

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055441	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Ivy Creek Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 115 Bridge St. San Gabriel, CA 91775	

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (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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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to address the recurrent behavior fluctuations of manic mood (mental state of an extreme highs or depressive lows) of verbally aggressive towards staff/others and diminished interest/pleasure in usual Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily), for (1) of two (2) sampled residents (Resident 2) while on Depakote (drug used to calm overactive nerves in the brain). This deficient practice resulted in Resident 1 being hit on the left leg by Resident 2's right hand and had the potential to place Resident 1 at risk for physical and psychosocial harm. Findings: During a review of Resident 1's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included but not limited to anxiety (a feeling of fear, dread, and uneasiness that may occur as a reaction to stress) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 12/13/2025, the MDS indicated Resident 1 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with toileting and shower and required supervision (helper provides cues) with oral and personal hygiene, upper and lower body dressing and putting on and taking off footwear. The MDS further indicated Resident 1 required setup assistance (helper sets up; resident completes activity) with eating. 2. During a review of Resident 2's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] and 8/23/2025 with diagnoses that included bipolar and delusional disorder (having false or unrealistic beliefs), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's physicians order dated 8/23/2025 timed at 9:59 AM, the physicians order indicated Depakote 125 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) to give 1 tablet by mouth 2 times a day (BID) for bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) manifested by recurrent behavior fluctuations between diminished interest/pleasure in usual ADLs to manic mood of verbally aggressive towards staff/others. During the same review of the physician's order dated 8/23/2025 timed at 9:59 AM, the physicians order indicated to monitor episodes of recurrent behavior fluctuations between diminished interest/pleasure in usual ADLs to manic mood of verbally aggressive towards staff/others. During a review of Resident 2's Care Plan initiated on 11/28/2023, the Care Plan indicated Resident 2 has a behavior problem manifested by recurrent outburst of anger for no reason hitting staff and recurrent behavior fluctuations between diminished interest/pleasure in usual ADLs to manic mood of verbally aggressive towards staff/others. The Care Plan approach plan indicated to monitor behavior episodes and attempt to determine underlying cause, consider location, time of day, person involved, and situations. The Care Plan also indicated to document behavior and potential causes. During a review of Resident 2's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of November 2025. The MAR indicated Resident 2 had 11 incidents of behavior disturbances. During a review of Resident 2's Minimum Data Set, dated [DATE], the MDS indicated Resident 2 had severe impairment in cognitive skills for daily decision making. The MDS also indicated Resident 2 required supervision with toileting, shower, upper and lower body dressing and putting on and taking off footwear. The MDS further indicated Resident 2 required setup assistance with eating, oral and personal hygiene. During an interview on 12/18/2025 at 1:41 PM, Licensed Vocational Nurse 1 (LVN 1) stated he heard someone yelling from Room A on 12/8/2025 at around 12:15 AM during the night shift (11PM - 7AM) but did not know who was the resident that was yelling. LVN 1 stated he went towards the room and saw Resident 2 hit Resident 1's left leg with his right hand. During a concurrent interview and record review on 12/18/2025 at 3:30 PM with LVN 2, Resident 2's MAR were reviewed. LVN 2 stated Resident 2 was on Depakote 125 mg BID. LVN 2 also stated Resident 2 was being monitored for verbally aggressive behaviors to staff and others and the MAR indicated Resident 2 did not have behavior from December 1 - 4, 2025 but had 11 episodes of behaviors from December 5 - 7, 2025. LVN 2 stated Resident 2's physician should have been notified of the resident's aggressive behaviors so that</p>		