STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055202	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosemead Healthcare Center	4096 Easy Street El Monte, CA 91731

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. 37662 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1), received the copy of the resident's medical records within two working days upon request as indicated in the facility's policy and procedure (P&P) titled, Resident Access to PHI. This deficient practice resulted in a delay of obtaining a copy of Resident 1's medical records for Resident 1's Requesting Party (RP). Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, the facility admitted Resident 1 on 5/13/24, with diagnoses that included unspecified sequelae (an aftereffect of a disease, condition, or injury) of cerebral infarction (stroke; occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), dysphagia (difficulty swallowing) oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat), and other abnormalities of gait and other mobility (inability to walk normally due to injuries or underlying conditions). During a review of Resident 1's History and Physical Examination (H&P), dated 5/14/24, the H&P indicated, Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment and care screening tool), dated 5/21/24, the MDS indicated, Resident 1 had modified independence (some difficulty in new situations only) in making decisions regarding tasks of daily life. The MDS indicated, Resident 1 was dependent (helper provided all the effort or the assistance of two or more helpers was required for the resident to complete the activity) for toileting hygiene, showering/bathing self, upper and lower body dressing, and putting on/taking off footwear. The MDS indicated, Resident 1 required substantial/maximal assistance (helper did more than half the effort) for rolling left and right in bed (the ability to roll from lying on back to left and right side and return to lying on back on the bed). (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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the document titled Authorization for the Release of Medical Information (Health Insurance Portability and Accountability Act [HIPAA- legislation that provides data privacy and security provisions for safeguarding medical information] Compliant), for Resident 1, dated 6/24/2024, the document indicated, Resident 1's RP signed the authorization to release Resident 1's medical records and sent the request to the facility via facsimile (fax; an exact copy, especially of written or printed material) on 6/25/24 at 12:13 PM. During an interview on 7/8/24 at 1:01 PM with the Medical Records (MR), the MR stated the MR took two to three days to provide medical records after it has been requested. The MR stated the importance of receiving the medical records on time was because the resident/requesting party was requesting the medical records for a particular reason such as insurance, billing, and/or health reasons. The MR stated the facility received a medical records request at the end of June, but the MR had to check with administration since the request had to deal with legal stuff. During an interview on 7/8/24 at 1:51 PM with the MR, the MR stated copy of Resident 1's medical records needed to be provided within two days of the request. The MR stated it was important for Resident 1 and/or requesting party to receive what they needed. During an interview on 7/8/24 at 2:23 PM with the administrator (ADM), the ADM stated the ADM sent the copy of Resident 1's medical records via mail on 7/8/24. During an interview on 7/8/24 at 2:55 PM with the ADM, the ADM stated it was important to provide a copy of the medical records upon request timely to follow the regulations. The ADM stated it was for residents to know what was going on with their plan of care, medications, and medical diagnoses. During a review of the facility's P&P titled, Resident Access to PHI, dated 10/1/23, the P&P indicated, if the resident and/or their personal representative requested a copy of the resident's medical record, the HIPAA Privacy Officer provided the resident and/or their personal representative with a copy of the medical record within two (2) working days after receiving the written request.

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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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37662 Based on interview and record review, the facility failed to readmit three of five sampled residents (Residents 2, 3, and 4) to the facility from the General Acute Care Hospital (GACH) after Residents 2, 3, and 4 were cleared by GACH to return to the facility. This deficient practice had the potential to violate Residents 2, 3, and 4's rights to return to the facility. Findings: a. During a review of Resident 2's Admission Record (AR), the AR indicated, the facility admitted Resident 2 to the facility on [DATE], with diagnoses that included other acute osteomyelitis (an infection of the bone or joint) of left ankle and foot, cellulitis (a bacterial infection of the skin and the tissue beneath the skin) of left lower limb, and dysphagia (difficulty swallowing) oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat). During a review of Resident 2's Minimum Data Set (MDS, a standardized resident assessment and care screening tool), dated 5/1/24, the MDS indicated, Resident 2 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated, Resident 2 was dependent (helper provided all the effort or the assistance of two or more helpers was required for the resident to complete the activity) on staff for oral hygiene, toileting hygiene, showering/bathing self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated, Resident 2 was dependent for rolling left and right in bed (the ability to roll from lying on back to left and right side and return to lying on back on the bed). During a review of Resident 2's Physician's Order (PO), dated 5/1/24, timed at 8:41 AM, the PO indicated, an order to send Resident 2 to GACH (unspecified) for emergency transfer for code sepsis (a life-threatening condition caused by an extreme immune response to infection that can lead to tissue damage, organ failure, or death). During a review of Resident 2's Progress Note (PN), dated 5/1/24, timed at 10:23 AM, the PN indicated, Resident 2 was transferred to GACH 1 via 911 (emergency) for further evaluation and work up. During a review of Resident 2's Notice of Proposed Transfer/Discharge (NPTD), dated 5/1/24, the NPTD indicated, Resident 2's transfer/discharge was necessary for Resident 2's welfare and Resident 2's needs could not be met in the facility. b. During a review of Resident 3's AR, the AR indicated, the facility admitted Resident 3 to the facility on [DATE], with diagnoses that included end-stage renal disease (ESRD; final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own), renal osteodystrophy (a complication of chronic kidney disease that weakens your bones), and other abnormalities of gait and other mobility (inability to walk normally due to injuries or underlying conditions). (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's MDS dated [DATE], the MDS indicated, Resident 3 had severe impairment in cognitive skills for daily decision making. The MDS indicated, Resident 3 was dependent on staff for oral hygiene, toileting hygiene, showering/bathing self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated, Resident 3 was dependent for rolling left and right in bed. During a review of Resident 3's PO, dated 5/17/24, timed at 11:25 PM, the PO indicated, an order to send Resident 3 to GACH 1 for further evaluation for right eye bleeding. The PO indicated, Resident 3's diagnosis was thrombocytopenia (a low number of platelets [small, colorless cell fragments in our blood that form clots and stop or prevent bleeding] in the blood). During a review of Resident 3's PN, dated 5/18/24, timed at 12:15 AM, the PN indicated, Resident 3 was transferred to GACH 1 for further evaluation via regular ambulance. During a review of Resident 3's NPTD, dated 5/18/24, the NPTD indicated, Resident 3's transfer/discharge was necessary for Resident 3's welfare and Resident 3's needs could not be met in the facility. c. During a review of Resident 4's AR, the AR indicated, the facility admitted Resident 4 to the facility on [DATE], with diagnoses that included dysphagia following cerebral infarction (stroke; occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), atelectasis (complete or partial collapse of a lung or a section [lobe] of a lung), and cardiomegaly (enlarged heart). During a review of Resident 4's MDS, dated [DATE], the MDS indicated, Resident 4 had modified independence (some difficulty in new situations only) in making decisions regarding tasks of daily life. The MDS indicated, Resident 4 was dependent on staff for eating, oral hygiene, toileting hygiene, showering/bathing self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated, Resident 4 was dependent for rolling left and right in bed. During a review of Resident 4's PO, dated 6/25/24, timed at 10:20 PM, the PO indicated, an order to send Resident 4 to GACH (unspecified) for further evaluation and treatment due to abdominal distention (bloating and swelling in the belly area) and gastrostomy tube (G-tube; a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) replacement due to leakage. During a review of Resident 4's PN, dated 6/26/24, timed at 11:51 AM, the PN indicated, Resident 4 was transferred to GACH 1 for further evaluation and treatment due to abdominal distention, abdominal pain, and G-tube leakage. During a review of Resident 4's NPTD, dated 6/26/24, the NPTD indicated, Resident 4's transfer/discharge was necessary for Resident 4's welfare and Resident 4's needs could not be met in the facility. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 7/8/24 at 1:32 PM with GACH 1's Director of Care Coordination (DCC), the DCC stated Resident 2 was cleared and ready to be discharged back to the skilled nursing facility on 5/13/24. The DCC stated the DCC contacted the facility on 5/13/24, 5/14/24, 5/15/24, 5/16/24, and 5/28/24 to transfer Resident 2 back to the facility, but the facility staff (unidentified) informed the DCC that the facility did not have an isolation room (a room designated for patients having or suspected of having an infectious illness) for Resident 2. The DCC stated Resident 2 was still at GACH 1 (as of 7/8/24) awaiting transfer back to the facility. During the same telephone interview, the DCC stated Resident 3 had discharge orders to return to the facility on [DATE]. The DCC stated the DCC contacted the facility on 6/17/24 and 6/18/24 to transfer Resident 3 back to the facility, but the facility staff (unidentified) informed the DCC that the facility did not have an isolation room for Resident 3. The DCC stated Resident 3 was still at GACH and awaiting placement to go to a skilled nursing facility. The DCC further stated Resident 4 had discharge orders to return to the facility on [DATE]. The DCC stated the DCC contacted the facility on 6/29/24 and 7/2/24 to transfer Resident 4 back to the facility, but the facility staff (unidentified) informed the DCC that the facility did not have an isolation room for Resident 4. The DCC stated Resident 4 was still at GACH 1 awaiting transfer back to the facility. During an interview on 7/8/24 at 3:15 PM with the Infection Preventionist (IP- responsible for the development, direction, implementation, management, and operation of the infection prevention in the facility), the IP stated the facility was accepting new residents and that when a resident went out to the hospital and was ready to be transferred back, the facility could accept the resident. The IP stated the facility could cohort (the practice of grouping patients together [who have the same infection or were exposed to the same infection] when single isolation room of individuals is not possible) residents with the same bacteria or virus. The IP stated when residents did not have the same bacteria or virus, then the facility could not cohort the residents. During an interview on 7/8/24 at 3:33 PM with the Admissions Coordinator (AC), the AC stated the facility's bed hold policy was that they could hold the bed for seven days and after that the resident falls out of bed hold. The AC stated after the seven days, the facility could accept the resident if the resident was not on isolation. The AC stated the resident might not be readmitted in the same room the resident was before. The AC stated readmitting a resident that required an isolation room depended on the type of isolation the resident was on. The AC stated when the facility had an isolation room available, the facility could accept the resident back. The AC stated the facility could isolate the resident by himself/herself if there was an isolation room available. The AC stated the facility needed to readmit the residents who were transferred to GACH because those residents were the facility's residents and for the facility to continue to provide the care that was given to the residents before the residents were sent out. The AC stated for Residents 2, 3, and 4, there were no isolation rooms available for them. The AC stated the residents would have to be on the same type of isolation. The AC stated the AC did not think the facility could put residents with two different types of isolation together. During an interview on 7/8/24 at 3:56 PM with the Director of Nursing (DON), the DON stated the facility would readmit Residents 2, 3, and 4 back to the facility. The DON stated it was important to readmit the residents they transferred out to GACH for continuation of care and because the facility was the residents' home. The DON stated it was the facility's goal to get the residents stable and stronger. The DON stated, We're all guests here. This is their house. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Bed Hold, dated 10/1/23, the P&P indicated, in the event that the resident was in the hospital for more than seven (7) days, met the standards for skilled nursing care, and was Medi-Cal (public health insurance program which provides needed health care services for low-income individuals) eligible, the facility readmitted the resident to the first available bed in a semi-private room. During a review of the facility's P&P titled, Transfer and Discharge, dated 10/1/23, the P&P indicated, a temporary transfer to an acute care facility was considered a facility-initiated discharge and notice must be provided to the resident/resident representative as soon as practicable. In a situation where the facility initiates discharge while the resident was in the hospital following emergency transfer, the facility must have evidence that the resident's status at the time the resident seeks to return to the facility meets one of the criteria for discharge outlined in the policy.