation level was at 97%. RN 4 stated when she called 911 EMS, she also called an overhead page Code CPR or Code Blue. RN 4 stated she called the Code Blue at the time Resident 119 ' s oxygen saturation level was 86 to 88%. RN 4 stated Resident 119 ' s oxygen saturation was fluctuating and at that time the heart rate was also fluctuating it was not one value, 110 to 115 and 97 to 99 [beats/minute] and was just fluctuating in the high-low. RN 4 stated she could not recall if Resident 119 ' s heart rate went lower than 97 beats/minute. During the same interview on 5/23/2025 at 9:42 AM, RN 4 stated Resident 119 ' s appearance was Still the same, open eyes and open mouth, he [Resident 119] does not talk. RN 4 stated she performed the chest rub to Resident 119 because the heart rate and oxygen was going up and down. RN 4 stated she changed Resident 119 ' s nasal cannula to a mask. RN 4 stated the crash cart was always there, in front of Resident 119 ' s room and she just grabbed the mask and went inside resident ' s room. RN 4 stated she grabbed the mask with the bag (non-rebreather mask). RN 4 stated when she returned to Resident 119 ' s room she and LVN 8 tried moving and repositioning Resident 119. RN 4 stated that after placing the resident at 5liters of oxygen, she performed the Valsalva maneuver (a breathing technique that involves pinching your nose and breathing out forcefully with the mouth closed) because Resident 119 ' s Heart rate, blood pressure was getting low, and heart rate was going up, both fluctuating. The resident ' s oxygen was up and down. RN 4 stated that together with LVN 8, they were doing the Chest maneuver/compression. RN 4 demonstrated with her one hand how she performed the chest maneuver/compression in circulation motion to Resident 119 ' s chest area and further stated she was rubbing in a circular, gentle pressing around the [resident ' s] chest area. RN 4 stated she did not know what the exact medical term was with the procedure she performed. RN 4 stated when the 911 EMS arrived, the EMS performed their own care. RN 4 stated the 911 EMS pronounced Resident 119 dead at 8:23 PM. RN 4 stated RN 4, LVN 8, and Resident 119 ' s family were at bedside during that time. RN 4 stated she thought the other licensed nurses working that day were in Resident 119 ' s room when she was performing CPR but could not recall exactly who was in the room, but they were helping. RN 4 stated none of the other licensed nurses were involved during the code blue the whole time because they had their own residents. RN 4 stated she could not recall what everyone was doing during the CPR because it was crazy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same interview on 5/23/2025 at 10:37 AM, RN 4 stated she was sure LVN 8 was in Resident 119 ' s room and a certified nursing assistant (CNA) was outside the door. RN 4 stated the CNA provided resident ' s belongings during that time. RN 4 stated it did not take long for the 911 EMS to arrive from the time she called 911. RN 4 stated Resident 119 was still breathing before and when the 911 EMS arrived. RN 4 stated she took Resident 119 ' s vital signs and it was the last one she entered in Resident 1 ' s electronic records. RN 4 stated before the paramedics arrived, Resident 119 had a blood pressure and a pulse. RN 4 stated when the 911 EMS arrived Resident 119 was still alive. RN 4 stated the 911 EMS brought their equipment. RN 4 stated she stepped aside when the EMS came. RN 4 stated she did not see what the EMS did. During the same interview on 5/23/2025 at 10:45 AM, RN 4 stated she could not recall if LVN 8 notified her of Resident 119 ' s fluctuating blood pressure. RN 4 stated around 3 to 3:30 PM on 3/17/2025, Resident 119 ' s blood pressure was not fluctuating. RN 4 stated LVN 8 only notified her about Resident 119 ' s oxygen saturation at 90% around 8 PM. RN 4 stated there was nothing alarming between 3 PM to 8 PM. RN 4 stated if Resident 119 had a change of condition like blood pressure going high or going low, she would assess the resident first, if assessment was abnormal she would call 911 immediately and notify physician before calling the family. At 8 PM, RN 4 stated LVN 8 grabbed her and said, come and see the oxygen. RN 4 stated when she came to Resident 119 ' s room, that was when she saw Resident 119 ' s oxygen was 90%, so she went to grab her own pulse oximeter, and Resident 119 ' s oxygen saturation was even lower than 90 % and was 85 to 86 %. RN 4 stated that was when she rushed to the Nurses Station then went back to the resident ' s room and started performing the chest maneuver to Resident 119. During a concurrent interview and record review of Resident 119 ' s Change of Condition on 5/23/2025 at 10:52 AM, RN 4 stated CPR was initiated because she saw Resident 119 ' s oxygen and blood pressure was getting low. RN 4 stated she had already called 911. RN 4 stated CPR was cardiopulmonary resuscitation. RN 4 stated the nurse have to check if resident was full code, then check the pulse, you can start CPR if there is still a pulse. RN 4 demonstrated CPR and stated you interlock hands make sure you press 1 to 2 inches deep about 100 to 120 times per minute, on the chest around the apex of the heart and if you are comfortable you can give mouth to mouth and I did not give breaths. RN 4 stated Resident 119 was breathing, He [Resident 119] was breathing all through until the last minute. RN 4 stated she started chest compressions when the resident ' s oxygen was low at 85 to 86%. RN 4 stated She was doing both chest rub and chest compressions at the same time. RN 4 stated she and LVN 8 were doing both at the same time, alternating chest rub and chest compressions. RN 4 stated the chest rub worked better. RN 4 stated she checked Resident 119 ' s wrist for pulse and it was present. RN 4 stated Resident 119 was desatting [short term for desaturate [oxygen levels are dropping]) which was why she started chest compressions. RN 4 stated Resident 119 ' s pulse was very low, and she still performed chest compressions. RN 4 stated she did not give Resident 119 rescue breaths and that no one did rescue breaths because I was focusing on chest more. RN 4 stated after calling 911 everything was going down. RN 4 stated the paramedics arrived already. RN 4 stated the vital signs were not going low at that time like 90 something, that was the last thing i wrote down. RN 4 confirmed she did not document the abnormal findings and details about what happened when Resident 119 was found unresponsive. RN 4 stated there was no reason why she did not include Resident 119 ' s abnormal vital signs. RN 4 stated she did not document of PCC the abnormal vitals, it was important to include the abnormal findings on the note, for reference to compare. RN 4 stated the abnormal findings should be documented. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/23/2025 at 3:32 PM, the Director of Nursing (DON) stated if staff find a resident unresponsive, they must take vital signs right away, call for help (emergency) call code, and 911. The DON stated there should be a team around and the nurse should start delegating tasks to each staff member like checking resident ' s chart for POLST, notifying family, calling 911, and overhead page the code. The DON stated if staff should check if resident has a pulse and should palpate for a pulse. The DON stated there should be a Crash Cart as soon as the code is called, anyone like the CNAs could bring the crash cart to the resident's room. The DON stated the backboard should be ready to place underneath the resident and if resident has a low air loss mattress staff should deflate it. The DON stated someone should bring oxygen tank and Ambu bag. The DON stated staff should continue CPR if no pulse is found and should administer breaths as well. The DON stated giving breaths is not an option, the Ambu bag should be used. The DON stated staff should not stop CPR until paramedics are in the building. The DON stated chest sternal rub was not compressions. The DON stated the purpose of compressions was to have the heart pump the blood to get to the brain and organs, to stimulate the heart by manually pumping the heart. The DON stated an interruption or stop in compressions would interrupt blood flow to the heart and staff should continue CPR as long as resident has no pulse. During a concurrent interview and record review of Resident 119 ' s order summary on 5/23/2025 at 4:21 PM, the DON stated nurses should be following physician orders at all times because it was a part of resident ' s care. During a review of the facility ' s undated policy and procedure (P&P) titled Oxygen Administration indicated to administer oxygen as per physician orders. The P&P indicated the oxygen tubing should be changed weekly and as needed, including changing the mask, cannula, nebulizer (small machine that turns liquid medicine into a mist that can be easily inhaled) equipment. The P&P indicated when not in use, the oxygen tubing should be stored in a clean bag. The P&P indicated the date, time, and initials should be noted on oxygen equipment when it is initially used and when changed. The P&P indicated oxygen tubing should be used in a manner that prevents it from touching the floor. During a review of the facility ' s undated P&P titled Oximetry, Spot Checks indicated if oxygen saturation (SpO2) is at a critical level, the physician must be notified and nursing informed. During a review of the facility ' s undated P&P titled Emergency Procedure-Cardiopulmonary Resuscitation indicated if an individual is found unresponsive, briefly assess for abnormal or absence of breathing, if sudden cardiac arrest is likely begin CPR: (1) instruct a staff member to activate the emergency response syst[TRUNCATED]

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide medically-related social service for one of three sampled residents (Resident 9), who was hard of hearing (HOH) and not satisfied with the hearing aids (HA, a device worn in or behind the ear designed to amplify sound for individuals who have difficulty hearing), by failing to follow up and make an appointment with the audiologist (a physician specialized in hearing loss). This deficient practice resulted in Resident 9 not utilizing the facility provided HA and leaving Resident 9 to remain hearing impaired and negatively impacting Resident 9 ' s quality of life and well-being. Findings: During a review of Resident 9 ' s admission Record (AR), the AR indicated that Resident 9 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including end stage renal disease (ESRD-irreversible kidney failure), legal blindness (a status of severe vision loss, acquired absence of right leg below knee, and acquired absence of left leg above knee. During a review of Resident 9 ' s Order Summary Report, the Report indicated Resident 9 had a physician order on 10/5/2023 for audiology consult as needed for hearing problems. During a review of Resident 9 ' s Minimum Data Set (MDS - a resident assessment tool) dated 3/7/2025, the MDS indicated the following: Resident 9 had difficulty in hearing and used a pair of HA, and Resident 9 ' s vision was severely impaired (no vision or sees only light, colors or shapes; eyes do not appear to follow objects) Resident 9 was cognitively intact (a person has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the environment). Resident 9 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) on eating and oral hygiene. Resident 9 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 toileting hygiene, shower/ bathe self, and lower body dressing. During a review of Resident 9 ' s Social Service Progress Note (SSPN), dated 3/6/2025, the SSPN indicated that new hearing aids were delivered to Resident 9, and were tested with a Registered Nurse (unspecified), Audiologist (unspecified), and SSD (Social Service Director). The note indicated the HA were working and Resident 9 was happy that he was able to hear well. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 9 ' s SSPN, dated 5/1/2025, the SSPN indicated Resident 9 ' s HA were checked on 4/29/2025 with Resident 9 ' s audiologist. The SSPN indicated during the visit, Resident 9 stated, he did not like the background noise when using the HA, so Resident 9 requested to return the HA. The SSPN indicated, Nurse (unspecified) told the audiologist that Resident 9 wanted to return his HA from the beginning and was suggested to have the audiologist check it one more time. The SSPM stated, the audiologist still did not take Resident 9 ' s HA back. During a review of Resident 9 ' s Licensed Nurses Weekly Notes (LNN), dated from 3/8/2025 to 5/10/2025, the LNN indicated that Resident 9 ' s hearing condition was highly impaired and required the use of a pair of HA. During a review of Resident 9 ' s SSPN dated from 3/6/2025 to 5/20/2025, there was no documented evidence that SSD clarified with Resident 9 or RP 1 for Provider 1 ' s contact information and no documented evidence that the SSD contacted Provider 1 for an audiologist appointment as Resident 9 requested. During a concurrent observation and interview on 5/20/2025 at 12:45 PM with Resident 9 and CNA 2 in the resident ' s room, Resident 9 was alert, lying in bed, and had to raise his voice when speaking to CNA 2, who also had to raise her voice to communicate with Resident 9. Resident 9 stated he was not using his HA. Resident 9 stated, when he received his HA by Provider 2 on 3/6/2025, the background noise was disturbing him, so did not like to use his HA. Resident 9 stated, he was told to give the new HA a try for a few more days. Resident 9 stated, he tried his HA but two days later, he requested to return his HA because it did not work properly for him, and he also requested for an appointment with Provider 1. Resident 9 stated, he requested updates for his HA and appointments with Provider 1, however had not had any updates regarding his HA or appointment scheduled with Provider 1 to obtain a new HA. During the same concurrent observation and interview, on 5/20/2025 at 12:45 PM, CNA 2 stated Resident 9 was hard of hearing with impaired vision. CNA 2 stated, when speaking with Resident 9, facility staff needed to speak close and raiser their voice, so that Resident 9 could hear. During a telephone interview on 5/22/2025 at 4:01 PM with Resident 9 ' s responsible party (RP 1), RP 1 stated about a week ago, the SSD told him that there was no solution, no new plan or schedule for Provider 1 ' s appointment related to Resident 9 ' s HA issue. RP 1 stated, he spoke with the SSD sometime in March 2025 regarding Resident 9 ' s HA which was received on 3/6/25. RP 1 stated Resident 9 requested the SSD to set an appointment with Provider 1; however, RP 1 never heard back from the SSD regarding an appointment with Provider 1 for Resident 9. During an interview on 5/23/2025 at 9:50 AM with Registered Nurse (RN) 2, RN 2 stated being present when Resident 9 received a new pair of HA on 3/6/2025. RN 2 stated, on 3/6/2025, Resident 9 tested his HA in front of the Audiologist and the SSD and told them that he still heard an echo and background noise. RN 2 stated after trying the new pair of HA for one to two days, Resident 9 was not happy with the HA, so RN 2 assisted Resident 9 to inform the SSD that the new HA did not work properly for him, and that Resident 9 requested an appointment with Provider 1, who provided his previous HA. RN 2 stated, the SSD responded that she would follow up. RN 2 stated, she helped Resident 9 a week ago and requested updates for the HA issue with the SSD, the SSD responded with not sure if Resident 9 ' s insurance will approve but will follow up. (continued on next page)

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San Gabriel Conv Center	8035 E Hill Drive Rosemead, CA 91770

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/2025 at 3:15 PM with the SSD, the SSD stated Resident 9 was hard of hearing and legally blind. SSD stated, Resident 9 could not hear adequately without his HA. During a concurrent record review and interview on 5/23/2025 at 9:50 AM with the SSD, Resident 9 ' s SSPN dated from 3/6/2025 to 5/22/2025 was reviewed. The SSD stated, on 3/6/2025, when Resident 9 received his new HA from Provider 2, Resident 9 tried the HA on in front of the SSD and stated, it was working, so she documented it as he was happy with his new HA. The SSD stated that two months ago, RN 2 reported to her that Resident 9 was not satisfied with his new HA and wanted to make an appointment with Provider 1. The SSD stated not being able to contact Provider 1. SSD stated she did not make appointment with Provider 1 for Resident 9. The SSD stated she received several requests for update from Resident 9, RP 1, and RN 2 regarding the HA. The SSD stated, she did not follow up because it was meaningless for her to call a number never picking up. During an interview on 5/23/2025 at 10:50 AM with the Administrator (ADM), the ADM stated the SSD was expected to assist with Resident 9 ' s referrals and appointments for his needs related to impaired hearing and for the use of HA. ADM stated, it was the SSD ' s responsibility to assess Resident 9 ' s needs, provide appropriate services related to his impaired hearing, and ensure Resident 9 was supported for their needs to be met. During a review of the facility ' s Policy and Procedures (P&P) titled Social Service revised 09/2021, the P&P indicated the following 1. The director of social service is a qualified social worker and is responsible for meeting or assisting with the medically-related social service needs of residents. 2. Medically-related social services are provided to maintain or improve each resident ' s ability to control everyday physical needs (e.g. appropriate adaptive equipment, etc). 3. The social worker/ social service staff are responsible for: a. Assisting or arranging for a resident ' s communication needs through the resident ' s preferred method of communication and/ or in a language that the resident understands. b. Making arrangements for obtaining needed items such as clothing and personal items. c. Making referrals and obtaining needed services from outside entities. During a review of the facility ' s Job Description (JD)- Social Worker dated 1/27/2022, the JD indicated that essential duties and responsibilities include the following: 1. Assist in the provision of medically-related social services to attain or maintain the highest practicable well-being of each resident, including those services identified in the State Operation Manual (SOM). 2. Facilitate any identified problems. Assist with supplying whatever tools necessary to ensure communication to make resident needs known. 3. Creates, reviews, and update care plan and progress notes. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Implement social service interventions that achieve treatment goals, address resident needs, link social support, physical care and physical environment to enhance quality of life. To perform the job successfully, an individual should demonstrate the following competencies: 1. Customer services- Manage difficult or emotional customer situations. Respond promptly to customer needs. Respond to request for service and assistance; Meets commitments. 2. Judgment- Exhibits sound and accurate judgment; makes timely decisions. 3. Professionalism- Follows through commitments. 4. Oral communication- Listens and gets clarification. 5. Quality- Demonstrates accuracy and thoroughness. 6. Dependability- Takes responsibility for own actions; Keep commitments.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to respond to the consultant pharmacist ' s (a medical professional responsible for a monthly review of all residents ' medication regimens) request for a gradual dosage reduction (GDR - a periodic attempt to lower the dosage of a medication or discontinue a medication to control a resident ' s symptoms with lower doses or fewer medications) related to the use of quetiapine (a medication used to treat mental illness) in one of five residents sampled for unnecessary medications (Resident 16.) The deficient practices of failing to respond to the consultant pharmacist ' s recommendation to perform a GDR related to the use of psychotropic medications (medications that affect brain activities associated with mental processes and behavior) increased the risk that Resident 16 could have experienced adverse effects (unwanted or dangerous medication-related side effects) related to psychotropic medication therapy, such as drowsiness, dizziness, constipation, or increased risk of fall, possibly leading to impairment or decline in her mental or physical condition or functional or psychosocial status. Cross referenced to F605. Findings: During a review of Resident 16 ' s admission Record (a document containing a resident ' s diagnostic and demographic information), dated 5/21/25, indicated she was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including: dementia (the loss of cognitive function, including memory, thinking, and reasoning, that interferes with daily life) and psychosis (a mental disorder characterized by a disconnection from reality which may occur as a result of psychiatric illness, a health condition, medication, or other drug use.) During a review of Resident 16 ' s History and Physical (H&P - a record of a comprehensive physician ' s assessment), dated 8/18/24, indicated she did not have the capacity to understand and make decisions. During a review of Resident 16 ' s Physician Order Summary (a monthly summary of all active physician orders), dated 3/24/25, indicated she was prescribed quetiapine (an antipsychotic medication) 25 milligrams (mg - a unit of measure for mass) by mouth on 2/21/25 for psychosis manifested by constant physical movement to exhaustion. During a review of Resident 16 ' s Order Audit Reports (a report with information about a previous medication order), dated 5/21/25, indicated, between 8/12/24 and 2/21/25, the orders for the use of quetiapine changed as follows: 8/12/24 to 8/13/24 - Quetiapine 25 mg once daily for schizophrenia (a mental illness characterized by hearing or seeing things that are not there or believing things that are untrue.) 8/13/24 to 11/5/24 - Quetiapine 25 mg once daily for psychosis. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/5/24 to 2/21/25 - Quetiapine 25 mg once daily for psychosis manifested by inability to eat and participate in daily living activities causing sadness. 2/21/25 to 5/21/25 - Quetiapine 25 mg once daily for psychosis manifested by constant physical movement to exhaustion. During a review of the consultant pharmacist ' s recommendations, dated 2/5/25, indicated the pharmacist recommend a GDR for Resident 16 ' s quetiapine. Further review of the pharmacist ' s recommendation indicated the facility left a message with the psychiatrist on 2/9/25 concerning the request but contained no response from the physician or documentation of any additional attempts to follow up. During a review of Resident 16 ' s clinical record indicated there was no record of Resident 16 receiving psychiatric care and no documentation that a physician considered a GDR request for quetiapine and either approved a lower dose or documented that an attempt would be contraindicated (should not be performed due to potential harm) with an accompanying resident-specific clinical rationale. During an interview on 5/21/25 at 9:32 AM with the Director of Nursing (DON), the DON stated the facility failed to identify a specific behavioral issue related to Resident 16's use of quetiapine. The DON stated the problematic behaviors identified in the physician ' s order and the informed consent documentation were different than the problematic behaviors identified in the resident's care plan and MAR. The DON stated this makes the reason for the use of quetiapine and the need for continued use unclear for Resident 16. The DON stated the facility was required to perform GDRs on psychotropic medications, including quetiapine, twice a year in the first year and then once a year thereafter. The DON stated the pharmacist requested a GDR on 2/5/25 for Resident 16's quetiapine, but a GDR was not done. The DON stated the dose of quetiapine for Resident 16 has not changed since it was initially prescribed in August 2024. The DON stated there was no documentation available concerning a response to the pharmacist's request indicating that a GDR attempt would be clinically contraindicated. The DON stated failing to define specific problematic behaviors, perform a GDR on psychotropic medications, or respond to the pharmacist's recommendations related to psychotropic medications could have increased this resident's drowsiness and fall risk, negatively affecting her quality of life and increasing her risk of medical complications from falls. During a review of the facility ' s policy Consultant Pharmacist Reports, dated June 2021, indicated Recommendations are acted upon and documented by the facility staff and or the prescriber. Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of nine sampled residents' (Resident 52) food preference was honored. This deficient practice had the potential for Resident 52 ' s to refuse meals and negatively affect Resident 52 ' s nutritional status. Findings: During a review of Resident 52's admission Record (AR), the AR indicated the facility admitted Resident 52 on 3/26/2025 and readmitted on [DATE] with diagnoses that included hypertension (high blood pressure), anemia (a condition that develops when the blood produces a lower-than-normal amount of healthy red blood cells), osteoarthritis (a common joint disease that causes pain, stiffness, and loss of mobility), dementia [the loss of cognitive functioning (thinking, remembering, and reasoning) to such an extent that it interferes with a person's daily life and activities], and muscle weakness. During a review of Resident 52 ' s Minimal Data Set (MDS-resident assessment tool), dated 4/29/2025, the MDS indicated Resident 52 ' s cognition (ability to think, remember, and reason) was moderately impaired and needed set up or clean up assistance in eating. During a review of Resident 52 ' s Order Summary Report, the Report indicated Resident 52 had a physician order on 5/13/2025 for no added salt (NAS) diet, mechanical soft texture (foods that are soft and easy to chew and swallow), and thin consistency. During a review of Resident 52 ' s Nutrition/Dietary Notes, dated 5/13/2025, indicated Resident 52 ' s food preferences indicated a dislike for beef. During a review of Resident 52 ' s Care plan, revised on 5/13/2025, indicated Resident 52 had alteration in nutritional status related to hypertension, anemia, and dementia. The Care Plan interventions indicated to honor Resident 52 ' s food preference. During a review of the facility ' s May menu for the week of 5/19/2025 to 5/25/2025, the menu indicated, on 5/20/2025 for lunch, the facility would serve beef chop suey (a dish that typically consists of sliced beef stir-fried with a variety of vegetables) and rice. During a concurrent observation and interview on 5/20/2025 at 12:10 PM with Restorative Nursing Assistant (RNA) 1 in the dining room, RNA 1 assisted Resident 52 with lunch. Resident 52 ' s lunch tray included beef while Resident 52 ' s meal ticket (card on the meal tray that indicated food allergies and food preferences) indicated the resident disliked beef. Resident 52 stated she did not like beef. RNA 1 stated, Resident 52 ' s lunch tray should not include beef since Resident 52 ' s preference indicated a dislike for beef. RNA 1 stated, alternative meat such as chicken, tofu or pork should have been served to Resident 52. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/20/2025 at 12:20 PM with Dietary Supervisor (DS) in the dining room, Resident 52 ' s lunch tray was served with beef. The DS stated, Resident 52 was served with beef chop suey and rice for lunch today. The DS stated, the [NAME] was responsible to prepare all residents ' food tray based on each resident ' s meal ticket. The DS stated, based on Resident 52 ' s meal ticket which indicated Resident 52 disliked beef, beef should not have been served to Resident 52. During an interview on 5/20/2025 at 12:25 PM with the facility ' s Cook, the [NAME] stated, he was the one who prepared Resident 52 ' s lunch tray. The [NAME] stated, he overlooked Resident 52 ' s meal ticket and still served Resident 52 beef for lunch. During an interview on 5/20/2025 at 12:30 PM with the DS, the DS stated, the [NAME] should review Resident 52 ' s meal ticket carefully when preparing the resident ' s lunch tray to ensure specific food preferences were honored. The DS stated, when Resident 52 was served food that she disliked, Resident 52 might not want to eat, which could potentially cause weight loss due to Resident 52 refusing to eat. During a review of the facility ' s Policy and Procedure (P&P) titled, Resident Food Preferences, indicated residents have the right to have their food preferences honored. During a review of the facility ' s P&P titled, Menu, indicated individual resident trays will have a meal ticket which identifies the residents name, room number, diet order. Also stated on the card: food preferences.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure five of five outdoor refuse containers (a waste container that a person controls that includes dumpsters, trash cans, garbage pails, and plastic trash bags) were closed with a tight-fitting lid and kept covered. This deficient practice had the potential to attract insects and harborage of pests in the refuse area that can cause a wide spread of diseases and affect the residents, staff, and visitors. Findings: During a concurrent observation and interview on 5/19/2025 at 9 AM, in the back driveway of the facility ' s parking lot, with Housekeeping (HK) 1, a total of seven (7) outdoor refuse containers were observed. HK 1 stated, the facility was sharing refuse containers with the facility next door, in which there were five (5) containers that belonged to the facility. HK 1 stated, HK 1 did not know which refuse containers belonged to the facility. During the same concurrent observation and interview, six outdoor refuse containers were observed overfilled with bags of trash. One of the six refuse containers was completely opened, and the other five containers could not close since the containers were overfilled. HK 1 stated, all of refuse containers were always overfilled so the lids of the refuse containers could not be fully closed. During a concurrent observation and interview on 5/9/2025 at 9:08 AM with HK 2, six outdoor refuse containers were observed overflowed with bags of trash. The refuse container was not closed. HK 2 stated she worked at the next-door nursing facility and threw the trash into any of the refuse containers. During a concurrent observation and interview on 5/19/2025 at 9:10 AM, with the Director of Maintenance (DM), the DM stated five of the refuse containers belonged to the facility, but there was no label or signs indicating which refuse container belonged to the facility. The DM stated the refuse containers were overfilled and the refuse container lids could not be closed. The DM stated the refuse containers could not be closed fully and tightly and stayed that way until the waste management company came to the facility around 2-3 PM that afternoon. The DM stated he was aware that the refuse containers were shared with the near by facility, and was the reason the refuse containers overflowed. The DM stated the issue of shared refuse containers was not addressed. The DM stated the lids of the refuse containers should be closed at all times to prevent infestation of insects and rodents, and to prevent illness to the residents, staff and visitors. During a review of the facility ' s policy and procedure (P&P) titled, Food-Related Garbage and Refuse Disposal, dated 10/2017, the P&P indicated all garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use and outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure to maintain a complete and accurate documentation of all services provided to the resident, progress toward the care plan goals, or any changes in the resident ' s medical, physical, functional or psychological condition, in accordance with the facility ' s policy and procedures (P&P) titled Change of Condition and Charting and Documentation. This deficient practice resulted in an inaccurate depiction of Resident 119 ' s care and health status and had placed Resident 119 at risk for having serious health complications. Cross referenced to F678, F695. Findings: During a review of Resident 119 ' s admission Record (AR), the AR indicated Resident 119 was readmitted to the facility on [DATE] with diagnoses that included pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), acute respiratory failure with hypoxia, and chronic obstructive pulmonary disease (COPD, lung disease causing restricted airflow and breathing problems) with (acute) exacerbation (worsening of a disease or an increase in its symptoms). During a review of Resident 119 ' s History and Physical (H&P), dated [DATE], the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 119 ' s Order Summary Report, dated [DATE], the Report indicated a physician order to administer Oxygen at 2L per minute via nasal cannula, may titrate up to 4L per minute for oxygen saturation less than 90% every shift. During a review of Resident 119 ' s care plan titled Oxygen, Resident is receiving Oxygen Therapy due to Acute Respiratory failure and COPD Exacerbation, dated [DATE], indicated to monitor oxygen saturation as ordered, notify physician for any significant change, and to provide oxygen as ordered. During a review of Resident 119 ' s care plan titled Resident is at risk for respiratory distress (shortness of breath (SOB), irregular respiration, wheezing/crackles, rhonchi, activity intolerance, edema) related to COPD, dated [DATE], the care plan indicated resident would have no unrecognized signs and/or symptoms of respiratory distress daily through the next assessment and would reduce episodes and symptoms of respiratory distress thru appropriate interventions daily through the next assessment. The care plan indicated to assess resident for SOB, irregular respiration, wheezing, crackles, rhonchi, coughing, weakness, activity intolerance, excessive secretions, and to inform physician promptly. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 119 ' s previous admission to a General Acute Care Hospital (GACH) 1 from the facility, the GACH 1 History and Physical (H&P) dated [DATE] indicated the resident presented to the emergency room from the facility for symptoms of respiratory distress. The GACH 1 H&P indicated in the emergency room Resident 119 was hypoxic at 88% with blood pressure of 54/32 and was also febrile with a temperature of 101 degrees. The GACH 1 H&P indicated Resident 119 was subsequently intubated for hypoxic respiratory failure and had lactic acidosis as well as leukocytosis and initial chest x-ray was unremarkable. The GACH 1 H&P indicated Resident 119 was started on broad-spectrum intravenous (IV) antibiotics for presumed healthcare associated pneumonia. The GACH 1 H&P indicated Resident 119 was septic on admission. During a review of Resident 119 ' s Change of Condition (COC)/Interact Assessment Form dated [DATE] timed at 8:23 PM, authored by RN 4, the COC Background indicated Onset of symptoms identified at 8:20 PM and Situation Identified indicated Hypoxia. The COC indicated Resident 119 ' s blood pressure was 98/58 mm/hg taken at [DATE] at 8:20 PM. The COC indicated Resident 119 ' s pulse was 90 bpm and taken at [DATE] at 8:20 PM. The COC indicated Resident 119 ' s respiration was 17 breaths/min and taken at [DATE] at 8:20 PM. The COC indicated Resident 119 ' s blood glucose was 120 and pain level was 0 (zero) and taken at [DATE] at 8:20 PM. The COC further indicated Resident 119 ' s oxygen saturation was 97 % and taken at [DATE] at 8:20 PM. The COC indicated the facility staff would Monitor vital signs and observe. During the same record review of Resident 119 ' s COC dated [DATE] timed at 8:23 PM authored by RN 4, under Licensed Nurse Note 1, the Note indicated [Resident 119] with history of pneumonia, acute respiratory failure with hypoxia, COPD, anemia, type 2 diabetes, bilateral contracture of the hand and elbow and upper arm, bilateral contracture of lower extremities, chronic kidney disease, dementia, Alzheimer's disease and major depression disorder. At 3 PM, [Resident 119] was received in bed during the beginning of the shift, vital signs were assessed, and with normal limit. [Resident 119] was on oxygen via nasal canula. Oxygen saturation was 99 % at 2 L. There was no apparent distress. Lungs were auscultated and there was clear lung sounds heard on both lungs. Breathing was even and unlabored, no respiratory distress. Bowel sounds were normal active in the four quadrants, when auscultated. [Resident 119] was on G-tube feeding. Diet was Glucerna 1.2 at 55 cc per hour for 20 hours via pump to provide 1100 CC/ 1320 kcal per day. Frequent monitoring and care were ongoing. At 4 PM, during rounds, [Resident 119] was assessed, and there was no apparent distress, he was made comfortable in bed. All orders were carried out per [Resident 119 ' s] physician. At 6 PM, [Resident 119] was seen in bed with no distress, Resident 119 was visited by his representatives at bedside. During care and making rounds at 8 PM, [Resident 119 ' s] oxygen was found to be 90 (%) at 2 L but there was no respiratory distress. Oxygen was titrated up to 5 L per physician order and the oxygen came up to 97 % [sic]. During the same record review of Resident 119 ' s COC dated [DATE] timed at 8:23 PM authored by RN 4, under Licensed Nurse Note 2, the Note indicated [Resident 119 ' s] physician was notified. 911 was called at 8:11 PM. CPR was done. 911 arrived at 8:16 PM, they performed their own care but at 8:23 PM, the resident passed away. [Resident 119 ' s] physician confirmed [Resident 119 ' s] death and and was discharged to his funeral homes. The body was released to a mortuary representative on [DATE] at 11:17 PM. [Resident 119 ' s] belongings were released to the resident ' s representative. The DON and ADM were informed about the deceased [sic]. During a review of Resident 119 ' s Blood Pressure (BP) Summary from [DATE] to [DATE], the BP Summary indicated the following information: (continued on next page)

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	055181	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Conv Center	8035 E Hill Drive Rosemead, CA 91770

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 6:55 PM 98/58 mmHg (Lying l/arm) [DATE] 12:47 PM 112/61 mmHg (Sitting r/arm) [DATE] 6:44 PM 118/68 mmHg (Lying l/arm) [DATE] 12:50 PM 110171 mmHg (Sitting l/arm) [DATE] 9:48 PM 118/64 mmHg (Lying l/arm) [DATE] 1:45 PM 120174 mmHg (Sitting r/arm) [DATE] 01:37 AM 110/68 mmHg (Lying l/arm) [DATE] 5:10 PM 126/66 mmHg (Lying l/arm) [DATE] 2:40 PM 124/67 mmHg (Lying l/arm) [DATE] 03:49 AM 128/70 mmHg (Lying l/arm) [DATE] 10:43 PM 135/65 mmHg (Lying l/arm) [DATE] 11:24 AM 124/68 mmHg (Lying l/arm) [DATE] 3:35 PM 110/70 mmHg (Lying r/arm) [DATE] 3:30 PM 110170 mmHg (Lying r/arm) During a review of Resident 119 ' s Oxygen Saturation (O2 Sat) Summary from [DATE] to [DATE], the O2 Sat Summary indicated the following information: [DATE] 6:19 PM 97 % (Oxygen via Nasal Cannula) [DATE] 6:18 PM 97 % (Room Air) [DATE] 10:31 AM 97 % (Oxygen via Nasal Cannula) [DATE] 04:33 AM 98 % (Room Air) [DATE] 03:34 AM 98 % (Oxygen via Nasal Cannula) [DATE] 6:10 PM 96 % (Oxygen via Nasal Cannula) [DATE] 10:20 AM 97 % (Oxygen via Nasal Cannula) [DATE] 02:34 AM 98 % (Oxygen via Nasal Cannula) [DATE] 12:39 AM 97 % (Room Air) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 3:49 PM 98 % (Oxygen via Nasal Cannula) [DATE] 3:44 PM 98 % (Oxygen via Nasal Cannula) [DATE] 10:38 AM 97 % (Oxygen via Nasal Cannula) [DATE] 10:37 AM 97 % (Oxygen via Nasal Cannula) [DATE] 8:07 PM 98 % (Oxygen via Nasal Cannula) [DATE] 8:07 PM 99 % (Oxygen via Nasal Cannula) [DATE] 11:01 AM 98 % (Room Air) 03/14 /2025 03:49 AM 98 % (Room Air) [DATE] 03:45AM 98 % (Room Air) [DATE] 5:43 PM 98 % (Room Air) [DATE] 5:42 PM 98 % (Room Air) [DATE] 1:59 PM 97 % (Oxygen via Nasal cannula) [DATE] 3:30 PM 98 % (Room Air) During a review of Resident 119 ' s Pulse Summary from [DATE] to [DATE], the O2 Sat Summary indicated the following information: [DATE] 6:55 PM 90 beats per minute (bpm) (Regular) [DATE] 12:46 PM 83 bpm (Regular) [DATE] 6:44 PM 80 bpm (Regular) [DATE] 12:50 PM 85 bpm (Regular) [DATE] 21:48 70 bpm (Regular) [DATE] 1:44 PM 76 bpm (Regular) [DATE] 01 :36 AM 84 bpm (Regular) [DATE] 6:10 PM 78 bpm (Regular) [DATE] 2:40 PM 72 bpm (Regular) [DATE] 03:24 AM 78 bpm (Regular) [DATE] 10:43 AM 68 bpm (Regular) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 11:24 AM 65 bpm (Regular) [DATE] 3:35 PM 99 bpm (Regular) [DATE] 3:34 PM 99 bpm (Regular) [DATE] 3:30 PM 99 bpm (Regular) During a review of Resident 119 ' s Respiration Summary from [DATE] to [DATE], the Summary indicated the following information: [DATE] 6:55 PM 20 Breaths/min [DATE] 6:19 PM 18 Breaths/min [DATE] 10:31 AM 18 Breaths/min [DATE] 04:33 AM 18 Breaths/min [DATE] 6:44 PM 20 Breaths/min [DATE] 6:10 PM 20 Breaths/min [DATE] 10:20 AM 18 Breaths/min [DATE] 12:39 AM 19 Breaths/min [DATE] 9:48 PM 18 Breaths/min [DATE] 3:49 PM 17 Breaths/min [DATE] 10:38 AM 18 Breaths/min [DATE] 01:37 AM 18 Breaths/min [DATE] 8:07 PM 16 Breaths/min [DATE] 11:01 AM 18 Breaths/min [DATE] 03:49 AM 18 Breaths/min [DATE] 5:43 PM 18 Breaths/min [DATE] 11:24 AM 20 Breaths/min 03/12 /2025 3:34 PM 24 Breaths/min 03/12 /2025 3:30 PM 24 Breaths/min (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During further review of Resident 119 ' s medical records (vital signs, COC, licensed nurses 'progress notes) from [DATE] to [DATE], there was no documented evidence of abnormal vital signs or low and fluctuating blood pressure readings and oxygen saturation levels below 90%. During a review of the Fire Department (FD) Paramedics (911 EMS) Report, dated [DATE], the report indicated the facility called 911 EMS on [DATE] timed at 8:11 PM and dispatch complaint of cardiac arrest. The FD Report further indicated FD paramedics arrived at the facility at 8:18 PM (9 minutes) and at Resident 119 ' s room at 8:20 PM (2 minutes). The FD Report under Disposition indicated Resident 119 was dead prior to arrival (DOA). The FD Report indicated Resident 119 was evaluated by the FD paramedics and further indicated No care or support services required. the FD Report indicated no transport was made to the acute hospital due to the resident being DOA. The FD Report under Patient Assessment further indicated Resident 119 ' s Distress Level as Severe. The FD Report under Primary Impression indicated as DOA/Obvious death. The FD Report indicated on [DATE] timed at 8:22 PM, further physical assessment was performed by the paramedics and showed Resident 119 as unresponsive, both eyes dilated, absent breath sounds to both lungs, skin was clammy and showed signs of lividity (a process where blood pools in the lowest parts of the body after the heart stops pumping that typically begins to appear within 30 minutes to an hour after death. Lividity is noticeable by the human eye within 1 to 2 hours after death). The FD Report Narrative indicated Patient determined to be dead (pronounced dead) at 8:23 PM. Patient found by staff in bed unresponsive. Compressions only CPR provided by staff, no BVM. Patient found pulseless, non-breathing, unresponsive at FD arrival, no lung sounds or heart tones, no response to painful stimuli, pupils fixed and dilated, lividity to lower back and legs, no obvious trauma. Per staff patient last seen alive 2-3 hours ago. No complaints prior, per staff patient bedridden. During a review of Resident 119 ' s Certificate of Death (COD) signed by the physician on [DATE], the COD indicated Resident 119 ' s date of death was [DATE]. The COD indicated Resident 119 ' s immediate cause of death (final disease or condition resulting in death) was cardiopulmonary arrest. The COD indicated Resident 119 ' s underlying cause of death (disease or injury that initiated the event resulting in death) was COPD. During an interview on [DATE] at 9:58 AM, Licensed Vocational Nurse (LVN) 10 (7 AM to 3 PM shift LVN assigned to Resident 119 on [DATE]), LVN 10 stated in the morning of [DATE], Resident 119 had low blood pressure readings that would fluctuate. LVN 10 stated she monitored the blood pressure consistently. LVN 10 stated Resident 119 ' s blood pressure she documented was about 98/58 mm/hg. LVN 10 stated she took Resident 119 ' s blood pressure 2 to 3 times and when he was repositioned the BP became stable. LVN 10 stated she only documented one blood pressure reading she took and could not recall the rest of the BP readings. LVN 10 stated she did not document anything unless something happens with Resident 119 ' s physical condition. During an interview on [DATE] at 10:36 AM, Registered Nurse (RN) 2 (7 AM to 3 PM shift RN assigned to Resident 119 on [DATE]) stated on the day of [DATE], Resident 119 was assessed throughout the dayshift ([DATE]) for fluctuating and low blood pressure readings. RN 2 stated Resident 119 ' s condition was stable on [DATE]. RN 2 stated that if Resident 119 ' s condition was stable, she does not document the low and fluctuating BP readings in the resident ' s records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:48 AM, Licensed Vocational Nurse (LVN) 8 stated she was the charge nurse assigned to Resident 119 on [DATE]. LVN 8 stated she made her resident rounds (regular visits made by nurses to check on their patients and assess their progress, well-being and safety) before she took her break at 7:30 to 8:00 PM and observed Resident 119 was stable. LVN 8 stated before she left for her lunch break at 7:30 PM, Resident 119 ' s oxygen saturation was fluctuating between 90 to 93% with continuous oxygen at 2 liters via nasal cannula. LVN 8 stated before she left for her break, Resident 119 was able to open eyes when called by name and mouth breathing was shallow. LVN 8 stated she could not recall the color of Resident 119 ' s skin, but appeared weak and tired. LVN 8 stated when she came back from her break at around 8:06 PM, she observed LVN 9 rushing to Resident 119 ' s room and Registered Nurse (RN) 4 was at the Nursing Station calling 911 EMS preparing paperwork for Resident 119 ' s possible transfer to GACH. LVN 8 stated she was informed by LVN 9 that there was an emergency going on with Resident 119. LVN 8 stated Resident 119's blood pressure was fluctuating two days ago and was on the low side with a systolic blood pressure reading about 80 mm/hg. LVN 8 stated Resident 119 appeared weaker during this current readmission to the facility ([DATE]). During the same interview on [DATE] at 12:04 PM, LVN 8 stated Resident 119's usual blood pressure from readmission was as low as 80/40 mm/hg and as high as 90 mm/hg. LVN 8 stated she would only document the good number in Resident 119 ' s electronic records, because if she wrote the bad number she would be questioned (by facility leadership). LVN 8 stated she thought the physician was aware of Resident 119 ' s fluctuating blood pressure. LVN 8 stated when she arrived on her shift on [DATE] at around 3 PM to 3:30 PM, Resident 119 ' s blood pressure was around 80/40 mm/hg and on the low side. LVN 8 stated she could not recall the other blood pressure readings Resident 119 had, but she reported to RN 4 the fluctuating blood pressures results of Resident 119. LVN 8 stated RN 4 informed her to monitor Resident 119 ' s blood pressure because the resident was just readmitted back from GACH 1 recently. LVN 8 stated she did not document Resident 119's fluctuating blood pressure. LVN 8 stated before she left for break, she endorsed to LVN 9 that at the time she did not see any sudden change of condition resident was at baseline. During a telephone interview with Physician 1 on [DATE] at 12:55 PM, Physician 1 stated he could not recall specifically if he was notified of Resident 119 ' s change of condition on [DATE]. Physician 1 stated usually nurses would notify the physician if a resident ' s blood pressure went below expected or if there was a change in a resident's status. Physician 1 stated if resident's blood pressure was unstable I would send him [Resident 119] to emergency room and according to family wishes. During an interview on [DATE] at 3:51 PM, the Director of Nursing (DON) stated nurses/staff should be documenting everything that occurred in a resident. The DON stated nurses should document correct result, to know what they did for the resident, if the physician was notified, and if interventions were provided for the resident. The DON stated if the nurses does not document the correct result and something happens to resident there could be a delay in interventions. The DON stated she expects the nurses to document abnormalities and to notify the physician so that the resident is safe. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:45 AM, RN 4 stated she could not recall if LVN 8 notified her of Resident 119 ' s fluctuating blood pressure. RN 4 stated around 3 to 3:30 PM on [DATE], Resident 119 ' s blood pressure was not fluctuating. RN 4 stated LVN 8 only notified her about Resident 119 ' s oxygen saturation at 90% around 8 PM. RN 4 stated there was nothing alarming between 3 PM to 8 PM. RN 4 stated if Resident 119 had a change of condition like blood pressure going high or going low, she would assess the resident first, if assessment was abnormal she would call 911 immediately and notify physician before calling the family. At 8 PM, RN 4 stated LVN 8 grabbed her and said, come and see the oxygen. RN 4 stated when she came to Resident 119 ' s room, that was when she saw Resident 119 ' s oxygen was 90%, so she went to grab her own pulse oximeter, and Resident 119 ' s oxygen saturation was even lower than 90 % and was 85 to 86 %. RN 4 stated that was when she rushed to the Nurses Station then went back to the resident ' s room and started performing the chest maneuver to Resident 119. During a concurrent interview and record review of Resident 119 ' s Change of Condition on [DATE] at 10:52 AM, RN 4 stated CPR was initiated because she saw Resident 119 ' s oxygen and blood pressure was getting low. RN 4 stated she had already called 911. RN 4 stated CPR was cardiopulmonary resuscitation. RN 4 stated the nurse have to check if resident was full code, then check the pulse, you can start CPR if there is still a pulse. RN 4 demonstrated CPR and stated you interlock hands make sure you press 1 to 2 inches deep about 100 to 120 times per minute, on the chest around the apex of the heart and if you are comfortable you can give mouth to mouth and I did not give breaths. RN 4 stated Resident 119 was breathing, He [Resident 119] was breathing all through until the last minute. RN 4 stated she started chest compressions when the resident ' s oxygen was low at 85 to 86%. RN 4 stated She was doing both chest rub and chest compressions at the same time. RN 4 stated she and LVN 8 were doing both at the same time, alternating chest rub and chest compressions. RN 4 stated the chest rub worked better. RN 4 stated she checked Resident 119 ' s wrist for pulse and it was present. RN 4 stated Resident 119 was desatting [short term for desaturate [oxygen levels are dropping]) which was why she started chest compressions. RN 4 stated Resident 119 ' s pulse was very low, and she still performed chest compressions. RN 4 stated she did not give Resident 119 rescue breaths and that no one did rescue breaths because i was focusing on chest more. RN 4 stated after calling 911 everything was going down. RN 4 stated the paramedics arrived already. RN 4 stated the vital signs were not going low at that time like 90 something, that was the last thing i wrote down. RN 4 confirmed she did not document the abnormal findings and details about what happened when Resident 119 was found unresponsive. RN 4 stated there was no reason why she did not include Resident 119 ' s abnormal vital signs. RN 4stated she did not document of PCC the abnormal vitals, it was important to include the abnormal findings on the note, for reference to compare. RN 4 stated the abnormal findings should be documented. During a review of the facility ' s undated policy and procedure (P&P) titled Change of Condition indicated the purpose was to ensure proper assessment and follow-through for any resident with a change of condition. The P&P indicated documentation of change in condition shall be performed by the Licensed Nurse accordingly: documenting for at least 72 hours, or longer if condition change warrants, using appropriate form for daily charting, documenting vital signs for each shift, and reassess resident condition as needed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s P&P titled Charting and Documentation dated 7/2017 indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident ' s medical, physical, functional or psychological condition, shall be documented in the resident's medical record. The P&P indicated documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. The P&P indicated documentation of procedures and treatments will include care-specific details, including: the date and time the procedure/treatment was provided; the name and title of the individual(s) who provided care; the assessment data and/or any unusual findings obtained during the procedure/treatment; and notification of family, physician or other staff if indicated.

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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 ensure the enteral tube feeding (a feeding tube is a medical device used to provide nutrition to people who cannot obtain nutrition by mouth) formula bag was labeled with the date and time for one of five sampled residents (Resident 80) in accordance to the facility's Policy and Procedure for Enteral Feeding Monitoring. This deficient practice had the potential to place Resident 80 at risk for infection. Findings: During a review of Resident 80's admission Record (AR), the AR indicated the facility originally admitted Resident 80 on [DATE] and readmitted her on [DATE] with diagnoses that included dementia (a group of thinking and social symptoms that interferes with daily functioning) and gastrostomy (creation of an artificial external opening into the stomach for nutritional support). During a review of Resident 80's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], indicated Resident 80 had severely impaired memory and cognition (ability to think and reason). The MDS indicated Resident 80 was dependent with oral hygiene, toileting hygiene, shower/bathe self, personal hygiene, and chair/bed-to-chair transfer. During a review of Resident 80 ' s Order Summary Report, dated [DATE], the report indicated the physician ordered to administer Fibersource HN 1.2 (a nutritionally complete tube feeding formula with fiber) at rate of 50 milliliter (ml, a unit of measurement) per hour for 20 hours via feeding pump (a medical device used to deliver liquid nutrition, medications, or special formulas to patients who cannot eat by mouth) to provide 1000 ml/1200 kcal (kilocalorie, a unit of measurement) per day, starting on [DATE]. The report also indicated a physician ' s ordered to turn the feeding pump on at 12 PM and to turn off the feeding pump at 8 AM, starting on [DATE]. During an observation on [DATE] at 9:48 AM, Resident 80 ' s gastrostomy tube (G-tube, a feeding tube inserted through the belly that brings nutrition directly to the stomach) feeding pump was secured on an intravenous (IV, a way of giving a drug or other substance through a needle or tube inserted into a vein) pole (a medical device to provide a secure place to hang bags of medicine or fluid for administration to a patient) next to Resident 80 ' s bed. G-tube feeding pump was turned off. An opened bag of Fibersource formula was observed hanging from the IV pole with the feeding tubing placed inside the feeding pump, ready for infusion. There was no open date indicated on the Fibersource formula bag indicating when the formula bag was opened and started. During a concurrent observation and interview on [DATE] at 9:50 AM, with licensed vocational nurse (LVN) 7, LVN 7 stated Resident 80 ' G-tube feeding was stopped at 8 AM on [DATE]. LVN 7 stated the nurse who opened and hung the current formula bag did not write down the open date on the formula bag. LVN 7 stated he did not know when the current bag was opened and hung, and could not state if the formula bag was expired. LVN 7 stated the nurse should write down the open date, and when the formula bag was hung, so licensed nurses (LN) would know when to change or dispose of Resident 80 ' s formula bag to prevent any potential for infection to the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:42 PM with the Director of Nursing (DON), the DON stated the G-tube feeding formula bag should be labeled with the open date when it was opened and hung, so the nurses would know when to change the formula bag, to prevent potential infection from the overgrowth of bacteria in the old formula bag. During a review of the updated facility ' s policy and procedure (P&P) titled, Enteral Feeding Monitoring, the P&P indicated Licensed nurse will write the time, date, and rate on the formula Bottle including initials and Closed system formula must be discarded after 48 hours.

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident room measured at least 80 square feet (sq ft- a unit of measurement) per resident for 27 of 50 sampled resident rooms (Rooms 101, 102, 103, 104, 105, 106, 107, 108, 109,110, 201, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 218, and 220). This deficient practice had the potential to impact the ability to provide safe nursing care and privacy to the residents. Findings: During an interview and record review on 5/23/25 at 1:13 PM with the Administrator (ADM), the Client Accommodations Analysis (CAA- a form used to identify the room sizes and number of beds in the room) form, dated 5/19/25 was reviewed. The form indicated the following 27 residents ' rooms did not measure 80 sq ft per resident: Rooms 101, 103, 104, 106 to 110, 201, 203 to 216, 218, and 220 were occupied by three residents in each room with a total room square footage of 217, providing each resident with a 72.33 sq ft care area. room [ROOM NUMBER] was occupied by three residents with a total room square footage of 223.24, providing each resident with a 74.41 sq ft care area. room [ROOM NUMBER] was occupied by three residents with a total square footage of 219, providing each resident with a 73 sq ft care area. During an interview on 5/22/25 at 9:22 AM with Licensed Vocation Nurse (LVN) 7, LVN 7 stated there was enough space in the room to perform tasks effectively and safely for each resident. During an interview on 5/22/25 at 9:28 AM with Resident 101, Resident 101 stated that there is enough space when the staff gets the resident into their wheelchair or up to shower and they do not have any concerns about the current room size. During an interview on 5/21/25 at 4:33 PM with Certified Nursing Assistant (CNA) 6 in Resident 17 ' s room, CNA 6 stated there is enough space in the room to use a mechanical lift (a device used to assist with transfers and movement of individuals who require support for mobility) without having to move Resident 17 ' s bedside commode or bed to make room. CNA 6 stated the current room did not affect the staff providing care to the residents safely. During a concurrent observation and interview on 5/21/25 at 4:32 PM in Resident 471 ' s room, Resident 471 was using a walker in their room and stated there is enough space to move around freely without issue. During an interview on 5/21/25 at 4:30 PM in Resident 7 ' s room, Resident 7 stated there is sufficient space in the room to use their walker and bedside commode without issue. (continued on next page)

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	05/23/2025

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an observation from 5/19/25 to 5/23/25, the above listed rooms had sufficient space for the residents' freedom of movement. The rooms had adequate space to provide nursing care, privacy during care, and the ability to maneuver resident care equipment with the room. The room size did not present any adverse effect on the residents' personal space, nursing care, and comfort. The facility's variance request (a request that allow minor deviations from zoning requirements that regulate how a room may be developed), dated 5/23/25, indicated that granting the variance will not adversely affect the residents' health and safety or impede the ability of any residents to obtain their highest level of partible wellbeing.