

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Rosemead Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027</p> <p>Based on interview and record review, the facility failed to ensure the Interdisciplinary Team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of the resident) Falls Committee met to review and document findings and interventions addressing the resident's falls on 4/19 and 4/22/2025 for one of two sampled residents (Resident 2)</p> <p>These failures had the potential to result in Resident 2 sustaining injury and/or harm due to falling while in the care of the facility.</p> <p>Findings:</p> <p>During a review of Resident 2's Admission Record (AR), the AR indicated the facility admitted Resident 2 on 3/27/2025 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), muscle weakness, and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly).</p> <p>During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 3/31/2025, the MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) from staff for bathing, lower body dressing, and toileting hygiene.</p> <p>During a review of the facility's (Facility) Falling Star (FL, Falls List), updated 5/16/2025, the FL indicated Resident 2 fell while in the care of the facility on 4/19/2025 and 4/22/2025.</p> <p>During an interview on 5/22/2025 at 10:42 a.m. with Resident 2, Resident 2 stated Resident 2 fell twice while residing at the facility. Resident 2 stated both falls happened when Resident 2 fell asleep in the wheelchair.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 5/22/2025 at 2:10 p.m. with the Director of Nursing (DON), Resident 2's Change in Condition Evaluation (COC) dated 4/19 and 4/22/2025 and Resident 2's Progress Notes (PN), dated 5/22/2025 were reviewed. The COCs indicated Resident 2 fell on [DATE] and 4/22/2025. The DON stated whenever a resident (in general) experienced a fall, part of the facility's fall management program included that the IDT meet after the fall to evaluate what interventions needed to be implemented to prevent further falls from occurring. The DON stated the IDT meeting would be documented in the residents (in general) Progress Notes or an IDT Assessment Form. The DON confirmed Resident 2's progress notes (PN) did not indicate the IDT met to address Resident 2's falls on 4/19/2025 and 4/22/2025. The DON stated the IDT did not meet following Resident 2's falls since the IDT meeting was not documented in Resident 2's medical record.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Fall Management Program, dated 10/1/2023, the P&P indicated, The IDT-Falls Committee will meet within 72 hours of a fall. The IDT-Falls Committee will review and document:</p> <ul style="list-style-type: none"> i. Summary of event following a fall. ii. Root cause analysis. iii. Referrals, as necessary. iv. Interventions to prevent future falls. 		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>44027</p> <p>Based on interview and record review, the facility failed to maintain a complete and accurate medical record for one of two sampled residents (Resident 1) when Licensed Vocational Nurse (LVN) 1 failed to document details of Resident 1's fall at the facility on 5/8/2025.</p> <p>This failure resulted in Resident 1's medical record containing incomplete information.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 11/14/2021 and readmitted Resident 1 on 2/24/2025 with diagnoses including hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebrovascular disease (a range of conditions that affect the blood vessels and blood flow in the brain), dementia (a group of thinking and social symptoms that interferes with daily functioning), and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 3/3/2025, the MDS indicated Resident 1 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for bathing and toileting hygiene. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) from staff for dressing and oral and personal hygiene.</p> <p>During a review of the facility's (Facility) Falling Star (FL, Falls List), updated 5/16/2025, the FL indicated Resident 1 fell while in the care of the facility on 3/20, 4/9, 5/7, and 5/8/2025.</p> <p>During an interview on 5/22/2025 at 10 a.m. with the Director of Nursing (DON), the DON stated Resident 1 had fallen multiple times while residing at the facility. The DON stated Resident 1's latest falls happened on 5/7/2025 and 5/8/2025.</p> <p>During a concurrent interview and record review on 5/22/2025 at 3:02 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's Change in Condition Evaluation (COC), dated 5/8/2025 was reviewed. The COC indicated Resident 1 had a fall on 5/8/2025. The COC failed to describe the events surrounding Resident 1's fall. LVN 1 stated a Certified Nursing Assistant (CNA) informed LVN 1 that Resident 1 had fallen. LVN 1 stated LVN 1 went to Resident 1 and found Resident 1 lying on the floor on the right side of Resident 1's bed. LVN 1 stated LVN 1 was a new staff person and that Registered Nurse (RN) 1 showed LVN how to document Resident 1's fall on 5/8/2025.</p> <p>During an interview on 5/22/2025 at 3:13 p.m. with RN 1, RN 1 stated RN1 was the supervisor on 5/8/2025 when Resident 1 fell . RN 1 stated Resident 1's fall was documented in the facility's risk management but not in Resident 1's medical record. RN 1 stated Resident 1's fall should be documented in Resident 1's progress notes to ensure Resident 1's healthcare team knew the health status of Resident 1.</p> <p>(continued on next page)</p>		

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