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	08/27/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50016 Based on observation, interview, and record review, the facility failed to ensure medications were administered timely for one of seven sampled residents (Resident 3) by failing to ensure Resident 3 received Resident 3's morning medications in a timely manner as indicated in the facility's policy and procedure (P&P), titled, Medication-Administration. This deficient practice had the potential to affect Resident 3 negatively and result in a physical decline to Resident 3. Findings: During a review of Resident 3's Admission Record (AR), the AR indicated the facility admitted Resident 3 on 1/22/2020, and readmitted the resident on 3/28/2024, with diagnoses including, type 2 diabetes mellitus (a condition that affects the way the body processes blood sugar), muscle wasting and atrophy (the decrease in size or wasting away of a body part or tissue), dysphagia (difficulty swallowing), and dementia (a decline in mental function that affects a person's ability to think, remember, and reason). During a review of Resident 3's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 6/30/2024, the MDS indicated Resident 3's cognition (ability to understand and process information) was severely impaired and Resident 3 was dependent with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was unable to ambulate (to walk or move about without any kind of assistance) due to illness. During a review of Resident 3's Medication Administration Record (MAR), dated August 2024, the MAR indicated Resident 3's morning medications were scheduled at 9AM and included: amlodipine (medication to treat high blood pressure) one tablet, aspirin (medication to prevent clotting) one tablet, bethanechol chloride (medication to treat urinary retention) one tablet, calcium (medication to treat osteoporosis [weak and brittle bones]) one tablet, carbidopa levadopa (medication to treat Parkinson's disease [a brain disorder, progressive disease of the nervous system, that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination]) one tablet, losartan potassium-HCTZ (hydrochlorothiazide) (medication to treat high blood pressure) one tablet, tradjenta (medication to treat diabetes mellitus type 2), depakote sprinkles (medication to treat impulse control disorder) one capsule, metformin (medication to treat diabetes mellitus type 2) one tablet, metoprolol tartrate (medication to treat high blood pressure), and tramadol (medication to treat pain) one tablet. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/26/2024 at 11 AM, Resident 3 was awake, laying in bed, and LVN 1 was checking Resident 3's blood pressure. During a concurrent observation and interview on 8/26/2024 at 11:05 AM with LVN 1 was observed preparing Resident 3's medications. LVN 1 stated Resident 3's morning medications were scheduled at 9 AM. LVN 1 stated LVN 1 fell behind on LVN 1's medication administration. LVN 1 stated the 5 basic rights of medication administration, included: right patient, right medication, right dose, right route, and the right time. LVN 1 stated administering medications at the right time ensured the effectiveness of medications. LVN 1 stated medications should be administered as ordered and administered at least 1 hour before or 1 hour after the scheduled time. LVN 1 stated many medications were time sensitive and must be administered at the proper time [to ensure] maximum effectiveness. During an interview on 8/26/2024 at 2:45 PM with Registered Nurse (RN) 1, RN 1 stated staff needed to ensure medications were administered at specific times, such as every morning, to keep the amount of drug in the resident's (in general) system. RN 1 stated taking a dose too soon could lead to drug levels that were too high, and missing a dose or waiting too long between doses could lower the amount of medication in the body and keep the medication from working properly. RN 1 stated the medication administration window was administering medications no more than 1 hour before the scheduled time or should not exceed more than 1 hour after the scheduled time. During an interview on 8/26/2024 at 3:05 PM, Director of Staff Development (DSD) 1 stated medications should be administered within a reasonable timeframe because certain medications often have specific intervals or window periods for optimal therapeutic effect. During an interview on 8/27/2024 at 3:50 PM, the Director of Nursing (DON) stated the basic 5 rights of medication administration were the right patient, right medication, right dose, right route, and right time. The DON stated administering medications on time was essential to ensure the body always had an effective amount of the drug. The DON stated that the DON expected his staff to administer medications as close to the prescribed time as possible to avoid deviations of more than an hour. A review of the facility's P&P titled, Medication-Administration, dated 10/1/2023, indicated medications must be given to the resident one hour before or after the scheduled medication administration time.

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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 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** 50016 Based on observation, interview, and record review, the facility failed to ensure smoking devices were stored in a secure area for one of seven sampled residents (Resident 1) as indicated in the facility's policy and procedure (P&P) and Resident 1's untitled care plan (CP), dated 6/20/2024, that addressed Resident 1 smoking, when on 8/27/2024, Resident 1 had an electronic smoking device resting on Resident 1's lap. This deficient practice had the potential to result in accidents and resulted in compromised safety to all residents residing at the facility. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 5/17/2024, with diagnoses including, hemiplegia (paralysis [unable to make voluntary muscle movements] that affects one side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) following cerebral infarction (occurs when blood flow to the brain becomes blocked by a blood clot or a piece of fatty plaque [deposits of fatty substances]), chronic embolism (a clot that moves through your bloodstream) and thrombosis (a clot in a blood vessel), urinary tract infection (an infection in any part of the urinary system: kidneys, bladder, or urethra [tube through which the urine leaves the body]), muscle wasting, and lack of coordination. During a review of Resident 1's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 5/20/2024, the MDS indicated Resident 1's cognition (the ability to think and process information) skills for daily decisions making were moderately impaired. The MDS indicated Resident 1 required substantial/maximal assistance with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was unable to ambulate (walk) due to medical conditions or safety concerns. During a review of Resident 1's untitled CP, initiated 6/20/2024, revised on 7/19/2024, the CP indicated: - The goal was for Resident 1 to be able to smoke according to facility policy with precautions taken for resident's safety, as well as the safety of others, and Resident 1 would not have smoke-related incidents in the facility until the CP's next review. - The nursing interventions indicated, based on smoking assessment, Resident 1: may smoke only in designated areas, according to facility policy and Resident 1 needed supervision while smoking. During a review of Resident 1's Smoking assessment dated [DATE], timed at 4 PM, the assessment indicated Resident 1 was a smoker and required supervision when smoking. (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 and interview on 8/27/2024 at 10 AM, Resident 1 was in Resident 1's room, lying in bed and had an electronic smoking device resting on Resident 1's lap. Resident 1's shared room had a fruity smoke like smell. Resident 1 denied smoking in the room or using the electronic smoking device. Resident 1 stated that Resident 1 preferred the liquid smoking flavors. Resident 1 stated Resident 1 was allowed to go to the smoking designated area during the scheduled times and was assisted by staff to the smoking patio in her wheelchair. During an interview on 8/27/2024 at 10:15 AM, CNA 2 stated CNA 2 worked the morning shift and at times worked other shifts. CNA 2 stated CNA 2 had seen Resident 1 with the electronic smoking device in Resident 1's room, and at times, the room smelled like smoke upon entering. CNA 2 stated CNA 2 had never physically seen Resident 1 smoke or use the electronic smoking device. CNA 2 stated smoking in a shared room was a safety issue and could potentially cause harm to the other residents (roommates) due to secondhand smoke inhalation. CNA 2 stated the facility had a designated area for smoking that was in the patio and the facility had a designated smoking schedule. CNA 2 stated the Activities Director (AD) or the receptionist assisted residents during smoking hours. CNA 2 stated CNA 2 notified the nurse supervisor (unidentified) that Resident 1 had an electronic smoking device [in Resident 1's possession] and CNA 2 did not know if the Director of Nursing (DON) or the Administrator (ADM) had been made aware. During an interview on 8/27/2024 at 10:30 AM, the Receptionist (RCPTN) 1 stated residents (in general) were required to return all smoking supplies [devices], such as lighters, cigarettes, vapes or electronic cigarettes when smoking session was done. RCPTN 1 stated all smoking supplies were placed in a secure lock box and weren't provided to the residents until the assigned smoking times. RCPTN 1 stated RCPTN 1 was never notified that Resident 1 was smoking inside the facility. During an interview and concurrent record review on 8/27/2024 at 3:50 PM, with the Director of Nursing (DON), the facility's P&Ps for Smoking and the resident smoking list and smoking schedules were reviewed. The DON stated the only area for residents to smoke was in the designated smoking area located in the patio. The DON stated the resident smoking list was kept in a binder and each resident smoker required a smoking assessment and a CP. The DON stated the DON's expectation was for staff to always maintain strict smoking supervision for the safety and well-being of the residents. The DON stated the facility continuously educated and advised residents about smoking cessation and offered alternative measures, such as nicotine patches. The DON stated that all smoking paraphernalia (smoking materials of all types) was kept in a secured lock box for the safety of residents. The DON stated smoking inside the facility was not allowed, especially in resident rooms due to safety hazards. During a review of the facility's P&P titled, Smoking, date implemented 10/1/2023, the P&P indicated its purpose was to respect resident/employee choice to smoke and to maintain a safe healthy environment for both smokers and non-smokers. The P&P indicated smoking was not allowed anywhere inside the facility, the facility permitted smoking in areas designated by the facility's safety committee, the facility ensured the residents who chose to smoke did so safely, residents who wanted to smoke would be assessed for their ability to smoke safely, residents who were not able to smoke independently and safely would be accompanied by facility staff while smoking. The P&P indicated, it applied to the use of cigarettes and electronic cigarettes. The P&P indicated all smoking materials would be stored in a secure area to ensure they were kept safe, e.g., locked drawers or cupboards in the resident's room, locked box in a resident's room, labeled box in a locked medication room and clearly identified with the resident's name and room number.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 Based on observation, interview, and record review, the facility failed to ensure infection control practices for 1 of 7 sampled residents (Resident 2) were followed. On 8/26/2024, Resident 2 accessed the meal cart unsupervised, without performing hand hygiene (procedures that include the use of alcohol-based hand rubs [containing 60%-95% alcohol] or hand washing with soap and water) and was able to obtain Resident 2's meal tray without assistance from staff. This deficient practice had the potential to result in transmission of infectious microorganisms (an organism that is seen through a microscope) and increased the risk of infection for the residents whose food trays were in the meal cart. Findings: During a review of Resident 2's Admission Record (Face Sheet), indicated the facility admitted Resident 2 to the facility on [DATE], and readmitted the resident on 4/2/2024, with diagnoses including but not limited to, lack of coordination, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions, metabolic encephalopathy (a brain condition that occurs when an underlying condition causes a chemical imbalance in the blood which affects brain function), dysphagia (difficulty swallowing), and abnormalities of gait (pattern of a person's walk) and mobility. During a review of Resident 2's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated 6/4/2024, the MDS indicated Resident 2's cognitive (the ability to think and process information) skills for daily decisions making were severely impaired, and Resident 2 required setup or clean-up assistance with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was independent with mobility. During an observation on 8/26/2024 at 12:09 PM, Resident 2 was walking toward the meal tray cart located in unit 1's hallway. Resident 2 grabbed Resident 2's meal tray from the tray cart without staff supervision and without performing hand hygiene. Resident 2 took a meal tray from the meal cart and walked back toward Resident 2's room. During an interview on 8/26/2024 at 12:15 PM, Certified Nurse Assistant (CNA) 1 stated CNA 1 observed Resident 2 grab the meal tray from the meal cart and Resident 2 walked back to Resident 2's room with a meal tray in hand. CNA 1 stated CNA 1 went to Resident 2's room to verify Resident 2 grabbed the correct meal tray before Resident 2 consumed the food. CNA 1 stated residents (in general) should not access meal carts and remove meal tray's themselves because it was a safety and an infection control issue. During an interview on 8/26/2024 at 2:45 PM, Registered Nurse (RN) 1 stated residents aren't allowed to grab food from the meal carts for safety reasons. RN 1 stated residents should not access the meal carts because it was a sanitary issue that could potentially expose residents to foodborne illnesses (illness caused by food contaminated with bacteria). RN 1 stated staff needed to ensure meal trays were corresponded and distributed to each individual resident, because of different diet orders, allergies, and preferences. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/26/2024 at 3:05 PM, Director of Staff Development (DSD) 1 stated DSD 1 had not witnessed residents grab meal trays from the meal carts. DSD 1 stated if DSD 1 witnessed a resident grab a meal tray directly from the meal cart, this required DSD 1 to in-service staff regarding the potential risks [associated with this action]. DSD 1 stated that accessing meal carts without following proper sanitary practices was an infection control issue that could possibly lead to foodborne infections. During an interview on 8/27/2024 at 3:10 PM, Infection Preventionist (IP) 1 stated residents weren't allowed to grab meal trays from the meal carts, because infection control practices should be implemented. IP 1 stated staff should [perform] hand hygiene before and after distributing [touching] meal trays to residents. IP 1 stated sanitizing hands was sufficient, and glove use was not required. During an interview on 8/27/2024 at 3:50 PM, the Director of Nursing (DON) stated residents should not have access to the meal carts and had to wait for staff to thoroughly check the trays before they were distributed. The DON stated, to follow infection control practices and address other safety issues, it was not the facility's practice to allow residents to remove trays themselves directly from the meal cart. The DON stated staff weren't required to wear gloves during meal pass [distribution] but the staff should, at the very least, sanitize their hands before and after each tray was passed. During a review of the facility's policy & procedure (P&P) titled, Infection Prevention and Control Program, dated 10/1/2023, the P&P indicated the purpose of the infection prevention and control program was to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with Federal and State requirements.