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	01/10/2025

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview, and record review the facility failed to provide and maintain dignity for two of two sampled residents (Residents 138 and 238) by failing to: a. Close Resident 138's privacy curtain and Resident 138's body was exposed and can be seen from the hallway. b. Close Resident 238's privacy curtain and Resident 238's upper extremities were exposed when Minimum Data Set Nurse (MDSN) checked the resident's surgical site. These deficient practices violated Residents 138 and 238's right to privacy. Findings: a. During a review of Resident 138's Admission Record (AR), the AR indicated Resident 138 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control) and generalized muscle weakness. During a review of Resident 138's History and Physical (H&P, a formal assessment that a doctor performs for information about a patient's health) dated 11/28/2024, the H&P indicated Resident 138 had the capacity to understand and make decisions. During a review of Resident 138's Minimum Data Set (MDS, a resident assessment tool) dated 11/30/2024, the MDS indicated Resident 138 had clear speech, had the capacity to understand others and make self understood and had intact cognition. The MDS indicated Resident 138 was dependent (helper does all of the effort) for toilet hygiene and rolling left and right. During a concurrent interview and observation on 1/7/2025 at 9:28 am, in Resident 138's room, Resident 138 was lying in bed and the resident's above the knee to chest area was exposed. Resident 138's privacy curtain was not closed and Resident 138's exposed body part could be seen from the hallway. Certified Nursing Assistant 6 (CNA6) stated, CNA 6 forgot to close Resident 138's privacy curtain after CNA 6 prepared Resident 138 for a bed bath. CNA 6 stated, when providing bed bath, staff should close the privacy curtain for resident's privacy and to respect their dignity. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42781 b. During a review of Resident 238's AR, the AR indicated Resident 238 was admitted to the facility on [DATE] with diagnoses that included fracture (broken bone) of unspecified part of the neck of the right femur (thigh bone). During a concurrent interview and observation in Resident 238's room on 1/7/2025 at 9: 43 am, Resident 238 was awake, lying in bed. The MDSN opened Resident 238's gown to check Resident 238's surgical site on the right upper thigh. The MDSN did not close the privacy curtain to provide Resident 238 privacy exposing Resident 238's thigh. The MDSN stated, the resident's privacy curtain needed to be closed to provide privacy to Resident 238. During an interview on 1/8/2025 at 11:30 am with the facility's Director of Nursing (DON), the DON stated the resident's privacy curtain needed to be closed during resident care to maintain Resident 238's dignity and privacy. During a record review of the facility's Policy and Procedure (P&P) titled, Resident Rights reviewed on 1/2024, the P&P indicated residents shall be examined and treated in a manner that maintains the privacy of their bodies. The P&P indicated a closed door or drawn curtain shields the residents from passers-by.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of residents' needs for four of four sampled residents (Residents 13, 20, 39, and 57). For Residents 13, 20 and 57, the call light (device that allows the resident to request assistance from nursing staff) was not within reach. For Resident 39, the resident did not know how to use the call light and the purpose of the call light was not explained to the resident. These failures had the potential for the residents not to receive care or receive delayed services to meet the residents' needs and could result in a fall or injury. Findings: a. During a review of Resident 13's Admission Record (AR), the AR indicated Resident 13 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and osteoarthritis (a progressive disorder of the joints caused by a gradual loss of cartilage). During a review of Resident 13's Minimum Data Sheet (MDS, a resident assessment tool) dated 11/8/2024, the MDS indicated Resident 13 had severely impaired cognition (ability to understand). The MDS indicated Resident 13 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral and personal hygiene, partial/moderate assistance (helper did less than half the effort) with upper body dressing, substantial/maximal assistance (helper did more than half the effort) with eating and shower, and dependent (helper did all of he effort, resident did none of the effort to complete the activity) with toileting and lower body dressing. During a review of Resident 13's untitled Care Plan (CP) dated 8/13/2024, the CP indicated Resident 13 was at risk for falls related to weakness, dementia, syncope, and seizures. The CP interventions indicated to ensure the call light was within reach and to encourage the resident to use it to call for assistance as needed. During a concurrent observation inside Resident 13's room and interview on 1/7/2025 at 10:56 am with Licensed Vocational Nurse 1 (LVN 1), Resident 13's call light was on the floor. LVN 1 stated, Resident 13's call light should be placed on the bed next to the resident's strong arm or hand for the resident to reach and call when help was needed. During an interview on 1/8/2025 at 11:08 am with the facility's Director of Nursing (DON), the DON stated the resident's call light should be placed on the bed within reach of the resident and on the non-affected side of the resident to be able to call for help and assistance and for staff to attend to the resident's needs immediately. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42781 b. During a review of Resident 20's AR, the AR indicated Resident 20 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Spondylolisthesis (a condition where a vertebra in the spine slips out of place, either forward or backward, relative to the neighboring vertebrae) and major depressive disorder (persistent feeling of sadness and loss of interest). During a review of Resident 20's CP titled Fall Risk, dated 4/20/2023, the CP indicated Resident 20 was as risk for falls related to gait/balance problems. The CP interventions indicated for the nursing staff to ensure the resident's call light was within reach and to encourage the resident to use the call light to call for assistance as needed. During a review of Resident 20's MDS dated [DATE], the MDS indicated Resident 20 had intact cognition for daily decision making. The MDS indicated Resident 20 needed supervision during shower. During a review of Resident 20's Fall Risk Assessment (FRA- method of assessing a patient's likelihood of falling) dated 11/16/2024, the FRA indicated Resident 20 was assessed as high risk for fall due to history of fall, required regular assistance with elimination, required the use of assistive devices and presence of predisposing disease condition. During a concurrent observation in Resident 20's room and interview on 1/7/2025 at 10:22 am, Resident 20 was awake, lying on bed. Resident 20's call light was hanging on the oxygen concentrator on the left side of bed, approximately 3 feet away from Resident 20. Resident 20 stated Resident 20 could not reach the call light. During a concurrent observation in Resident 20's room and interview on 1/7/2025 at 10:23 am with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated, Resident 20 could not reach the call light because it was hanging on the oxygen concentrator, which was 3 feet away from Resident 20. c. During a review of Resident 39's AR, the AR indicated Resident 39 was admitted to the facility on [DATE] with diagnoses that included difficulty in walking and need for assistance with personal care. During a review of Resident 39's CP titled Fall Risk dated 7/10/2024, the CP indicated Resident 39 was at risk for falls due to status post (after) fall. The CP interventions indicated for the nursing staff to be ensure the call light was within reach and to encourage the resident to use the call light to call for assistance as needed. During a review of Resident 39's History and Physical (H&P) dated 7/30/2024, the H&P indicated Resident 39 had the capacity to understand and make decisions. During a review of Resident 39's MDS dated [DATE], the MDS indicated Resident 39 had moderately impaired cognition for daily decision making. The MDS indicated Resident 39 was dependent (helper does all of the effort) to staff for toileting hygiene, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 39 needed moderate assistance with oral hygiene, upper body dressing and personal hygiene. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 39's FRA dated 10/14/2024, the FRA indicated Resident 39 was assessed as high risk for fall due to disorientation, history of falls, regularly incontinent, poor vision, and presence of predisposing disease condition. During an observation in Resident 39's room on 1/7/2025 at 9:58 am, Resident 39 was awake and lying in bed. Resident 39 stated I did not know how to use it (pointing to the call light) and it was not explained to me. Resident 39 stated Resident 39 would shout if Resident 39 needed help. During an interview on 1/7/2025 at 9:59 am, with the MDS Nurse (MDS N), the MDSN stated, the use and purpose of the call light needed to be explained to Resident 39. The MDSN stated, residents needed to use the call light to communicate with the staff. d. During a review of Resident 57's AR, the AR indicated Resident 57 was admitted to the facility on [DATE] with diagnoses that included muscle weakness, need for assistance with personal care and dementia (long term and often gradual decrease in the ability to think, severe enough to affect a person's daily functioning). During a review of Resident 57's CP titled Fall Risk dated 7/10/2024, the CP indicated Resident 57 was at risk for falls due to status post fall. The CP interventions indicated for the nursing staff to ensure the call light was within reach and to encourage the resident to use the call light to call for assistance as needed. During a review of Resident 57's MDS dated [DATE], the MDS indicated Resident 57 had severely impaired cognition for daily decision making. The MDS indicated Resident 57 was dependent to staff for toileting hygiene, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 57 needed moderate assistance for eating, oral hygiene, upper body dressing and personal care. During a concurrent observation in Resident 57's room and interview on 1/7/2025 at 10:18 am, Resident 57 was awake and lying in bed. Resident 57 stated I did not see my call button (call light). Resident 57's call light was tangled on the right side rail (bed rail; a narrow bar attached to the bed) of the bed. During a concurrent observation in Resident 57's room and interview on 1/7/2025 at 10:19 am, with the facility's Director of Staff and Development (DSD), the DSD stated Resident 57's call light was tangled on the right side rail of the bed. The DSD stated the call light needed to be within reach for the resident to use to ask for assistance or help from staff. During an interview on 1/8/2025 at 11:32 am, with the facility's DON, the DON stated the resident's call light needed to be within reach for the resident to use when needed and staff could assist the resident in a timely manner. The DON stated, upon admission, the licensed nurse needed to explain to the resident how to use the call light and its purpose. During a review of the facility's Policy and Procedure (P&P) titled, Call Light, dated 1/2024, the P&P indicated it is the policy of the facility to provide the resident a means of communication with the nursing staff. P&P indicated to answer the light/bell within reasonable time and place the call device within resident's reach before leaving the room.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview, and record review, the facility failed to provide an effective communication method for one of one non-English speaking sampled resident (Resident 138). This failure had the potential for Resident 138 not to receive necessary care and services. Findings: During a review of Resident 138's Admission Record (AR), the AR indicated Resident 138 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control) and generalized muscle weakness. During a review of Resident 138's History and Physical (H&P, a formal assessment that a doctor performs for information about a patient's health) dated 11/28/2024, the H&P indicated Resident 138 had the capacity to understand and make decisions. During a review of Resident 138's Minimum Data Set (MDS, a resident assessment tool) dated 11/30/2024, the MDS indicated Resident 138 had clear speech, had the capacity to understand others and make self understood and had intact cognition. The MDS indicated Resident 138 was dependent (helper does all of the effort) for toilet hygiene and rolling left and right. The MDS indicated Resident 138's preferred language was Spanish. During an observation in Resident 138's room and concurrent interview on 1/7/2025 at 9:28 am, Resident 138 was lying in bed. Resident 138 was not able to communicate in English. Resident 138 stated Resident 138 spoke Spanish. The Minimum Data Set Coordinator (MDSC) stated, the MDSC did not find a communication board (a tool for communication between the patient and care team) in Resident 138's room. MDSC stated, Resident 138 spoke Spanish and the facility should provide a communication board next to Resident 138's bedside so that non-Spanish speaking staff could understand Resident 138. The MDSC stated, an effective communication between staff and residents would improve the resident's quality of life and quality of care. During an interview on 1/8/2025 at 4:19 pm, with Social Service Director (SSD), the SSD stated, for non-English speaking residents, the facility should provide communication board in the resident's room to ensure staff understood the resident's request and provided care to meet the resident's need. The SSD stated it was the resident's right to choose a preferred language to use. During a review of the facility's undated Policy and Procedure (P&P) tilted, Non-English Speaking & Aphasic (non-verbal) Residents Communication for, the P&P indicated, Social service, activity or designee will supply residents and/or family members with the use of a communication board that has universally known drawings, whenever desired.

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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** 45553 Based on observation, interview, and record review, the facility failed to provide an environment free of accident hazard for one of two sampled residents (Resident 40) by failing to ensure Resident 40's bed was in the lowest position. This deficient practice had the potential to place Resident 40 at risk for recurrent fall with injury. Findings: During a review of Resident 40's Admission Record (AR), the AR indicated Resident 40 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (a brain dysfunction that occurs when there's an imbalance of chemicals in the blood), muscle weakness, Parkinsonism (movement disorder), end stage renal disease (condition when the kidneys can no longer function on their own), gout (a type of arthritis[swelling of the joints]) and need for assistance with personal care. During a review of Resident 40's Care Plan (CP) titled, At risk for Falls related to multiple Medical Conditions, initiated on 7/29/24, the CP indicated Resident 40 was at risk for falls related to Parkinson's disease, arthritis, history of falls and status post (after) right femur (thigh bone) IM (intramedullary) nailing and ORIF (Open Reduction and Internal Fixation [the broken bone is surgically realigned and secured with a metal rod]). The CP indicated for staff to adjust the bed in the lowest position for fall reduction measures. During a review of Resident 40's History and Physical (H&P) dated 7/31/24, the H&P indicated Resident 40 had the capacity to understand and make decisions. During a review of Resident 40's Fall Risk Evaluation (FRE- method of assessing a patient's likelihood of falling) dated 11/1/24, the FRE indicated Resident 40 was assessed as a medium risk for fall due to disorientation, regularly incontinent (involuntary leakage of urine from the bladder), and predisposing disease condition. During a review of Resident 40's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 11/4/24, the MDS indicated Resident 40 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 40 required set up or clean up assistance with eating, oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 40 required partial/moderate assistance with toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear. During a concurrent observation in Resident 40's room and interview on 1/7/25 at 12:57 p.m., Resident 40 stated Resident 40 had a previous fall at home and broke Resident 40's femur. Resident 40's bed was observed not in the lowest position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation in Resident 40's room and interview on 1/8/25 at 10:06 a.m. with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated Resident 40 needs assistance to put Resident 40's shoes on/off, and the resident needs help to transfer into a wheelchair. Resident 40's bed was observed not in the lowest position, 25 to 26 inches from top of bed mattress to the floor. CNA 3 stated Resident 40's bed should be in the lowest position because Resident 40 was at risk for falls. During a review of the facility's Policy and Procedure (P&P) titled, Fall Management System, revised 6/2020, the P&P indicated the facility will provide an environment that remains as free of accident hazards as possible. The P&P further indicated the facility will provide each resident with appropriate assessment and intervention to prevent falls and to minimize complications if a fall occurs.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40438 Based on observation, interview, and record review, the facility failed to provide necessary care and services for residents with indwelling catheter (including Foley Catheter- a soft flexible tube inserted into the bladder to drain urine, nephrostomy tube- a thin, flexible tube that drains urine from the kidney into a bag outside the body, and suprapubic catheter- a catheter inserted through a hole in the abdomen and then directly into the bladder) in accordance with the facility's Policy and Procedure (P&P) for four of five sampled residents (Residents 19, 26, 32 and 78) by failing to: a. Ensure Resident 19's Foley Catheter (FC) tubing was kept secured and monitored for the presence of white sediments (visible particles) in the urine. b. Ensure Resident 26's Suprapubic Catheter (SC) tubing was kept secured and the suprapubic catheter site dressing clean and dry. c. Ensure Resident 32's Nephrostomy Tubes (NT) were covered with a privacy bag and positioned lower than the bladder. d. Ensure Resident 78's FC was assessed and monitored for the presence of white sediments. These failures placed Residents 19, 26, 32 and 78 at risk for infection related to the use of indwelling catheter. Findings: a. During a review of Resident 19's Admission Record (AR), the AR indicated Resident 19 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included quadriplegia (partial or total loss of function in all four limbs), epilepsy (brain disorder in which a person has repeated seizures [convulsions] over time) and urinary tract infections (UTI, an infection in the bladder/urinary tract). During a review of Resident 19's untitled Care Plan (CP) dated 7/26/2023, the CP indicated Resident 19 had an indwelling catheter with a diagnosis of neurogenic bladder (damage to the nerves that control bladder function). The CP interventions included for staff to apply statlock or catheter stabilizer, to be changed as needed if dislodged. During a review of Resident 19's Order Summary Report (OSR) dated 2/5/2024, the OSR indicated Resident 19 had an order for licensed staff to monitor the character of the urine as clear, cloudy, with sediments or blood tinged/hematuria (blood in the urine), every shift. During a review of Resident 19's untitled CP dated 11/19/2024, the CP indicated Resident 19 had a history of UTI. The CP interventions included for staff to monitor/document/report to medical doctor (MD) as needed for signs and symptoms of UTI such as frequency, urgency, foul smelling urine, dysuria (difficulty urinating), fever, nausea and vomiting, pain, hematuria (blood in the urine), cloudy urine, altered mental status, loss of appetite and behavioral changes. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 19's Minimum Data Set (MDS, a resident assessment tool) dated 12/21/2024, the MDS indicated Resident 19 had severely impaired cognition (ability to understand). The MDS indicated Resident 19 was dependent (helper did all of the effort, resident did none of the effort to complete the activity) with oral and toileting hygiene, shower, upper and lower body dressing and personal hygiene. The MDS indicated Resident 19 had an indwelling catheter. During a concurrent observation inside Resident 19's room and interview on 1/7/2025 at 10:16 am with Certified Nurse Assistant 2 (CNA 2), Resident 19 had a foley catheter. The Foley catheter tubing had white sediments. CNA 2 stated, Resident 19's foley catheter tubing was not secured with a statlock or stabilizer on the thigh and the statlock was broken. CNA 2 stated Resident 19's foley catheter tubing should be secured to prevent pinching and pulling during movement. During an interview on 1/8/2025 at 11:08 am with the facility's Director of Nursing (DON), the DON stated treatment nurses and licensed nurses should monitor foley catheter tubing for the quality of the urine such as color and the presence of sediments, every shift to prevent UTI. The DON stated, Resident 19's Foley catheter tubing should be secured on the thigh to prevent from pulling and getting dislodged during movements. b. During a review of Resident 26's AR, the AR indicated Resident 26 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included paraplegia (loss of movement and/or sensation to some degree, of the legs), neuromuscular dysfunction of the bladder (also known as neurogenic bladder) and calculus of kidney (a small, hard deposit that forms in the kidneys and painful when passed). During a review of Resident 26's untitled CP dated 11/18/2024, the CP indicated Resident 26 had a suprapubic catheter related to neurogenic bladder. The CP interventions included to secure the suprapubic catheter to facilitate flow of urine, prevent kinking of tubing, and accidental removal. During a review of Resident 26's OSR dated 11/19/2024, the OSR indicated for licensed staff to clean Resident 26's suprapubic site with normal saline (NS) daily, pat dry and cover with drain sponge. During a review of Resident 26's MDS dated [DATE], the MDS indicated Resident 26 had intact cognition. The MDS indicated Resident 26 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed activity) with oral hygiene, and dependent with toileting hygiene, shower, and lower body dressing. The MDS indicated Resident 26 had an indwelling catheter. During a concurrent observation inside Resident 26's room and interview on 1/7/2025 at 10:47 am with Certified Nurse Assistant 3 (CNA 3), Resident 26 had a suprapubic catheter, and the resident was lying on his suprapubic catheter tubing. CNA 3 stated Resident 26's suprapubic catheter tubing was not secured and was under the left leg of the resident. Resident 26's suprapubic catheter site dressing was wet and not clean. CNA 3 stated, Resident 26's suprapubic catheter tubing should be secured to prevent from accidental pulling whenever the resident moves. During an interview on 1/7/2025 at 11:11 am with the facility's Treatment Nurse (TN), TN stated, Resident 26's suprapubic catheter dressing should be changed daily and as needed to prevent infection and skin irritation. (continued on next page)

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Garden View Post Acute Rehabilitation	14475 Garden View Lane Baldwin Park, CA 91706

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/8/2025 at 11:08 am with the DON, the DON stated Resident 26's suprapubic catheter site dressing should be checked and changed by licensed staff every shift and as needed to prevent infection and skin irritation around the suprapubic site. The DON further stated, Resident 26's suprapubic catheter tubing should be secured on the thigh to prevent from pulling and getting dislodged during movements. c. During a review of Resident 32's AR, the AR indicated Resident 32 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included neuromuscular dysfunction of the bladder, calculus of kidney and UTI. During a review of Resident 32's MDS dated [DATE], the MDS indicated Resident 32 had moderately impaired cognition. The MDS indicated Resident 32 required set up or clean-up assistance (helper sets up or cleans up, resident completes the activity) with oral hygiene, upper body dressing and personal hygiene and dependent with toileting hygiene and lower body dressing. The MDS indicated Resident 32 had an indwelling catheter. During a review of Resident 32's untitled CP dated 9/4/2024, the CP indicated Resident 32 had right and left nephrostomy tubes with a goal to be free from any complication related to the nephrostomy. The CP interventions included for staff to position the resident's nephrostomy bag and tubing below, ensuring no kinks on the tube and to secure nephrostomy tube to facilitate flow of urine, prevent kinking of tubing, and accidental removal. During a concurrent observation inside Resident 32's room and interview on 1/7/2025 at 11:09 am with the TN, Resident 32 had right and left nephrostomy tubes with nephrostomy bags not covered with a privacy bag. The nephrostomy bags were placed on the leg part of the bed next to the resident. The leg part of the bed was elevated. The TN stated the nephrostomy bags were positioned higher than Resident 32's bladder. The TN stated the nephrostomy bags should be covered for the privacy and dignity of the resident. The TN stated, the nephrostomy tubing and bags should be positioned lower than the resident's bladder or on the side of the bed lower than the resident's bladder to prevent backflow of urine and cause urinary tract infection. During an interview on 1/8/2025 at 11:08 am with the DON, the DON stated, all indwelling catheter bags should be covered for the dignity and privacy of the resident. The DON stated all indwelling catheter tubing and bags should be placed below the level of the resident's bladder for urine to drain properly and prevent backflow and cause infection or re-infection of the resident. 42781 d. During a review of Resident 78's AR, the AR indicated Resident 78 was admitted to the facility on [DATE] with diagnoses that included acute kidney failure (a sudden decline in kidney function) and retention of urine. During a review of Resident 78's Physician's Order (PO) dated 12/15/2024, the PO indicated for licensed staff to insert indwelling (foley) catheter French (a type of catheter) 16 (size of the catheter) to closed drainage system for urinary retention. (continued on next page)

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	01/10/2025

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 78's untitled CP initiated on 12/16/2024, the CP indicated Resident 78 had an indwelling catheter for urinary retention. The CP interventions included for staff to monitor/record/report for signs and symptoms of UTI such as pain, burning, blood-tinged urine, cloudiness, no urine output, deepening of urine color, increased pulse, increase temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns to Resident 78's MD. During a review of Resident 78's MDS dated [DATE], the MDS indicated Resident 78 had intact cognition for daily decision making. The MDS indicated Resident 78 was dependent (helper did all the effort and lifted or held trunk or limbs) to staff for toileting hygiene, shower, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During an observation in Resident 78's room on 1/7/2025 at 10:03 am, Resident 78 was awake, lying in bed. Resident 78 had foley catheter hanging on the right side of bed. Resident 78's foley catheter tubing had approximately 2 inches of white sediments. During a concurrent observation in Resident 78's room and interview with MDS Nurse (MDSN) on 1/7/2025 at 10:05 am, the MDSN stated the FC tubing had approximately 2 inches of white sediments. The MDSN stated white sediments in the tubing could indicate a sign of infection. The MDSN stated, Resident 78's MD needed to be notified of the presence of white sediments in the foley catheter tubing. During an interview on 1/8/2025 at 11:27 am, with the facility's DON, the DON stated Resident 78's foley catheter needed to be monitored by licensed nurses every 8 hours for signs and symptoms of infection such as quality of urine, color of the urine, foul odor, and presence of sediments in the urine, to prevent UTI. During a review of the facility's P&P titled, Catheter Care and Management, revised 1/2024, the P&P indicated, Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. The urinary bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. Catheter tubing should be strapped to the resident's inner thigh. The P&P further indicated to observe for other signs and symptoms of urinary tract infection or urinary retention and to report findings to the physician or supervisor immediately. During a review of the facility's P&P titled, Indwelling Urinary Catheter Care, revised 12/2023, the P&P indicated, May secure the tubing with a securement device to prevent migration, friction, or tension of the catheter. Maintain the drainage tubing below the level of the bladder. Cover the drainage bag with a privacy bag to maintain dignity.

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	055187	A. Building B. Wing	01/10/2025

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Garden View Post Acute Rehabilitation	14475 Garden View Lane Baldwin Park, CA 91706

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview, and record review, the facility failed to label the nasal cannula (NC) tubing (an oxygen delivery device) for one of two sampled residents (Resident 64). This failure had the potential to result in infection for Resident 64. Findings: During a review of Resident 64's Admission Record (AR), the AR indicated Resident 64 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure (lungs cannot adequately provide oxygen to the body) and dysphagia (difficulty swallowing). During a review of Resident 64's Minimum Data Set (MDS, a resident assessment tool) dated 12/6/2024, the MDS indicated Resident 64 had clear speech, had the ability to understand others and usually made self understood. The MDS indicated Resident 64 was dependent (helper does all of the effort) for toilet hygiene and chair/bed-to-chair transfer. During a review of Resident 64's Order Summary Report (OSR) for 1/2025, the OSR indicated Resident 64 was ordered continuous oxygen via NC at 2 liters per minute every shift. During an observation in Resident 64's room on 1/7/2025 at 10:03 am, Resident 64 was in bed. Resident 64 was receiving oxygen via NC at 2 liters per minute. Resident 64's NC was not dated nor labeled with application date. During a concurrent interview, Infection Preventionist Nurse (IPN) stated, Resident 64's NC should be labeled with date when NC was applied to the resident and should be changed weekly for infection control purposes. The IPN stated, changing the NC routinely would prevent bacteria to accumulate on the NC. The IPN stated, without labeling, staff would not know when the NC was changed. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Therapy, dated1/2024, the P&P indicated Oxygen tubing needed to be replaced every 7 days.

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	055187	A. Building B. Wing	01/10/2025

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

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to implement its Policy and Procedure (P&P) on the use of bedrails (a bar that runs along the side of a bed) and grab bars (a bar or loop that helps the resident move in and out of the bed) for two of two sampled residents (Residents 33 and 51) by failing to: a. Ensure the use of appropriate alternatives to grab bars were attempted and did not meet the needs of the resident before its installation for Resident 51. b. Ensure the use of appropriate alternatives to bedrails were attempted and did not meet the needs of the resident. In addition, the facility failed to ensure the use of siderails was consented before its installation for Resident 33. These failures placed Residents 33 and 51 at risk for entrapment and injury from the use of bedrails or grab bars. Findings: a. During a review of Resident 51's Admission Record (AR), the AR indicated Resident 51 was admitted to the facility on [DATE] with diagnoses that included displaced fracture (a broken bone where the pieces were out of alignment) of left lower leg and dislocation (separation of two bones) of the left ankle joint. During a review of Resident 51's Minimum Data Sheet (MDS, a resident assessment tool) dated 11/25/2024, the MDS indicated Resident 51 had moderately impaired cognition (ability to understand). The MDS indicated Resident 51 required partial/moderate assistance (helper did less than half the effort) with oral and personal hygiene and dependent (helper did all of the effort, resident did none of the effort to complete the activity) with toileting, shower, and lower body dressing. During a concurrent observation inside Resident 51's room and interview on 1/7/2025 at 9:24 am, Resident 51 was in bed, lying on her back with grab bars up on both sides of the bed. Resident 51 stated she did know why she had grab bars on her bed. During a concurrent interview and record review on 1/8/2025 at 10:17 am with the MDS Coordinator (MDS C), Resident 51's medical chart and PointClickCare (PCC, a cloud-based software platform) chart were reviewed. MDS C stated there was no documented evidence that appropriate alternative interventions were attempted and did not meet the needs of Resident 51 before the grab bars were installed for the safety of the resident to prevent potential entrapment and injury. b. During a review of Resident 33's AR, the AR indicated Resident 33 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (muscle weakness on the arms, legs, and facial muscles on one side of the body) and neuropathy (weakness, numbness, and pain from nerve damage). (continued on next page)

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	01/10/2025

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

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 33's MDS dated [DATE], the MDS indicated Resident 33 had intact cognition. The MDS indicated Resident 33 required setup or clean-up assistance (helper sets up or cleans up, resident completes the activity) with oral hygiene, supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as residents completes the activity) with personal hygiene and dependent with toileting and lower body dressing. During a concurrent observation inside Resident 33's room and interview on 1/7/2025 at 9:53 am, Resident 33 was in bed, lying on her back with 1/4 bedrails up on both sides of the bed. Resident 33 was alert and coherent. Resident 33 stated her bedrails had been up since she was transferred in the room. Resident 33 stated she did not know why her bedrails were up and she did not request for it. During a concurrent interview and record review on 1/8/2025 at 10:33 am with the MDS C, Resident 33's medical chart and PCC chart were reviewed. The MDS C stated there was no documented evidence that appropriate alternative interventions were attempted and did not meet the needs of Resident 33 before the siderails were installed for the safety of the resident to prevent potential entrapment and injury. The MDS C stated Resident 33 did not have a consent for the use of bedrails. During an interview on 1/8/2025 at 11:08 am with the facility's Director of Nursing (DON), the DON stated appropriate alternatives should have been attempted and did not meet the resident's needs prior to the installation of the grab bars and ensure the resident was educated and understood the risks and benefits of using the grab bars. The DON stated the use of bedrails or grab bars should not be started without the consent from the resident or responsible party. During a review of facility's Policy and Procedure (P&P) titled, Bed Rails, revised 12/2023, the P&P indicated, Bed rails include, but were not limited to side rails, bed side rails, and safety rails; and grab bars and assists bars. After the facility had attempted alternatives to bed rails and determined that these alternatives failed to meet the residents' assessed needs, the facility interdisciplinary team (IDT) will assess the resident for risks of entrapment. The risks and benefits regarding the use of bed rails will be considered for each resident. It the use of bed rails is recommended by the IDT, the facility must obtain informed consent from the resident, or if applicable, the resident representative for the use of bed rails prior to installation or use.

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	055187	A. Building B. Wing	01/10/2025

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

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 48905 Based on interview and record review, the facility failed to post actual number of nursing staff who worked on 1/2/2025, 1/3/2025, 1/5/2025 for one of one sampled Nursing Station. This failure resulted in inaccurate information to the residents and family members and had the potential to affect the quality of care provided to the residents. Findings: During a concurrent interview and record review on 1/8/2025 at 5:14 PM with the Director of Staff Development (DSD), the facility's nurse staffing information forms (NSI) were reviewed. The NSI's indicated the following: On 1/1/2025 on the 10:30 PM to 6:30 AM (night) shift, five Certified Nursing Assistants (CNA) worked instead of six. On 1/2/2025 on the 6:30 AM to 2:30 PM (morning) shift, 16 CNAs worked instead of 14. On 1/3/2025 on the morning shift, 13 CNA's worked instead of 14. On 1/5/2025 on the night shift, 7 CNA's worked instead of 6. The DSD stated the number of staff who worked, and the actual hours worked were not accurate. The DSD stated the risk of not posting accurate staffing information was that it would not reflect the actual numbers worked to the residents and family members. During a review of the facility's undated Policy and Procedure (P&P) titled, Staffing Numbers, Posting the P&P indicated for staff to post the number of staff working who are directly responsible for resident care.

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	055187	A. Building B. Wing	01/10/2025

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

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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** 40037 Based on interview and record review, the facility failed to act upon the consultant pharmacist's medication regimen review (MRR, a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication use) recommendation for one of five sampled residents (Resident 40). This deficient practice had the potential for Resident 40 to receive unnecessary medication and adverse (harmful) consequences related to medication therapy. Findings: During a review of Resident 40's Admission Record (AR), the AR indicated Resident 40 was readmitted to the facility on [DATE] with diagnoses that included depression disorder (persistent feelings of sadness and worthlessness and a lack of desire to engage in formerly pleasurable activities) and hypertension (high blood pressure). During a review of Resident 40's Physician's Order (PO) dated 7/29/2024, the PO indicated Resident 40 was prescribed Ondansetron (medication to prevent nausea [having the urge to vomit] and vomiting [the physical act of ejecting stomach contents through the mouth]) tablet 4 milligram (mg- unit of measurement), one tablet by mouth every 6 hours as needed (PRN) for nausea and vomiting. During a review of the facility's MRR performed between 8/1/2024 to 8/26/2024, the MRR indicated Please indicate the length of therapy for the Ondansetron (medication to prevent nausea and vomiting) PRN (as needed) order. Nausea/vomiting is usually short-term for Resident 40. During a review of Resident 40's Minimum Data Set (MDS, a resident assessment tool) dated 11/4/2024, the MDS indicated Resident 40 had clear speech, had the ability to understand others and made self understood. The MDS indicated Resident 40 required setup or clean-up assistance (helper sets up or cleans up, resident completes activity) for personal hygiene, upper body dressing and sit to stand. During a review of Resident 40's PO dated 12/3/2024, the PO indicated to discontinue the use of Ondansetron tablet 4 mg (milligram) one tablet by mouth every 6 hours as needed for nausea and vomiting. During an interview on 1/8/2025 at 6:09 pm with Registered Nurse 1(RN 1), RN 1 stated, there was no documentation or change of order regarding the pharmacist's MRR recommendation performed between 8/1/2024 to 8/26/2024 for Resident 40's Ondansetron PRN order before it was discontinued on 12/3/2024. RN 1 stated, the facility did not act upon the MRR recommendation to provide the length of therapy for Resident 40's Ondansetron PRN use. RN 1 stated this recommendation was missed. RN 1 stated, the facility should notify Resident 40's prescribing physician regarding the pharmacist's recommendation and update the order as needed. RN 1 stated, not following the MRR could put Resident 40 at risk for receiving unnecessary medication that could affect the resident's health condition. (continued on next page)

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	01/10/2025

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/2025 at 6:49 pm with the facility's Director of Nursing (DON), the DON stated, the consultant pharmacist's MRR should have been carried out, one week after the MRR report performed between 8/1/2024 to 8/26/2024 was received. The DON stated, there was no documentation in Resident 40's medical record that indicated the consultant pharmacist's recommendation was reviewed and acted upon. The DON stated, the facility should contact Resident 40's physician to validate the pharmacist's recommendation. The DON stated, if the MRR was not acted upon timely, the resident could receive unnecessary medication, increase the risk of drug reaction, and affect their health conditions. During a review of the facility's Policy and Procedure (P&P) titled Medication (Drug) Regimen Review (MRR), dated 5/2024, the P&P indicated Nursing documentation review: nursing personnel will provide a written response to the review within 7 days.

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	055187	A. Building B. Wing	01/10/2025

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on interview and record review, the facility failed to identify and document specific indication for the use of Mirtazapine (antidepressant- medication to treat depression [mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily functioning]) for one of five sampled residents (Resident 20) as indicated in the facility's policy titled Psychotropic Medications This deficient practice had the potential to result in unnecessary psychotropic drug use which could result in significant adverse (harmful) consequences to Resident 20. Findings: During a review of Resident 20's Admission Record (AR), the AR indicated Resident 20 was admitted to the facility on [DATE] with diagnoses that included Spondylolisthesis (a condition where a vertebra in the spine slips out of place) and major depressive disorder (persistent feeling of sadness and loss of interest). During a review of Resident 20's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/16/2024, the MDS indicated Resident 20 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 20 required supervision during shower. During a review of Resident 20's Physician Order (PO) dated 10/30/2024, the PO indicated for licensed staff to give Resident 20 Mirtazapine 15 milligram (mg, unit of measurement) by mouth at bedtime related to major depressive disorder manifested by mood, sleep and appetite stimulant. During a concurrent interview and record review on 1/10/2025 at 9:17 am with the facility's Director of Nurses (DON) of Resident 20's Medical Record (chart), the DON stated Resident 20's medication (Mirtazapine) needed to be administered with specific diagnosis and symptoms. The DON stated mood, sleep and appetite stimulant is not a manifestation or behavior. During a review of the facility's Policy and Procedure (P&P) titled, Psychotropic Medications, revised 12/2023, the P&P indicated psychotropic medications shall not be administered for the purpose of discipline or convenience, they are to be administered only when required to treat the resident's medical symptoms. The P&P indicated the appropriateness of the diagnosis, its indication, behavior monitors and related adverse side effects prior to verification of admission orders with the attending physician.

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	055187	A. Building B. Wing	01/10/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to implement its policy and procedure on infection control by failing to: a. Ensure one of one Certified Nurse Assistant (CNA 2) wore the required personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) while providing care for a resident on enhanced barrier precaution (EBP, a set of infection control practices that use PPE to reduce the spread of multidrug-resistant organisms [MDROs}]) for one of one sampled resident (Resident 34). b. Follow infection prevention guidelines for Resident 62 on Enhanced Barrier Precaution on 1/8/2025 when one of one Licensed Vocational Nurse (LVN 4) entered Resident 62's room without donning/wearing the required PPE prior to checking the resident's gastrostomy tube (G-tube, feeding tube that is inserted into the stomach) placement for medication administration. c. Ensure one of one Certified Nurse Assistant (CNA 6) who entered Resident 138's room on EBP wore the required PPE. These failures had the potential to result in the spread of infection and cross contamination (transfer of harmful bacteria from one object or place to another). Findings: a. During a review of Resident 34's Admission Record (AR), the AR indicated Resident 34 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included obstructive (occurs when urine can't drain through the urinary tract) and reflux (urine backs up into the kidneys) uropathy and benign prostatic hyperplasia (enlarged prostate). During a review of Resident 34's Order Summary Report (OSR) dated 4/4/2024, the OSR indicated Resident 34 was placed on EBP for the presence of indwelling catheter (Foley catheter- a thin, flexible tube inserted into the bladder to drain urine into an external collection bag) and PPEs were required for high resident contact care activities. During a review of Resident 34's Minimum Data Sheet (MDS, a resident assessment tool) dated 11/2/2024, the MDS indicated Resident 34 had intact cognition (ability to understand). The MDS indicated Resident 34 was independent (resident completes the activity by themselves) with eating, oral and personal hygiene and dependent (helper did all of the effort, resident did none of the effort to complete the activity) with toileting, shower, and lower body dressing. The MDS indicated Resident 34 had an indwelling catheter. During an observation of 1/7/2025 at 10:29 am inside Resident 34's room, Resident 34 had a foley catheter. Certified Nurse Assistant 2 (CNA 2) was providing care to Resident 34. CNA 2 was not wearing a gown and only wore gloves while providing care to Resident 34. (continued on next page)

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	055187	A. Building B. Wing	01/10/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/7/2025 at 11:19 am with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated residents with Foley catheter were placed on EBP because they were high risk of getting an infection. LVN 1 stated staff needed to wear the required PPEs of gown and gloves while providing care to Resident 34 for infection control. During an interview on 1/8/2025 at 11:08 am with the facility's Director of Nursing (DON), the DON stated staff should wear the required PPEs when providing care to Resident 34 on EBP to protect the resident and prevent the spread of infection. During a review of the facility's Policy and Procedure (P&P) titled, Infection Control, revised 3/2024, the P&P indicated, Enhanced Barrier Precaution is used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident (e.g., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs). Enhanced Barrier Precautions PPE used for these situations: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care. 48905 b. During a review of Resident 62's AR the AR indicated Resident 62 was admitted to the facility on [DATE] with diagnoses that included presence of a G-tube and dysphagia (difficulty in swallowing). During a review of Resident 62's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 10/4/2024, the H&P indicated Resident 62 was alert and oriented to person only. During an observation on 1/8/2025 at 9:08 am outside of Resident 62's room, an EBP sign was observed outside of Resident 62's room. LVN 4 entered Resident 62's room without donning (wearing) PPE and LVN 4 checked Resident 62's G-tube placement for medication administration. During an interview on 1/8/2025 at 9:20 am with LVN 4, LVN 4 stated LVN 4 should have donned on PPE prior to entering Resident 62's room because Resident 62 was on EBP for the presence of G-tube. LVN 4 stated the risk of not donning on PPE was that infection could be transmitted to other residents. During an interview on 1/8/2025 at 10:27 am with the Infection Prevent Nurse (IPN), the IPN stated staff were required to don on PPE when providing medications, changing the G-tube dressing, or anytime when exposed to the G-tube. The IPN stated LVN 4 should have donned on PPE when performing G-tube care to Resident 62 to prevent the spread of stomach contents, blood, and bodily fluids. During an interview on 1/8/2025 at 4:25 pm with the facility's DON, the DON stated staff needed to don on PPE to protect Resident 62 (on EBP) while providing G-tube care. The DON stated the risk of not donning on the proper PPE was the risk of transmitting infections to other residents. (continued on next page)

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	01/10/2025

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, IPCP Standard and Transmission-Based Precautions revised 3/2024, the P&P indicated high contact resident care activities that required a gown and glove use for EBP included device care or use and feedings tubes. 40037 c. During a review of Resident 138's AR, the AR indicated Resident 138 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control) and generalized muscle weakness. During a review of Resident 138's MDS dated [DATE], the MDS indicated Resident 138 had clear speech, had the capacity to understand others and made self understood. The MDS indicated Resident 138 had intact cognition. The MDS indicated Resident 138 was dependent (helper does all of the effort) for toilet hygiene and rolling left and right. During an observation outside Resident 138's room on 1/7/2025 at 9:28 am, there was a signage posted outside Resident 138's door indicating Resident 138 was on EBP and PPE was required before entering the room. There was another signage posted next to the EBP signage regarding the steps for donning (put on) and doffing (take off) PPE. During an observation on 1/7/2025 at 9:35 am, Certified Nursing Assistant 6 (CNA6) entered Resident 138's room with clean linen and towels and closed the curtain, without donning a gown. During an interview with the IPN on 1/7/2025 at 9:45 am, the IPN stated Resident 138 was on EBP because Resident had an open wound, and staff needed to wear PPE when providing close contact care including bed bath and changing of the resident. The IPN stated, EBP provided protection to the resident and staff for infection control. During an interview with CNA 6 on 1/7/2025 at 9:52 am, CNA 6 stated, CNA 6 was in Resident 138's room to provide bed bath to Resident 138. CNA 6 stated, CNA 6 saw the signage for PPE on Resident 138's door and CNA 6 understood that EBP required staff to wear gown and gloves before entering the room. CNA 6 stated, CNA 6 was in a hurry and did not wear gown when CNA 6 entered Resident 138's room. CNA 6 stated, PPE was required for infection control. During a review of the facility's P&P titled IPCP Standard and Transmission-Based Precautions, dated 3/2024, the P&P indicated Enhanced Barrier Protection (EBP): used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities ., examples of high-contact resident care activities requiring gown and gloves use for Enhanced Barrier Precautions include: bathing/showing and providing hygiene.

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	01/10/2025

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

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to keep an electric fan (a powered machine used to create a flow of air to cool and ventilate rooms and control humidity) in a safe, operating, and sanitary condition for one of one sampled resident (Resident 4). This failure had the potential to affect Resident 4's quality of life and health. Findings: During a review of Resident 4's Admission Record (AR), the AR indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently) and asthma (a condition in which a person's airways become inflamed, narrowed, and swollen). During a review of Resident 4's Minimum Data Sheet (MDS, a resident assessment tool) dated 10/30/2024, the MDS indicated Resident 4 had severely impaired cognition (ability to understand). The MDS indicated Resident 4 was dependent (helper did all of the effort, resident did none of the effort to complete the activity) with eating, oral and toileting hygiene, shower, upper and lower body dressing and personal hygiene. During a concurrent observation inside Resident 4's room and interview on 1/7/2025 at 10:01 am with Certified Nurse Assistant 4 (CNA 4), a white, small electric fan was at Resident 4's bedside. The electric fan had dust and the cover was full of lint. CNA 4 stated the dust and lint were not good for Resident 4's health condition. During an interview on 1/8/2025 at 11:08 am with the facility's Director of Nursing (DON), the DON stated, housekeeping staff should keep the resident's personal equipment clean and in good working condition. During a review of the facility's Policy and Procedure (P&P) titled, Housekeeping Department, revised 6/2007, the P&P indicated, The facility was required for an effective environmental sanitation to lessen the hazards of exposure to contaminated air, dust, furnishings, equipment and other fomites. Frequent cleaning of the facility's interior will aid in physically removing some of the micro-organisms which might cause these hazards. The housekeeping supervisor will work closely with the infection control team to establish and maintain consistent practices and high standards of cleanliness.