STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055441	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ivy Creek Healthcare & Wellness Centre	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45523 Based on observation, interview and record review, the facility failed to provide care in a manner that maintained or enhanced dignity and respect in full recognition of the resident's individuality for two (2) of 19 sampled residents (Resident 11 and 37). The facility staff was observed standing above the resident's eye level while assisting the resident during a meal. This deficient practice had the potential to affect Resident 11's and 37's self-esteem and self-worth. Findings: 1. A review of Resident 11's Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnosis of, but not limited to, dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), dysphagia oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat). A review of Resident 11's History and Physical (H&P) dated 3/3/24 indicated Resident 11 does not have the capacity to understand and make decisions. A review of Resident 11's Minimum Data Set (MDS, a standardized assessment and screening tool) dated 4/5/24, indicated the resident required touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient/resident completes activity) for eating and oral hygiene. Resident 11 required partial or moderate assistance (the resident can perform 50% of the mobility task while the caregiver assists with 50%) for toileting hygiene, shower, and lower body dressing. During a meal observation on 4/09/24 at 12:09 PM, at Resident 11's room, Resident 11 was observed seated at side of bed. Certified Nursing Assistant 2 (CNA2) was observed standing while feeding lunch to Resident 11. Resident 11 was observed extending his neck to look up at CNA2. During an interview with CNA2 on 4/9/24 at 12:11 PM, CNA2 stated she should have sat down on a chair next to Resident 11 while feeding him to ensure CNA2 is at an eye level of the resident and resident does not have to look up/ extend his neck. CNA2 stated, I am sorry, that was my mistake. When feeding a resident, I am supposed to sit next to the resident and take my time feeding them. (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

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 04/12/2024
NAME OF PROVIDER OR SUPPLIER Ivy Creek Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 115 Bridge St. San Gabriel, CA 91775	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 4/11/24 at 2:15 PM, the DON stated staff should sit down while feeding residents to be at the resident's eye level. A review of the facility's Policy and Procedure titled, Resident Rights-Quality of Life, revised March 2017 indicated, Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and receives services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable well-being. A review of the facility's Policy and Procedure titled, Restorative Dining Program, revised 1/1/2012 indicated under techniques is to position resident comfortably and safely with feet flat on floor, knees, hips at feet 90 degrees and staff member should sit while assisting or feeding resident. 42223 2. A review of Resident 37's Admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnosis of dysphagia (difficulty swallowing) and protein-calorie malnutrition (lack of proper nutrition caused by not eating enough). A review of Resident 37's H&P, dated 2/29/24, indicated resident does not have the capacity to understand and make decisions. A review of Resident 37 MDS, dated [DATE], indicated the resident was severely impaired with cognitive skills for daily decision making. The MDS also indicated resident was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. A review of Resident 37 Care Plan, dated 3/17/24, with focus of Activities of Daily Living (ADL; activities related to personal care such as bathing/showering, dressing, getting in and out of bed or a chair, walking, using the toilet and eating) self-care performance deficit indicated interventions will provide privacy and dignity when giving care at all times. During a concurrent observation in Resident 37's room and interview with Certified Nursing Assistant 8 (CNA8) on 4/9/24 at 12:20 PM, CNA 8 was observed feeding Resident 37 while standing up. CNA 8 stated it is not okay to assist Resident 37 during mealtime and CNA 8 was supposed to sit while feeding the resident. CNA 8 also stated sitting down at the resident's eye level was important to ensure to provide dignity and respect to the resident. During a concurrent observation and interview on 4/9/24 at 12:25 PM, Director of Staff Development (DSD) stated it is not okay for the CNAs to feed the resident standing up because they need to maintain at resident's eye level to maintain dignity. DSD also stated the resident can feel rushed while eating. A review of the facility's Policy and Procedure titled, Resident Rights, dated 1/1/12, indicated employees are to treat all residents with kindness, respect, and dignity and honor the exercise of residents' rights.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on observation, interview and record review, the facility failed to reasonably accommodate the needs of three (3) of 19 sampled residents (Resident 37, 73, and 3) by failing to have residents call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) within reach. This deficient practice had the potential for the residents not to be able to call the staff for assistance, which could result to not receiving or delayed needed care or services necessary for the residents' well-being. Findings: 1. A review of Resident 37's Admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnosis of dysphagia (difficulty swallowing) and protein-calorie malnutrition (lack of proper nutrition caused by not eating enough). A review of Resident 37's History and Physical (H&P), dated 2/29/24, indicated resident does not have the capacity to understand and make decisions. A review of Resident 37's Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 3/7/24, indicated the resident is severely cognitively impaired for daily decision making. The MDS also indicated resident is dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. A review of Resident 37's Care Plan, dated 3/17/24, with focus of Activities of Daily Living (ADL; activities related to personal care such as bathing/showering, dressing, getting in and out of bed or a chair, walking, using the toilet and eating) self-care performance deficit indicated encourage the resident to use bell to call for assistance. During a concurrent observation in Resident 37's room and interview on 4/9/24 at 12:09 PM, Resident 37's call light was on the right side of the bed and out of the resident's reach. Certified Nursing Assistant (CNA) 8 stated it is not okay that the call light is not within reach of Resident 37 because she would not be able to call and ask for assistance when needed. During an interview on 4/11/24 at 8:31 AM, Director of Staff Development (DSD) stated it is not okay that the call light was not within reach because if the residents were to have an emergency, she should be able to call the staff right away. DSD also stated the facility staff should always make sure the resident's call light are within reach. A review of the facility's Policy and Procedure titled, Communication - Call System, dated 1/1/12, indicated call cords will be placed within the resident's reach in the resident's room. 46919 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 73's Admission Record indicated Resident 73 was admitted to the facility on [DATE] with diagnoses that included dementia (a brain disorder that results in memory loss, poor judgement, and confusion), neurocognitive disorder with Lewy bodies (type of progressive dementia that leads to a decline in thinking, reasoning, and independent function), and pigmentary retinal dystrophy (an eye condition that damages the retina which leads to decreased vision). A review of Resident 73's H&P, dated 12/17/23, indicated Resident 73 did not have the mental capacity to understand and make decisions due to dementia. A review of Resident 73's MDS, dated [DATE], indicated Resident 73 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making and required partial/moderate assistance (helper does less than half the effort) with shower/bathe self, upper body dressing, sit to stand, and chair/bed-to-chair transfer. The MDS indicated Resident 73 required supervision/touching assistance (helper provides verbal cues and/or touching assistance as resident completes activity) with eating, oral hygiene, and personal hygiene. Resident 73's ability to see in adequate light (with glasses or other visual appliances) was assessed to be moderately impaired (limited vision, not able to see newspaper headlines but can identify objects). A review of Resident 73's Care Plan, revised on 1/26/23, indicated Resident 73 was at risk for falls related to impulsive behavior, trying to be independent beyond ability, difficulty walking. The care plan interventions indicated to be sure the resident's call light is within reach and encourage resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. During a concurrent observation in Resident 73's room and interview, on 4/9/24 at 9:28 AM, Resident 73 was sitting on his wheelchair listening to the television. Resident 73 stated he had impaired vision and did not know where his call light was. Resident 73 stated the facility staff did not tell him where his call light was this morning. During a concurrent observation in Resident 73's room and interview with Certified Nursing Assistant (CNA 10), on 4/9/24, at 9:32 AM, CNA 10 entered Resident 73's room and retrieved Resident 73's call light behind the resident's bed. CNA 10 stated the call light fell between Resident 73's headboard and mattress. 3. A review of Resident 3's Admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and eventually the ability to carry out the simplest tasks), encounter for attention to gastrostomy (G-tube, a flexible tube surgically inserted through the wall of the abdomen directly into the stomach for feeding, fluid, and medication administration), and dysphagia (difficulty or discomfort in swallowing). A review of Resident 3's H&P, dated 10/17/23, indicated Resident 3 did not have the mental capacity to understand and make decisions due to dementia. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 3's MDS, dated [DATE], indicated Resident 3 was severely impaired (never/rarely made decisions) with cognitive skills (ability to make decisions) for daily decision making. The MDS also indicated Resident 3 was dependent (helper does all of the effort) with shower/bathe self, lower body dressing, personal hygiene, rolling left and right, sit to lying, and tub/shower transfer. In addition, the MDS indicated Resident 3 also required substantial/maximal assistance (helper does more than half the effort) with oral hygiene, toileting hygiene, and upper body dressing. A review of Resident 3's Care Plan, revised on 12/3/23, indicated Resident 3 was at risk for falls related to psychoactive drug use. The care plan interventions indicated to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. The care plan further indicated the resident needs a safe environment with a working and reachable call light, the bed in low position at night and personal items within reach. During a concurrent observation in Resident 3's room and interview with Infection Control Nurse (IPN), on 4/9/24, at 10:10 AM, Resident 3 was in bed. Resident 3's call light was on the floor and was not within the resident's reach. IPN entered Resident 3's room and stated the call light should be next to Resident 3 so resident can reach the call light when resident needs to call for staff's assistance. During an interview with CNA 11, on 4/12/24, at 9:21 AM, CNA 11 stated Resident 73's call light needs to be within the resident's reach at all times. CNA 11 stated Resident 73 had impaired vision and needs to be reminded where the call light is. CNA 11 stated the residents use the call light to inform staff when they need water or assistance to use the restroom. CNA 11 stated not having the call light within reach can cause residents to soil themselves or cause a fall which can lead to injury or hospitalization . During an interview with the Director of Nursing (DON), on 4/12/24, at 9:58 AM, the DON stated it is important for residents to have the call light within reach so staff can provide assistance to the residents. The DON stated if the call light is not within the resident's reach, unstable residents can fall, get injured and end up in the hospital. A review of the facility's Policy and Procedure (P&P) titled, Resident Rights- Accommodation of Needs, revised on 1/1/22, indicated the purpose is The facility's environment is designed to assist the resident in achieving independent functioning and maintaining the resident's dignity and well-being. Facility Staff will assist residents in achieving these goals.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523 Based on observation, interview, and record review, the nursing staff failed to provide privacy and confidentiality (safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent of the resident and/or the individual's surrogate or representative) of the resident's medical records by not closing the unattended computer screen for one (1) of 19 sampled residents (Resident 11). This deficient practice violated Resident 11's right for privacy and confidentiality. Findings: A review of Resident 11's Admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnosis of, but not limited to, dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), dysphagia, oropharyngeal phase (swallowing problems occurring in the mouth and/or the throat). A review of Resident 11's History and Physical (H&P) dated 3/3/24 indicated Resident 11 does not have the capacity to understand and make decisions. A review of Resident 11's Minimum Data Set (MDS, a standardized assessment and screening tool) dated 4/5/24, indicated the resident required touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient/resident completes activity) for eating and oral hygiene. Resident 11 required partial or moderate assistance (helper does less than half the effort) for toileting hygiene, shower, and lower body dressing. During concurrent observation in the nursing station East and record review on computer with RNS1 on 4/10/24 at 8:39 AM, RNS1 walked away from nursing station to call nursing staff to assist with printing resident's documents from computer and left the Resident 11's care plan information on the computer screen. During observation in the nursing station East on 4/10/24 at 8:43 AM, RNS1 got up a 2nd time from the nursing station to get water leaving the computer screen open with Resident 11's care plan information and there were multiple staff (unable to identify) passing by the nursing station East while the computer screen was left open. During an observation in the nursing station East with RNS1 on 4/10/24 at 8:50 AM, RNS1 got up a third time and walked away from nursing station without closing the computer screen and leaving Resident 11's medical orders information on screen to look for the Director of Nursing (DON). (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation in the nursing station East, interview, and record review with the DON on 4/10/24 at 9:05 AM, the DON stated it is not okay to leave the computer screen open. The DON stated, there is patient information on the screen and we want to be in compliance with Health Insurance Portability Accountability Act (HIPAA, the Privacy Rule that protects all individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral) if you leave the station at least close the screen because anyone passing by can read it. During an observation in the nursing station [NAME] and interview on 4/11/24 at 8:07 AM, RNS1 was assisting surveyor with record review at nursing station West. Observed RNS1 logged in to computer with name and password. RNS1 stated she would get the wound care nurse (WCN) to assist surveyor to complete record review. RNS1 asked a passing staff to call wound care nurse to the station. During a concurrent observation in the nursing station [NAME] and interview on 4/11/24 at 8:14 AM, WCN arrived at nursing station [NAME] to assist surveyor with record review on the computer. RNS1 got up from desk and allowed WCN to sit at the desk where the computer with wound care information that was opened without logging out from RNS1's account. WCN then proceeded to use same computer screen that held wound care information and navigated the screen assisting surveyor to locate the wound care orders, treatments, and care plans without logging in to computer with own name and password. During an observation on 4/11/24 at 8:22 AM, WCN completed the record review needed with the surveyor. WCN then proceeded to get up from nursing station and walked away without closing computer screen with wound care and medical orders information still visible to any passerby at nursing station West. During an observation on 4/11/24 at 8:32 AM, multiple staff walked by nursing station [NAME] and computer screen was still displaying wound care and medical order information. During an interview with both Administrator and DON on 4/11/24 at 8:32 AM, Administrator and the DON stated the computer screen should not be open displaying resident's medical information and all staff should log off and close the computer screens before leaving the nursing station. A review of the facility's Policy and Procedure (P&P) titled, Resident Rights, revised 1/01/12 indicated, To promote and protect the rights of all residents at the facility including to provide privacy and confidentiality. A review of the facility's P&P titled,Notice of Privacy Practices, revised 12/1/12 indicated, Facility staff will be trained on the privacy practices of the facility, including the practices outlined in the Privacy Notice upon hire and annually.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to ensure residents were provided a homelike environment for three (3) of four (4) sampled residents (Residents 19, 81, and 20) for the environment care area by: 1. and 2. Failing to provide Residents 19 and 81 a room without unfinished and peeling paint on the walls and unmaintained baseboards (wooden or plastic board covering the lowest part of a wall). 2. Leaving a plastic cup of frozen beverage, owned by staff, on top of Resident 20's hand sanitizer dispenser. These deficient practices have the potential for an unsafe and unsanitary resident's environment which had the potential to negatively affect the resident's quality of life. Findings: 1. A review of Resident 19's Admission Record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (damage or disease that affects the brain), chronic obstructive pulmonary disease (COPD, a lung disease characterized by long term poor airflow), and cerebral infarction (when the blood supply to part of the brain is blocked or reduced). A review of Resident 19's History and Physical Examination (H&P), dated 3/10/24, indicated Resident 19 did not have the capacity to understand and make decisions. A review of Resident 19's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/16/24, indicated Resident 19 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making and required substantial/maximal assistance (helper does more than half the effort) with oral hygiene, toileting hygiene, lower body dressing, and personal hygiene. Resident 19 was dependent (helper does all of the effort) with shower/bathe self and required setup or clean up assistance (helper sets up of cleans up) with eating. During an observation of Resident 19's room on 4/9/24, at 8:42 AM, Resident 19's room was observed to have brown baseboards that were peeling off the wall. Resident 19's wall paint was observed to be peeling. 2. A review of Resident 81's Admission Record indicated Resident 81 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included gout (a form of arthritis that causes pain and swelling in the joints), type 2 diabetes mellitus (a disease that occurs when the blood sugar is too high), and difficulty in walking. A review of Resident 81's H&P, dated 1/5/24, indicated Resident 81 did not have the capacity to make decisions due to dementia (a brain disorder that results in memory loss, poor judgement, and confusion). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 81's MDS, dated [DATE], indicated indicated Resident 81 was severely impaired with cognitive skills for daily decision making and required and required partial/moderate assistance (helper does less than half the effort) with shower/bathe self, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. Resident 81 required supervision or touching assistance with toilet transfer, sit to stand, eating, oral hygiene, and toileting hygiene. During an observation of Resident 81's room on 4/9/24, at 8:47 AM, Resident 81's room was observed to have peeling paint and white patches on the wall next to his bed and around the electrical outlet. During an interview with the Director of Nursing (DON), on 4/10/24, at 3:23 PM, the DON stated the resident's rooms should be presentable and personalized to what the resident likes. The DON stated it is important for the rooms to look and feel like they are at home. The DON stated when the residents have a nice room, they feel dignified and respected. The DON stated broken baseboards, peeling paint, and white patches on the walls is not considered homelike. The DON stated the Maintenance Department is responsible for checking which rooms need to be repaired. The DON stated facility staff also rounds to check which rooms need to be repaired. The DON stated he was unsure if the partially removed baseboard, peeling paint, and white patches on the walls had been addressed during rounds. During an interview with Maintenance Assistant (MA 1), on 4/10/24, at 3:33 PM, MA 1 stated he was told by the Maintenance Supervisor (MS) to fix the baseboard today. MA 1 stated MS was the person who does the rounds in the facility to see what needs to be repaired. MA 1 stated he was not sure how long the paint has been peeling and how long the white patches has been on the walls. MA 1 stated the baseboard in Resident 19's room should have been fixed right away for the safety of the resident and facility staff. MA 1 stated the residents like it when everything in their room is fixed and homelike. 3. A review of Resident 20's Admission Record indicated Resident 20 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included respiratory failure (a condition in which the blood does not have enough oxygen or has too much carbon dioxide), type 2 diabetes mellitus, and dysphagia (difficulty or discomfort in swallowing). A review of Resident 20's H&P, dated 1/20/24, indicated Resident 20 did not have the capacity to understand and make decisions. A review of Resident 20's MDS, dated [DATE], indicated Resident 20 was moderately impaired with cognitive skills for daily decision making and required substantial/maximal assistance with toileting hygiene, shower/bathe self, lower body dressing. Resident 20 required partial/moderate assistance with oral hygiene, upper body dressing, personal hygiene, and sit to stand. Resident 20 required setup or clean-up assistance with eating. During a concurrent observation in Resident 20's room and interview with Registered Nurse 1 (RN 1), on 4/11/24, at 4:59 PM, a plastic cup of frozen beverage was observed placed on top of Resident 20's hand sanitizer (a liquid, gel, or foam generally used to kill viruses and bacteria on the hands) dispenser. RN 1 stated the beverage belonged to facility staff and should not have been left in Resident 20's room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON, on 4/11/24, at 5:29 PM, the DON stated facility staff are not allowed to leave their beverages in resident's rooms. The DON stated the beverage should not have been left in Resident 20's room because it is not Resident 20's property. The DON stated Resident 20's room is his own private space and it is not homelike if facility staff leaves their beverages there. A review of the facility's policy and procedure (P&P) titled, Resident Rights, revised on 1/1/12, indicated, Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of resident's rights. A review of the facility's P&P titled, Resident Rooms and Environment, revised on 1/1/12, indicated the following: 1. The Facility will provide residents with a safe, clean, comfortable and homelike environment. 2. Facility Staff aim to create a personalized, homelike atmosphere, paying close attention to the following: a. Cleanliness and order A review of the facility's P&P titled, Maintenance Service, revised on 1/1/12, indicated, The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. The P&P further indicated, Functions of the Maintenance Department may include, but are not limited to: maintaining the building in good repair and free from hazards.

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NAME OF PROVIDER OR SUPPLIER: Ivy Creek Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE: 115 Bridge St. San Gabriel, CA 91775	

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a qualified health professional conducts resident assessments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45099 Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) signed and certified the Minimum Data Set (MDS, standardized assessment and care screening tool)/ Care Area Assessment (CAA, provides guidance to focus on key issues identified in the comprehensive MDS) for one (1) of two (2) sampled residents (Resident 84), for Resident Assessment Care Area, in accordance with the facility's policy. This deficient practice had the potential to result in an incomplete assessment and inaccurate depiction of resident specific issues affecting the development of an individualized care plan. Findings: A review of Resident 84's Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnosis that included type 2 diabetes mellitus (DM, body's failure to regulate and use sugar as a fuel). A review of Resident 84's History and Physical (H&P), dated 11/10/23, indicated Resident 84 had the capacity to understand and make decisions. A review of Resident 84's MDS, standardized assessment and care screening tool), dated 11/16/23, indicated Resident 84 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 84 required substantial assistance (helper does more than half the effort) with toileting, shower, lower body dressing, and putting on/taking off footwear and required partial assistance (helper does less than half the effort) on upper body dressing. It also indicated that MDS 1/Licensed Vocational Nurse 6 (LVN 6) signed the MDS section verifying assessment completion, CAA, and care planning sections which required a signature of an RN Assessment Coordinator. During a concurrent interview and record review on 4/12/24 at 11:41 AM, the Clinical Consultant (CC) confirmed and verified MDS 1/LVN 6 was the one who signed the MDS assessment, dated 11/16/23. The CC stated a Registered Nurse (RN) should be signing and validating the completion of the MDS and not an LVN per facility policy. The CC also stated that the CAA section should be signed by an RN. A review of the facility policy and procedure titled, Resident Assessment Instrument (RAI) Process, dated October 4, 2016, indicated that the facility utilizes the RAI process as the basis for the accurate assessment of each resident's functional capacity and health status, as outlined in the Centers for Medicare and Medicaid Services (CMS) RAI MDS 3.0 Manual. A review of the CMS RAI version 3.0 Manual, dated October 2023, indicated that federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment was complete on section requiring Signature of RN coordinator verifying assessment completion. The CMS RAI version 3.0 manual also indicated that CAAs and Care Planning sections requiring a signature, needs to be signed by the RN coordinator.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to implement the care plan for one (1) of two (2) sampled residents (Resident 18) to ensure the head of bed (HOB) was elevated while resident was on oxygen. This deficient practice had the potential to result in complications from hypoxia (lack of sufficient oxygen in the body) and can lead to shortness of breath, rapid breathing, confusion, and loss of consciousness, and irregular heartbeat. Findings: A review of Resident 18's Admission Record indicated Resident 18 was admitted to the facility on [DATE] with diagnoses that included COVID -19 (Coronavirus, a respiratory illness caused by a virus that can spread from person to person), pneumonia (an infection that affects one or both lungs) due to Coronavirus disease 2019, and respiratory failure. A review of Resident 18's History and Physical Examination (H&P), dated 1/5/24, indicated Resident 18 did not have capacity to make decisions due to dementia. A review of Resident 18's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/9/24, indicated Resident 18 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making and was dependent (helper does all of the effort) with toileting hygiene, shower/bathe self, roll left and right (the ability to roll from lying on back to left and right side), sit to lying, and lying to sitting on side of the bed. Resident 18 required substantial/maximal assistance (helper does more than half the effort) with upper/lower body dressing and personal hygiene. A review of Resident 18's Care Plan, dated 3/3/24, indicated Resident 18 had oxygen therapy related to respiratory failure. The staff interventions included were to position resident to facilitate ventilation/perfusion (flow of air into and out of the lungs) matching: use upright, high-Fowler's position (seated upright with the spine straight) whenever possible to allow for optimal diaphragm (a dome-shaped muscle in the abdomen responsible for controlling inhalation and exhalation), when on side, the good side should be down (e.g. [example] damaged lung should be up). During a concurrent observation of Resident 18 and interview with Licensed Vocational Nurse 3 (LVN 3) on 4/10/24, at 10:51 AM, Resident 18 was observed sleeping in bed on 2 liters of oxygen per minute (LPM) via nasal cannula (oxygen tubing used to deliver supplemental oxygen that is placed directly on the nostrils). Resident 18 was laying on her back with the HOB in flat position. LVN 3 stated Resident 18's HOB should be elevated since she is on oxygen. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN 3, on 4/10/24, at 3:51 PM, LVN 3 stated it is important for Resident 18's HOB to be elevated to allow the lungs to expand and take in more air. LVN 3 stated having the HOB flat can cause Resident 18 to experience shortness of breath, decreased oxygen in the body, and tachycardia (increased heart rate). LVN 3 stated if Resident 18 does not get enough oxygen she can get sick and end up getting hospitalized . During an interview with the Director of Nursing (DON), on 4/12/24, at 10:02 AM, the DON stated all interventions in Resident 18's care plan should be followed which includes having the HOB in an upright and elevated position. The DON stated Resident 18 can have shortness of breath, respiratory distress, and can end up in a hospital if the HOB is flat. The DON stated it is important for Resident 18's care plan for oxygen therapy to be followed because it is specific to Resident 18's needs. The DON stated Resident 18's care plan interventions are assessed and evaluated so the goal can be reached. A review of the facility's Policy and Procedure (P&P) titled, Oxygen Therapy, revised on 11/2017 indicated oxygen is administered under safe and sanitary conditions to meet resident needs. Licensed Nursing staff will administer oxygen as prescribed. A review of the P&P titled, Comprehensive Person Centered Care Planning, revised on 11/18, indicated, It is the policy of this Facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being.

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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** 42223 Based on observation, interview, and record review, the facility failed to ensure one (1) of 1 sampled resident (Resident 17) for the activities of daily living (ADL) care area, who was unable to carry out ADL received the necessary services to maintain good personal hygiene. This deficient practice resulted in Resident 17 having white crust on the eyelids and brownish stains around the mouth. Findings: A review of Resident 17's Admission Record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnosis of dementia (Impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and encounter for palliative care (interdisciplinary [combination of multiple academic disciplines into one activity] medical caregiving approach aimed at optimizing quality of life and mitigating suffering among people with serious, complex, and often terminal illness). A review of Resident 17's History and Physical (H&P), dated 5/1/23, indicated resident does not have the capacity to understand and make decisions. A review of Resident 17's Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 3/1/24, indicated resident is severely impaired (never/rarely made decisions) with cognitive skills for daily decision making. The MDS also indicated Resident 17 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/ taking off footwear and personal hygiene. A review of Resident 17's Care plan, dated 1/30/22, with focus of resident ADL self-care performance deficit indicated resident personal hygiene and oral care is dependent. Care plan also indicated to provide dignity and care during care at all times. During a concurrent observation in Resident 17's room and interview on 4/9/24 at 3:20 PM, Resident 17 was observed with white crust around the eyes and brownish stains around the mouth. Certified Nursing Assistant (CNA) 9 stated it is not okay for the resident to be with brown stains around mouth and white crust around the eyes, and staff should be cleaning the resident. CNA 9 also stated it is for to ensure resident gets proper hygiene. During an interview on 4/10/24 at 4:05 PM, Director of Staff Development (DSD) stated it is not okay that the resident has white crust around the eyes and brownish stains around the mouth. DSD stated the resident should be cleaned right away and reported to the charge nurse if there is any changes in the resident's condition. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy and Procedure titled, Bed bath, review date 8/31/22, indicated when washing the residents face to wash the resident's eyes from the nose to the outside of the face. A review of the facility's Policy and Procedure titled, Resident Rights, dated 1/1/12, indicated employees are to treat all residents with kindness, respect, and dignity and honor the exercise of residents' rights.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to ensure two (2) of 19 sampled residents (Residents 3 and 30) received treatment and care in accordance with the physician's order, care plan, and professional standards of practice by failing to: 1. Ensure facility staff applied Resident 3's abdominal binder (a wide compression belt that wraps around the abdomen) to prevent the gastrostomy tube (g-tube, a flexible tube surgically inserted through the wall of the abdomen directly into the stomach for feeding, fluid, and medication administration) dislodgement as ordered by the physician. This deficient practice had the potential to result in Resident 3 pulling her g-tube and suffer complications and hospitalization . 2. Reassess and monitor Resident 30's right big toe as indicated in the resident's care plan. This deficient practice had the potential to result in the recurrence of Resident 30's diabetic foot ulcer (an open wound that occurs in approximately 15 percent of residents with diabetes [body failure to regulate and uses sugar as a fuel], commonly located on the bottom of the foot). Findings: 1. A review of Resident 3's Admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills and eventually the ability to carry out the simplest tasks), encounter for attention to gastrostomy, and dysphagia (difficulty or discomfort in swallowing). A review of Resident 3's History and Physical (H&P), dated 10/17/23, indicated Resident 3 did not have the mental capacity to understand and make decisions due to dementia. A review of Resident 3's Minimum Data Set (MDS, standardized assessment and care screening tool), dated 2/20/24, indicated Resident 3 was assessed having severely impaired (never/rarely made decisions) cognitive skills (ability to make decisions) for daily decision making. Resident 3 was dependent (helper does all of the effort) with shower/bathe self, lower body dressing, personal hygiene, rolling left and right, sit to lying, and tub/shower transfer. Resident 3 also required substantial/maximal assistance (helper does more than half the effort) with oral hygiene, toileting hygiene, and upper body dressing. A review of Resident 3's Order Summary Report, dated 4/12/24, indicated a physician order, with an order date of 10/24/22, for abdominal binder on at all times for g-tube placement, management, may remove for showers and ADL's. A review of Resident 3's Care Plan, revised on 9/18/22, indicated Resident 3 required tube feeding related to dysphagia. Staff interventions indicated to have abdominal binder on at all times for g-tube placement management, may remove for showers and activities of daily living (ADLs). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation in Resident 3's room and interview with Licensed Vocational Nurse 4 (LVN 4), on 4/11/24, at 2:15 PM, Resident 3 was observed lying in bed. Resident 3 did not have an abdominal binder covering her g-tube site. LVN 4 stated Resident 3's abdominal binder was being washed in the laundry because it got soiled from an earlier diaper change. LVN 4 stated she did not know if Resident 3 had an extra abdominal binder. LVN 4 stated she could not find an extra abdominal binder in Resident 3's drawer. LVN 4 stated she did not ask other staff to get a replacement abdominal binder for Resident 3. During an interview with LVN 3 on 4/11/24, at 2:18 PM, LVN 3 stated Resident 3 had a history of pulling her g-tube. LVN 3 stated Resident 3 was ordered to wear an abdominal binder to prevent her from pulling the g-tube. During an interview with Registered Nurse Supervisor 1 (RNS 1) on 4/11/24, at 2:25 PM, RNS 1 confirmed Resident 3 had a history of pulling her g-tube. RNS 1 stated it is important for Resident 3's g-tube site to be covered with the abdominal binder to prevent dislodgement. RNS 1 stated Resident 3 moves very fast and can easily pull her g-tube if it is not covered. RNS 1 stated Resident 3 needs to have an extra abdominal binder to replace the binder that is dirty. RNS 1 stated if Resident 3's g-tube gets dislodged she will not be able to receive her ordered g-tube feeds or she can end up in the hospital. During an interview with the Director of Nursing (DON), on 4/12/24, at 9:59 AM, the DON stated it is important for Resident 3 to always have her binder on to prevent her g-tube from getting pulled. The DON stated the abdominal binder was ordered by the physician to prevent Resident 3 from pulling her g-tube. The DON stated Resident 3 will not receive adequate nutrition if her g-tube is dislodged. A review of the Policy and Procedure titled, Comprehensive Person Centered Care Planning, revised on 11/18, indicated, It is the policy of this Facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being. 45099 2. A review of Resident 30's Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnosis that included type 2 diabetes mellitus. A review of Resident 30's H&P, dated 2/25/24, indicated Resident 30 does not have the capacity to make decisions. A review of Resident 30's MDS, dated [DATE], indicated Resident 30 had moderate impairment in cognitive skills for daily decision making. The MDS also indicated Resident 30 required substantial assistance with oral and personal hygiene, and upper body dressing, and was dependent with toileting, shower, lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 30 had a diabetic foot ulcer. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 30's Care Plan, initiated on 3/6/23, indicated a staff intervention which included inspecting Resident 30's feet daily for open areas, sores, pressure areas (damage caused by unrelieved pressure when a soft tissue is compressed between areas where bones are close to the surface for a prolonged period), blisters, edema, or redness. A review of Resident 30's Weekly Skin/Wound Assessment, dated 4/8/24, did not indicate any documentation of any skin impairment or redness on Resident 30's right big toe. During an observation on 4/9/24 at 9:33 AM, Resident 30 was seen with redness on the right big toe measuring 1.2 by 1.5 centimeter (cm, unit of measurement). During a concurrent observation and interview on 4/11/24 at 11:21 AM, Treatment Nurse 1 (TN 1) confirmed Resident 30 had a 1.2 by 1.5 cm. blanchable (discoloration disappears with pressure, but then returns because the blood is still inside the vessels being moved around) redness on the right big toe which was not currently being treated. TN 1 also stated that skin checks were supposed to be done by the Certified Nursing Assistant (CNA) daily and any skin abnormalities reported to the charge nurse so they can catch any abnormal skin conditions while it is still early. TN 1 further stated early detection of skin abnormalities was essential to prevent it from getting worse and treatment can be initiated right away. During an interview on 4/11/24 at 12:12 PM, RNS 1 stated the nurses should have checked Resident 30's foot for any redness and open wounds and the charge nurse should have notified the physician so treatment could be provided right away to prevent complications that could result to amputation. During an interview on 4/11/24 at 3:42 PM, CNA 3 stated she noticed redness on Resident 30's right big toe few days ago and notified her charge nurse (could not recall the date she noticed the redness and the name of the charge nurse she reported to). CNA 3 also stated any unusual skin conditions observed on Resident 30 should have been reported so the resident could get proper treatment. During an interview on 4/11/24 at 3:54 PM, LVN 1 stated Resident 30's care plan should have been followed and residents' feet monitored because the resident had issues with delayed healing due to DM. LVN 1 also stated the goal of care for Resident 30 was for the wound not to get worse. A review of the facility's Policy and Procedure titled, Care of the Foot, revised 1/1/12, indicated its purpose was to provide hygienic care of the feet, to prevent skin breakdown or infections and to promote comfort. The policy also indicated to report any unusual observations to the charge nurse for follow up.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on observation, interview, and record review, the facility failed to follow its policy to ensure licensed nurses administer oxygen to two (2) of 2 sampled residents (Resident 143 and 85) for Respiratory Care area, as indicated on the care plan. This deficient practice had the potential for Residents 143 and 85 not to receive the appropriate respiratory care and services, which can affect the residents' overall wellbeing. Findings: 1. A review of Resident 143's Admission Record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the diagnoses of dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and chronic kidney disease (long standing disease of the kidneys [organs that filter waste and excess fluid from the blood] leading to renal failure [a condition in which the kidneys lose the ability to remove waste and balance fluids]). A review of Resident 143's History and Physical (H&P), dated 4/8/24, indicated the resident does not have the capacity to understand and make decisions. A review of Resident 143's Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 1/10/24, indicated resident was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. MDS also indicated Resident 143 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bathe self, upper body dressing, lower body dressing and putting on/taking off footwear. MDS indicated Resident 143 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene and personal hygiene. MDS indicated Resident 143 had a respiratory treatment of oxygen therapy. A review of Resident 143's Physician Orders, dated 4/5/24, indicated oxygen (a gas that will help support life) at 2 liters (L, unit of measure) per minute via nasal cannula to keep oxygen saturation (level of oxygen found in a person's blood) above 92% every shift for chronic respiratory failure (respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body) with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions). A review of Resident 143's Medication Administration Record (MAR) for the month of April, indicated oxygen at 2 L/ per minute via nasal cannula to keep oxygen saturation above 92% every shift for chronic respiratory failure with hypoxia. A review of Resident 143's Care Plan, revised 1/20/23, indicated Resident has a diagnosis of respiratory failure with hypoxia. Staff interventions included oxygen at 2 L/ per minute via nasal cannula to keep oxygen saturation above 92% every shift for chronic respiratory failure with hypoxia, which was the responsibility of Licensed Nurses. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/9/24 at 9:43 AM, observed Certified Nursing Assistant 7 (CNA7) picking up Resident 143's nasal cannula tubing (device that helps deliver oxygen through a tube to the nose) from the floor and connecting it to the oxygen concentrator (a medical device that helps breathe up to 95% pure oxygen). CNA 7 stated she was not supposed to connect the tubing to the oxygen concentrator because she does not know how much oxygen the resident was supposed to get, and it was the licensed nurse job to administer the oxygen to the resident. 2. A review of Resident 85's Admission Record indicated resident was admitted on [DATE] with the following diagnosis of chronic obstructive pulmonary disease (COPD, respiratory diseases that cause airflow blockage and breathing related problems) and dependence on supplemental oxygen. A review of Resident 85's MDS, dated [DATE], indicated resident had intact cognitive skills for daily decision making. MDS also indicated Resident 85 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene, toileting hygiene, shower/bath self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. MDS indicated Resident 85 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with eating. MDS indicated Resident 85 had respiratory treatment of oxygen therapy. A review Resident 85's Physician Orders, dated 3/17/24, indicated oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath (SOB) or to keep oxygen saturation above 91%. A review of Resident 85's Medication Administration Record (MAR) for the month of April, indicated oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath (SOB) or to keep oxygen saturation above 91%. A review of Resident 85's Care Plan, dated 11/15/23, indicated Resident has COPD. Staff interventions included oxygen at 2 L/ per minute via nasal cannula to keep oxygen saturation above 91%, which was the responsibility of Licensed Nurses. During an observation on 4/9/24 at 10:21 AM, observed CNA 10 putting the nasal cannula tubing on Resident 85's nostrils and regulating the oxygen concentrator. CNA 10 stated it should be the licensed nurse who needs to administer the oxygen to Resident 85 for the safety of the resident. CNA 10 also stated she should not administer oxygen to the resident. During an interview on 4/10/24 at 4:02 PM, Director of Staff Development (DSD) stated it should be the charge nurse that connects the tubing to the oxygen concentrator and regulates it. DSD also stated the CNA should have reported to the charge nurse that the resident needed the oxygen. During an interview on 4/10/24 at 4:16 PM, Infection Preventionist Nurse (IPN) stated it is the Licensed Vocational Nurses responsibility to connect the nasal cannula tubing to the oxygen concentrator. During an interview on 4/10/24 at 4:21 PM, Director of Nursing (DON) stated it is the licensed nurse's responsibility and not the CNA to administer the oxygen to the residents and regulate the oxygen concentrator. (continued on next page)

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 04/12/2024
NAME OF PROVIDER OR SUPPLIER: Ivy Creek Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE: 115 Bridge St. San Gabriel, CA 91775	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Policy and Procedure titled, Oxygen Therapy, dated 11/2017, indicated oxygen is administered under safe and sanitary conditions to meet residents' needs. Licensed nursing staff will administer oxygen as prescribed. A review of the facility's Policy and Procedure titled, Oxygen Safety and Handling, dated 10/21/21, indicated purpose of the policy is the proper safety and handling regulations for the use of oxygen and oxygen cylinders to ensure resident safety.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523 Based on observation, interview, and record review, the facility failed to ensure the storage, preparation and distribution of food were done under sanitary conditions by failing to ensure: 1. One red fruit Jello was labeled with use by date and expiration date. 2. Apple sauce tray cups were labeled with a use by date. 3. Rice noodles and garlic bag were labeled with received, use by, and expiration date. 4. Expired cilantro bag was not mixed in with carrots in same container. 5. Chorizo container labeled as Chorizo, contained a bacon and not a chorizo. These deficient practices have the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever, which could lead to hospitalization . Findings: 1. 2. and 3. During concurrent observation and interview with the Dietary Staff Supervisor (DSS) on [DATE] at 8:30 AM, DSS confirmed there was no use by date on a red fruit Jello container in the walk in freezer. DSS also confirmed that apple sauce cups, rice noodles and garlic bags were not labeled with received, use by and expiration date. During a concurrent observation and interview with DSS and Dietary Aid (DA) on [DATE] at 8:31 AM, DSS and DA confirmed the red fruit Jello container for snack was not labeled. DSS stated, Yes, it is not labeled, maybe the Cook forgot. Dietary supervisor stated the red fruit Jello was made yesterday on [DATE]. During a concurrent interview with DA on [DATE] at 8:35 AM, DA stated, The red fruit Jello is for dessert. The cook was supposed to label this from yesterday. I was supposed to throw it away yesterday but the Supervisor told me not to, that maybe we can use it for today. 4. During concurrent observation and interview with DSS on [DATE] at 8:41 AM, DSS confirmed the cilantro inside the bag was spoiled and mixed in with the same container with the carrots. DSS stated, The cilantro is not good. I will have to toss it since it's already spoiled. I should have thrown it out yesterday. 5. During concurrent observation and interview with DSS on [DATE] at 8:43 AM, DSS confirmed the container labeled, Chorizo, with a use by date of [DATE] did not have chorizo inside. DSS stated, It's bacon inside, bacon bag is labeled with use by date [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Policies and Procedures titled, Food Storage, revised on [DATE] indicated, Food items will be stored, thawed, and prepared in accordance with good sanitary practice. All items will be correctly labeled and dated. A review of the facility's Policies and Procedures titled, Dietary Department-Infection Control for Dietary Employees, revised [DATE] indicated, To ensure that the dietary department is maintained in a sanitary condition in order to prevent food contamination and the growth of disease producing organisms and toxins.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on interview and record review, the facility failed to ensure there was a coordination of care between facility and hospice (care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure) staff for one (1) of 1 sampled resident (Resident 79), for hospice care area, by failing to ensure Hospice nursing/ visitation notes were maintained in the resident's medical record, in accordance with the hospice policy. This deficient practice had the potential to result in a delay or lack of coordination in delivery of hospice care and services to Resident 79. Findings: A review of Resident 79's Admission Record indicated Resident 79 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and eventually the ability to carry out the simplest tasks), iron deficiency anemia (a condition in which the blood does not have enough healthy red blood cells to carry oxygen in the body), and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). A review of Resident 79's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/11/24, indicated Resident 79 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making and was dependent (helper does all of the effort) with eating, oral hygiene, upper/lower body dressing, personal hygiene, sit to stand, sit to lying, and tub/shower transfer. A review of Resident 79's Order Summary Report, dated 4/12/24, indicated a physician order, with a start date of 1/9/24, to admit to Hospice on 12/11/23, with hospice diagnosis of Alzheimer's Dementia. A review of Resident 79's Order Summary Report, dated 4/12/24, indicated a physician order, with a start date of 12/11/23, for Hospice frequency visits: Skilled Nurse (SN) 1 time a week, Certified Home Health Aide (CHHA) 2 times a week, Medical Social Worker (MSW) initial and as needed, Spiritual Counselor (SC) initial and as needed. A review of Resident 79's Care Plan, dated 12/19/23, indicated Resident had a terminal prognosis related to Alzheimer's Dementia. The care plan interventions indicated to work cooperatively with hospice team to endure the resident's spiritual, emotional, intellectual, physical, and social needs are met. During an interview with Certified Nursing Assistant 12 (CNA 12), on 4/11/24, at 8:55 AM, CNA 12 stated the CHHA comes twice a week to check Resident 79's vital signs, reposition, and give a bed bath. CNA 12 stated she has not talked or received report from the CHHA because the CHHA comes in the afternoon. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 79's hospice binder with the Director of Nursing (DON) on 4/11/24, at 10:50 AM, the DON stated the hospice should have a copy of the resident's Physician Orders for Life-Sustaining Treatment (POLST, describes health care wishes for someone facing a life-threatening medical condition), schedule of visits, physician's orders, plan of care, and nursing notes. The DON confirmed the last Licensed Vocational Nurse (LVN) note in the hospice binder was from 2/13/24. The DON confirmed the last CHHA note in the hospice binder was from 3/8/24. The DON stated he does not know who is responsible for making sure all the hospice notes are in Resident 79's hospice binder. The DON stated all hospice notes should be in the Resident 79's hospice binder to communicate with the facility staff what type of care was provided to Resident 79. A review of the facility's Policy and Procedure (P&P) titled, Hospice Care of Residents, revised on 1/1/12, indicated, Hospice notes will be included in the Facility Progress notes. The P&P further indicated, All documentation concerning hospice services will be maintained in the resident's medical record.

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NAME OF PROVIDER OR SUPPLIER Ivy Creek Healthcare & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 115 Bridge St. San Gabriel, CA 91775	

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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** 42223 Based on observation, interview, and record review, the facility failed to enforce its policy and procedure on infection control by : 1. Certified Nursing Assistant 6 (CNA 6) did not perform hand hygiene after doffing (remove) dirty gloves and donning (put on) clean gloves during resident care. 2. CNA 7 picked up resident's nasal cannula tubing (device used to deliver supplemental oxygen from the tube to nose) off the floor and connecting it to the oxygen concentrator (a device that concentrates oxygen by removing nitrogen giving a supply of 95% oxygen) from the floor and attached it to the resident's oxygen concentrator. 3. Failing to disinfect the laundry washers after every use. These deficient practices have the potential to transmit infectious microorganisms and increase the risk of infection for the residents. Findings: 1. and 2. A review of Resident 143's Admission Record indicated resident was originally admitted on [DATE] and was readmitted on [DATE] with the following diagnoses of dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and chronic kidney disease (long standing disease of the kidneys [organs that filter waste and excess fluid from the blood] leading to renal failure [a condition in which the kidneys lose the ability to remove waste and balance fluids]). A review of Resident 143's History and Physical (H&P), dated 4/8/24, indicated the resident does not have the capacity to understand and make decisions. A review of Resident 143's Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 1/10/24, indicated resident was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. MDS also indicated Resident 143 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bathe self, upper body dressing, lower body dressing and putting on/taking off footwear. MDS indicated Resident 143 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene and personal hygiene. MDS indicated Resident 143 was always incontinent of both bowel (intestine) and bladder (organ that acts as a reservoir for urine). A review of Resident 143's Physician Orders, dated 4/5/24, indicated oxygen (a gas that will help support life) at two (2) liters (L, unit of measure) per minute via nasal cannula to keep oxygen saturation (level of oxygen found in a person's blood) above 92% every shift for chronic respiratory failure (respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body) with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions). (continued on next page)

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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 - Few	During an observation on 4/9/24 at 9:43 AM, observed CNA7 picking up Resident 143's nasal cannula tubing from the floor and connecting it to the oxygen concentrator (a medical device that helps breathe up to 95% pure oxygen). During an interview on 4/10/24 at 4:02 PM, Director of Staff Development (DSD) stated the nasal cannula tubing that was on the floor should be changed. DSD also stated that this was an infection control issue. During an interview on 4/10/24 at 4:16 PM, Infection Preventionist Nurse (IPN) stated picking up the tubing off the floor and connecting it to the oxygen concentrator was an infection control issue. During a concurrent observation and interview on 4/11/24 at 10:35 AM, CNA 6 did not perform hand hygiene after doffing of dirty gloves and donning clean gloves during peri-care. CNA 6 stated she did not and should have performed hand hygiene after doffing gloves. CNA 6 stated, hand hygiene prevents the spread of germs and bacteria. During an interview on 4/11/24 at 11:22 AM, Director of Staff Development (DSD) stated CNAs are supposed to perform hand hygiene in between glove changes for infection control and to prevent infection like urinary tract infection (UTI, condition in which bacteria invade and grow in any part the urinary system which includes the kidneys, bladder, ureters [tube that carries urine from the kidney to the urinary bladder], and urethra [canal from the bladder]). A review of the facility's Policy and Procedure titled, Oxygen Therapy, dated 11/2017, indicated oxygen is administered under safe and sanitary conditions to meet resident needs. Policy also indicated oxygen tubing, mask, and cannulas will be changed no more than every seven (7) days and as needed. A review of the facility's Policy and Procedure titled, Infection Control, dated 1/1/12, indicated policy is intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. During an interview on 4/11/24 at 11:27 AM, IPN stated CNAs are supposed to perform hand hygiene in between glove changes to prevent the spread of infection. A review of the facility's Policy and Procedure titled, Hand Hygiene, dated 9/1/20, indicated the following situations require appropriate hand hygiene such as before donning and after doffing Personal Protective Equipment (PPE, equipment worn to minimize exposure to a variety of hazards such as gloves, foot and eye protection, respirators, gown). 3. During a concurrent observation and interview with IPN on 4/12/24 at 8:45 AM, Laundry Staff (LS) 1 was observed wearing gloves and loading dirty linen into Washer 1. LS 1 was then observed doffing gloves and proceeded to the dirty linen area without performing hand hygiene. LS 1 also did not disinfect Washer 1 after loading the dirty linen. LS 1 stated the washers are disinfected daily after the shift. IPN stated LS 1 did not and should have performed hand hygiene after doffing of PPE. IPN also stated LS 1 did not and should have wiped down the machines after use. During a concurrent observation on 4/12/24 at 8:48 AM, LS 2 was observed taking clean laundry out of Washer 2 and loaded them in Dryer 1 and Dryer 2. (continued on next page)

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	055441	A. Building B. Wing	04/12/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/12/24 at 9 AM, IPN stated LS 1 should have performed hand hygiene after she removed her gloves. IPN also stated LS 1 should be wiping down the washers after every use so they are not contaminated. IPN stated this is to prevent the spread of infection. IPN stated LS 1 can contaminate the dryers and spread infection as LS 2 takes the clothes from the washers to the dryers. A review of the facility's Policy and Procedure titled, Laundry Supply and Storage, dated 1/1/12, indicated after each use of the washing machine or dryer, and at least daily all machines are wiped down with a disinfectant solution. A review of the facility's Policy and Procedure titled, Hand Hygiene, dated 9/1/20, indicated the following situations require appropriate hand hygiene such as before donning and after doffing PPE. A review of the facility's Policy and Procedure titled, Infection Control, dated 1/1/12, indicated for the facility to maintain a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 45523 Based on observation and interview, the facility failed to maintain equipment in the kitchen in safe operating condition when the kitchen burners did not ignite when Cook turned knob on 4/9/24. This failure had the potential to cause the staff to burn their hands while igniting burners, which could result to hospitalization and death. Findings: During the initial tour observation and interview with DSS (Dietary Staff Supervisor) and Cook on 4/9/24 at 8:58 AM, Cook turned one of the kitchen burners on with a piece of paper. Cook stated he usually turns the burner on that way because the flame is small and that way, he can get the flame to be bigger. During an interview with DSS on 4/9/24 at 9:01 AM, DSS stated, The cook uses the paper to ignite the burners, he should not ignite them with paper it's dangerous, there's an igniter we use for that, maybe he misplaced it. During concurrent interview with Cook on 4/9/24 at 9:03 AM, Cook stated, I've burned myself before when igniting the burners. I do have an igniter, a lighter, but sometimes the staff will borrow it when they smoke and don't return it so I just use the paper instead. During a concurrent interview with DSS on 4/9/24 at 9:05 AM, DSS stated, We will get a new igniter for the cook. Maintenance comes in once a month or as needed to repair, replace, or maintain equipment in the kitchen. DSS acknowledged the burners needed to be replaced and stated she would contact the maintenance supervisor immediately. During an interview with Maintenance Assistant on 4/10/24 at 11:06 AM, MA stated he was not made aware the kitchen burners did not ignite automatically During a review of the facility's Policy and Procedure titled, Equipment Operation, revised 11/1/14 indicated, To establish guidelines for safe equipment operation. During a review of the facility's Policy and Procedure titled, Maintenance Service, revised 1/01/12, indicated, To protect the health and safety of residents, visitors, and Facility Staff. I. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. III. The Director of Maintenance is responsible for developing and maintain a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. VIII. Maintenance Staff follow established safety regulations to ensure the safety and well-being of all concerned.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523 Based on observation, interview, and record review, the facility failed to ensure four (4) of 47 resident bedrooms measure at least 80 square feet (sq. ft.) per resident in multiple resident bedrooms. Rooms 24, 26, 28, and 44 measured less than 80 sq. ft. per resident. This deficient practice had the potential to cause the residents in these rooms not to have enough room for activities of daily living and hinder staff from providing care to the residents. Findings: During a general observation of the facility from 4/9/24 to 4/12/24 of Rooms 24, 26, 28, and 44, room [ROOM NUMBER] was occupied by two residents with one empty bed. room [ROOM NUMBER], 28 and 44 were occupied with three residents. The spaces were sufficient for the resident's use and staff had enough space to safely provide care to the residents. A concurrent interview with the Administrator and review of the Client Accommodation Analysis record on 4/11/24 at 12:01 PM, the Administrator stated the record indicated Rooms 24, 26, 28, and 44, did not meet the 80 square feet per resident requirements per federal regulation. The record indicated the following: Room # Room Size Number of beds 24 230.84 square feet 3 26 221.56 square feet 3 28 217.74 square feet 3 44 237.6 square feet 3 A review of the facility room waiver request, dated 4/9/24, indicated the facility's request for a room size waiver for 4 resident rooms. The request indicated that there is adequate space for nursing care and the health and safety of residents occupying these rooms are not in jeopardy. It also indicated that the facility's letter is the written request for re-authorization of waivers for the following 4 resident 3-bed rooms floor areas ranging from 215-235 square feet per room. The Department is recommending the room waiver for Rooms 24, 26,28, and 44, as requested by the facility.