STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055187	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden View Post Acute Rehabilitation	14475 Garden View Lane Baldwin Park, CA 91706

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to readmit one of ten sampled residents (Resident 1) to the first available bed in a private room when the General Acute Care Hospital 2 (GACH 2) contacted the facility regarding Resident 1's readmission to the facility on 3/10/2026. This deficient practice resulted in Resident 1 remaining in GACH 2 from 3/10/2026 through 5/7/2026, a total of 59 days, following an inquiry from GACH 2 for Resident 1 to be readmitted to the facility. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was readmitted to the facility on [DATE] with diagnoses that included pneumonia (an infection that inflames the sacs in one or both lungs), respiratory failure (lungs cannot get enough oxygen into the blood or fail to remove carbon dioxide), and chronic obstructive pulmonary disease (COPD- progressive, long-term lung disease). During a review of Resident 1's History & Physical (H&P, physician assessment and evaluation of the resident), dated 12/4/2025, the H&P indicated Resident 1 had altered level of consciousness (ALOC- a temporary, significant deviation from a person's waking mental state) and dementia (a decline in mental ability severe enough to interfere with daily life). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 11/23/2025, the MDS indicated Resident 1's cognition (ability to understand and process thoughts) was severely impaired and Resident 1 was dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of the Physician Orders (PO), dated 2/2/2026, the PO indicated Resident 1 was transferred to GACH 1 via 911 on 2/2/2026 due to (d/t) ALOC. During a review of the GACH 2 Case Manager admission Assessment (CMAA), dated 2/17/2026, the CMAA indicated that Resident 1 was admitted to GACH 2 from GACH 1 on 2/16/2026 for continual care with a diagnosis of sepsis (the body's life-threatening response to an infection). During a record review of the GACVH 2 Discharge Plan (DP), dated 5/5/2026, the DP indicated the Case Manager, RN (CMRN) reached out to Admissions (ADM 1) at the facility and ADM 1 stated no isolation bed was available for Resident 1. The CMRN indicated barriers for discharge were isolation bed availability at resident ?s previous facility for candida auris (multi-drug-resistant fungus) and CRE (highly drug-resistant bacteria) and no Medi-Care benefit days left. During a phone interview, on 5/5/2026, at 3:48 p.m., with the CMRN, the CMRN stated Resident 1 was admitted to GACH 2 on 2/16/2026 for continued care and continued antibiotic use. The CMRN stated Resident 1 had candida auris (multi-drug-resistant fungus) and CRE (highly drug -resistant bacteria), that was present upon admission to GACH 2. The CMRN stated the CMRN first contacted facility on 3/10/2026 for readmission of Resident 1 to the facility. CMRN stated CMRN communicated with the facility's ADM 1. During a phone interview, on 5/6/2026, at 4:08 p.m., with ADM 1, ADM 1 stated the reason Resident 1 was not readmitted was because Resident 1 had two specific isolations and Resident 1 required a private restroom for Resident 1's isolation. ADM 1 stated GACH 2 had reached out, and the facility had been in contact with GACH 2 and advised GACH 2 that it had been kind of tricky to find a room for Resident 1. ADM 1 stated other residents had been moved around but residents could not be forced to change rooms; and a room for Resident 1 was not created. ADM 1 stated ADM 1's last contact with the CMRN was probably last (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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	week. During a phone interview, on 5/6/2026, at 4:33 p.m., with the Infection Preventionist (IP), the IP stated Resident 1 required contact Isolation (infection control measure used to prevent the spread of germs that are transmitted through direct or indirect contact). The IP stated the IP made recommendations to the admissions team, and the admissions team made the determination regarding availability of rooms. During a concurrent interview and record review, on 5/6/2026, at 5:03 p.m., with the Director of Nursing (DON) and the Administrator (ADMIN), the facility Census list was reviewed. The Census indicated there were seven available beds in the facility. During a concurrent interview and record review, on 5/7/2026, at 12:37 p.m., with ADM 1, the facility Admission/Discharge To/From Reports, dated 3/10/2026-5/7/2026, were reviewed. The Reports indicated there was a total of 34 beds available from 3/10/2026. ADM 1 stated eight rooms in the facility had a private bathroom. During an interview, on 5/7/2026, at 2:00 p.m., with the DON, the DON stated in general, when we transfer a resident to the hospital, we would have to take our patient back. The DON stated that Resident 1 is a long-term resident and Resident 1 would have to come back to the facility. The DON stated that according to the facility Policy, readmissions are given the first available bed. During a review of the facility's Policy and Procedure (P&P), titled, Admission/Transfer/Discharge- Bed Hold, revised November 2016, the P&P indicated if the resident's hospitalization or therapeutic leave exceeds the bed-hold period of seven (7) days, the resident may return to the facility to their previous room, if available or immediately upon the first availability of a bed in a semi-private room, if the resident: Requires the services provided by the facility; and Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assess and monitor one of ten sampled residents (Resident 6) in accordance with facility's policy and procedure (P&P) titled, Change in Condition, after discovering an incident on 5/4/2026 that involved Resident 6 and Resident 7. This deficient practice resulted in Resident 6 receiving inadequate care and had the potential to negatively affect Resident 7's psychosocial well-being. a. During a review of Resident 6's admission Record, dated 5/6/2026, the admission Record indicated Resident 6 was originally admitted to the facility on [DATE]. The admission Record indicated Resident 6's diagnoses included morbid obesity (a chronic disease in which a person weighs 100 pounds or more over his/her ideal body weight), acquired absence of right leg above the knee (the surgical removal of the right leg starting somewhere above the kneecap), and muscle weakness. During a review of Resident 6's History and Physical Examination (H&P - a physician's assessment and evaluation of the resident), dated 9/26/2025, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated 3/13/2026, the MDS indicated Resident 6 was dependent (helper does all the effort to complete the activity) on staff for toileting hygiene and lower body dressing. During a concurrent observation and interview on 5/4/2026 at 2:18 p.m. with Resident 6, Resident 6 was observed lying in bed in Resident 6's room and Resident 6's various personal belongings were observed on top of Resident 6's bedside tray table. Resident 6 stated on 5/4/2026 at approximately 6:30 a.m., Resident 6 saw Resident 6's roommate (Resident 7) close their room door and then walked toward Resident 6's side of the room. Resident 6 stated Resident 7 was wearing only a diaper that appeared to be soiled and falling off. Resident 6 stated Resident 6 pressed Resident 6's call light so that the nursing staff could assist Resident 7. Resident 6 stated Resident 7 walked closer to Resident 6, grabbed the water pitcher that was on top of Resident 6's bedside tray table and threw it in the direction of Resident 6, who was in bed. Resident 6 stated Resident 7 then grabbed Resident 6's left leg from under the bedsheet but Resident 6 was able to free themselves. Resident 6 stated Resident 7 grabbed a half-filled cannister of potato chips and hit Resident 6 with the cannister which resulted in potato chips landing all over Resident 6 and around the room. Resident 6 stated Certified Nursing Assistant 1 (CNA 1) was the first staff member to come inside the room and separated Resident 7 from Resident 6. During an interview on 5/4/2026 at 4:42 p.m. with Resident 6, Resident 6 stated night shift Registered Nurse 1 (RN 1) came to assist CNA 1 by watching Resident 7 while CNA 1 picked up Resident 6's belongings from the floor and placed them back on Resident 6's bedside tray table. Resident 6 stated CNA 1 cleaned the potato chips off Resident 6's body and off Resident 6's bed. Resident 6 stated when Licensed Vocational Nurse (LVN) 1 arrived in the room shortly after the incident, Resident 6 told LVN 1 that Resident 6 wanted Resident 7 to be taken out of their shared room. b. During a review of Resident 7's admission Record, dated 5/6/2026, the admission Record indicated Resident 7 was originally admitted to the facility on [DATE]. The admission Record indicated Resident 7's diagnoses included repeated falls, unspecified dementia (when a person has symptoms of mental decline, such as memory loss or confusion, but the exact cause is unknown), and Alzheimer's disease (a progressive brain disorder that slowly destroys memory, thinking skills, and the ability to carry out basic daily tasks). During a review of Resident 7's Change of Condition (COC - a form of documentation that describes when the condition or care needs of a resident has changed), dated 5/4/2026, the COC indicated at approximately 7:15 a.m. on 5/4/2026, Resident 7 was found walking with only [an] incontinent pad and had went to roommate['s] bedside table and threw all on the floor. The COC indicated Resident 2 was very aggressive / combative, throwing things on the floor, threatening to strike at staff. During an interview on 5/5/2026 at 10:10 a.m. with CNA 1, CNA 1 stated on 5/4/2026 at around 6:40 a.m., CNA 1 heard the bed alarm coming from Resident 6 and Resident 7's shared room. CNA 1 stated CNA 1 saw (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 6 and Resident 7's room door closed and the call light above the door was lit. CNA 1 stated when CNA 1 opened the door, CNA 1 saw Resident 7 standing at the foot of Resident 6's bed. CNA 1 stated CNA 1 heard Resident 7 verbalized that Resident 6 needed to get out of Resident 7's house. CNA 1 stated Resident 6 looked very agitated, and that Resident 6 reported that Resident 7 was throwing Resident 6's belongings. CNA 1 stated CNA 1 saw potato chips, a water pitcher, and Resident 6's personal items on the floor. CNA 1 stated CNA 1 first moved Resident 7 away from Resident 6's area, and then CNA 1 picked up Resident 6's personal items from the floor and placed them back on Resident 6's bedside tray table. CNA 1 stated CNA 1 also assisted in removing and cleaning the potato chips off Resident 6's body. During a phone interview on 5/5/2026 at 11:04 AM with RN 1, RN 1 stated RN 1 was the assigned night shift nurse for Resident 6 and Resident 7 on 5/4/2026. RN 1 stated on 5/4/2026 at approximately 6:40 a.m., a staff member (unidentified) from the morning shift had asked RN 1 to go to the shared room of Resident 6 and Resident 7 because an incident had occurred. RN 1 stated when RN 1 arrived at Resident 6 and Resident 7's room, RN 1 heard Resident 7 said that the room was Resident 7's house, and Resident 7 was asking why Resident 6 was inside Resident 7's house. RN 1 stated RN 1 saw some of Resident 6's personal belongings on the floor, including a pair of scissors. RN 1 stated RN 1 picked up the scissors and placed them in RN 1's pocket because RN 1 did not want Resident 7 to see the scissors. RN 1 stated he saw Resident 6 looked irritated, and RN 1 heard Resident 6 verbalize that Resident 6 wanted Resident 7 to be removed from their shared room. RN 1 stated RN 1 did not ask Resident 6 what had happened that resulted in Resident 6's belongings all over the floor. RN 1 stated RN 1 did not assess Resident 6 because the morning shift took over handling the incident. When asked what RN 1 would have done if RN 1 was handling the aftermath of any incident, RN 1 stated RN 1 would first make sure the residents involved were safe. RN 1 stated RN 1 would then assess the situation by asking each resident what had happened so that RN 1 can appropriately plan the residents' care. During an interview on 5/5/2026 at 2:55 PM with Resident 6, Resident 6 stated after the incident involving Resident 7 occurred, LVN 1 and RN 1 did not approach Resident 6 to ask Resident 6 the details of what had happened. Resident 6 stated LVN 1 and RN 1 did not check Resident 6's body after the incident. Resident 6 stated sometime in the afternoon of 5/4/2026, Resident 6 noted a discoloration on the back of his right hand that Resident 6 had not noticed prior to the 5/4/2026 dated incident. Resident 6 stated Resident 6 was unsure what caused the discoloration. During an interview on 5/5/2026 at 3:16 p.m. with Director of Social Services (DSS), DSS stated on 5/4/2026 at approximately 2:00 p.m., RN 1 informed DSS that Resident 6 wished to speak with DSS. DSS then spoke with Resident 6 who reported that Resident 7 threw potato chips at Resident 6. DSS stated Resident 6 also reported that Resident 7 was going through Resident 6's belongings, and that Resident 7 had touched Resident 6's left leg. DSS stated Resident 6 expressed a desire to file a grievance regarding the incident involving Resident 7. During a concurrent interview and record review on 5/6/2026 at 8:59 a.m. with LVN 1, Resident 7's electronic medical record was reviewed. LVN 1 stated on 5/4/2026 at around 7:00 AM, LVN 1 was instructed by RN 2 to go to the shared room of Resident 6 and Resident 7 because an incident had occurred. LVN 1 stated when LVN 1 entered the room, LVN 1 saw chips on the floor of the entire room. LVN 1 stated LVN 1 saw CNA 1 standing in between Resident 6 and Resident 7. LVN 1 stated Resident 7 was sitting on Resident 7's bed wearing only a pull-up diaper. LVN 1 stated LVN 1 heard Resident 7 verbalize that Resident 7 wanted Resident 6 to get out of Resident 7's house. LVN 1 stated that RN 2 instructed LVN 1 to assist in transferring Resident 7 to a new room. LVN 1 stated after assisting with the transfer of Resident 7, LVN 1 documented LVN 1's observations in the COC Follow Up Nurses Note, dated 5/4/2026 which indicated Resident 7 was noted with aggressive and combative behavior. LVN 1 stated LVN 1 did not specifically assess Resident 6 because LVN 1 was concentrated on Resident 7. LVN 1 stated LVN 1 only documented LVN 1's assessment of Resident 7. LVN 1 stated LVN 1 should have also assessed Resident 6 by getting information from Resident 6 on what had happened, and by physically checking (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 6 to see if Resident 6 got injured during the incident. LVN 1 stated it is important to assess each resident involved in any incident to find out what happened, and to determine if there was any injury that resulted from the incident. During an interview on 5/6/2026 at 9:46 AM with RN 2, RN 2 stated on 5/4/2026, RN 2 was doing RN 2's initial morning rounds (when nursing staff check on each resident in the facility) when RN 2 saw Resident 7 standing inside Resident 7's room wearing only a pull-up diaper and verbalizing that Resident 7's room was Resident 7's house. RN 2 stated RN 2 saw Resident 6's personal items on the floor, and CNA 1 was already in the room standing between Resident 6 and Resident 7. RN 2 stated RN 2 instructed CNA 1 not to get too close to Resident 7 because Resident 7 appeared agitated. RN 2 stated RN 2 instructed staff to transfer Resident 7 to a different room, while RN 2 contacted Resident 7's doctor and obtained a medication order to assist in calming Resident 7 down. RN 2 stated after Resident 7 was transferred to a new room and had visibly calmed down, RN 2 completed a COC for Resident 7. During a concurrent interview and record review on 5/6/2026 at 10:08 a.m. with RN 2, Resident 6's electronic medical record was reviewed. RN 2 stated RN 2 did not complete a COC for Resident 6. RN 2 stated Resident 6's medical record contained a COC that was completed by the Director of Nursing (DON) on 5/4/2026 at 2:16 p.m., which was about seven hours after the incident involving Resident 6 and Resident 7 had initially occurred. RN 2 stated RN 2 did not specifically ask Resident 6 what had happened because it was chaos when RN 2 discovered the incident. RN 2 stated on 5/4/2026 RN 2 did not ask Resident 6 about what had happened with Resident 7. RN 2 stated RN 2 did not physically assess Resident 6 after the incident occurred. RN 2 stated RN 2 should have assessed Resident 6 by asking Resident 6 questions about the incident and if Resident 6 felt threatened. RN 2 stated RN 2 should have also competed a body check of Resident 6 after the incident, which is a physical assessment of Resident 6's body to determine if there was any injury. During a phone interview on 5/6/2026 at 11:43 a.m. with the DON, the DON stated a resident has a change of condition if something outside of the normal occurs, whether it be physical or mental changes. When asked what a licensed nurse should do if he/she enters a resident's room and discovers personal belongings all over the floor, DON stated it is standard nursing practice for a licensed nurse to assess the situation and assess the residents involved in the incident. DON stated licensed nurses need to ask residents questions to find out what happened to them during an incident. DON stated nursing assessment is important because it will assist in determining if there was any harm that occurred. DON further stated that licensed nurses needed to assess incidents timely so that the licensed nurses can determine the plan of action and the next steps to take. During a review of the facility's policy and procedure (P&P) titled, Change in Condition, dated 4/2025, the P&P indicated the following: It is the policy of this facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical mental and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and plan of care. The P&P further indicated: If, at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the Licensed Nurse or Nurse Supervisor should be made aware. The nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions.