

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 04/10/2025
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47362</p> <p>Based on observation, interview, and record review the facility failed to promote respect and dignity for one (1) of 1 sampled resident (Resident 56) by not providing privacy during brief change.</p> <p>This deficient practice had the potential for Resident 56 to experience loss of dignity, self-esteem, and affect resident's psychosocial well-being.</p> <p>Findings:</p> <p>During a review of Resident 56's Admission Record, the Admission Record indicated Resident 56 was initially admitted to the facility on [DATE] with diagnosis which included history of falling, adult failure to thrive (adults whose independence is declining), bed confinement status (unable to get up from bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair).</p> <p>During a review of Resident 56's Minimum Data Set (MDS, a resident assessment tool), dated 3/21/2025, the MDS indicated Resident 56 cognitive skills (processes of thinking and reasoning) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 56 was dependent (helper does all the effort) on toilet hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or heaving bowel movement), personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing and drying face and hands).</p> <p>During observation on 4/8/2025 at 6:39 AM at the hallway outside Resident 56's room, observed certified nursing assistant 3 (CNA 3) changing Resident 56's briefs (protective underwear to prevent leakage) with the privacy curtain and door open.</p> <p>During an interview on 4/8/2025 at 6:40 AM with CNA 3, CNA 3 stated the privacy curtain, and door should have been closed while changing Resident 56.</p> <p>During an interview on 4/9/2025 at 2:53 PM with the Director of Nursing (DON), the DON stated when changing residents, the staff should provide full privacy, close door and curtains completely. The DON also stated this can possibly make the resident feel embarrassed.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview 4/10/2025 at 2:37 PM with CNA 4, CNA 4 stated when changing residents, privacy should be provided by closing the privacy curtain and door. CNA 4 also stated privacy is important to promote self-esteem, dignity and for resident to feel more comfortable. Privacy was supposed to be provided for alert and not alert residents.</p> <p>During a review of the facility's Policy and Procedure titled, Residents Rights - Quality of Life, revised 3/2017, the policy indicated to ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. The P&P 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 wellbeing. The P&P also indicated facility staff promotes, maintains and protects resident privacy, including bodily privacy when assisting with personal care and during treatment procedures.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47362</p> <p>Based on interview and record review, the facility failed to develop and implement a comprehensive resident-centered care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs) for two (2) of 19 sampled residents (Resident 25 and Resident 245) as indicated on the facility's policy:</p> <ol style="list-style-type: none"> 1. Resident 25 did not have a comprehensive resident-centered care plan for the use of Eliquis (a drug to prevent and treat blood clots) 2.5 milligram (mg, a unit of measurement of mass in the metric system equal to a thousandth of a gram) for peripheral vascular disease (PVD, chronic disease that blocks blood flow). 2. Resident 245 did not have a comprehensive resident - centered care plan for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) functional abilities and bowel incontinence as assessed on the Minimum Data Set (MDS, a resident assessment tool) and admission nursing assessment. <p>This deficient practice had the potential to result in a delay of nursing care and medical interventions which could affect Residents 25 and 245's overall wellbeing.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a record review of Resident 25's Admission Record, the Admission Record indicated Resident 25 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues. It can cause tiredness, weakness and shortness of breath.), Muscle weakness, insomnia (difficulty either falling or staying asleep). <p>During a review of Resident 25's Physician's Order Summary Report, dated 11/27/2024, the Physician's order indicated Eliquis 2.5 mg, give 1 tablet by mouth two times a day for peripheral vascular disease (PVD, is a slow and progressive disorder of the blood vessels. Narrowing, blockage, or spasms in a blood vessel).</p> <p>During a review of Resident 25's MDS, dated [DATE], the MDS indicated Resident 25's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. The MDS indicated Resident 25 required partial/moderate assistance (helper does less than half the effort) with personal hygiene. Resident 25 required substantial/ maximal assistance (helper does more than half the effort) on toilet hygiene, shower bath self.</p> <p>During a review of Resident 25's Care Plans, the care plan did not reflect any care plan for the use of Eliquis 25 mg.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During concurrent interview and record review of Resident 25's care plan on 4/8/2025 at 4:10 PM with the Director of Nursing (DON), the DON stated of Resident 25 did not and should have a care plan initiated for Eliquis 25 mg for Resident 25.</p> <p>During an interview on 4/10/2025 at 2:52 PM with Infection Preventionist Nurse (IPN), IPN stated as soon as the order for Eliquis 25 mg was received, the care plan should have been developed so the staff will know how to take care of the resident, including what to observe.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 8/24/202, the P&P indicated the baseline care plan must reflect the residents' stated goals and objectives and include interventions that address his/ her needs. The P&P indicated comprehensive care plan within seven days from the completion of the comprehensive MDS assessment, the comprehensive care plan will be developed.</p> <p>48152</p> <p>2. During a review of Resident 245's Admission Record, the Admission Record indicated resident 245 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), gastro esophageal reflux disease (GERD - chronic digestive disease where the contents of the stomach refluxes and irritates the esophagus) and fusion of thoracic spine (a surgical procedure where two or more bones in the mid-back are joined together to eliminate movement between them).</p> <p>During a review of Resident 245's MDS, dated [DATE], the MDS indicated Resident 245 was moderately impaired with cognitive skills for daily decision making. The MDS also indicated Resident 245 was dependent (helper does all effort needed to complete activity) with toileting hygiene and dressing, required substantial/maximal assistance (helper does more than half the effort needed to complete the activity) with bathing, and required partial/ moderate assistance (helper does less than half the effort needed to complete the activity) with oral hygiene and supervision or touching assistance (helper provides verbal cues, touching/steadying and/or contact guard assistance during activity) with eating. The MDS also indicated Resident 245 was always incontinent of bowel (no continent episodes of bowel movements).</p> <p>During a review of Resident 245's History & Physical (H&P), dated 4/3/2025, the H&P indicated Resident 245 with a complaint of severe leg weakness and weakness in the low back.</p> <p>During a review of Resident 245's Baseline Care Plan, dated 3/30/2025, the care plan indicated Resident 245's functional abilities with self-care was supervision or touching assistance with eating and oral hygiene, dependent with bathing, toileting and lower body dressing and partial/moderate assistance with upper body dressing and personal hygiene. The care plan also indicated Resident 245 was frequently incontinent of bowel.</p> <p>During a review of Resident 245's Bowel and Bladder (B&B) Program Screener, dated 3/30/2025, the B&B Screener indicated Resident 245 was incontinent of stool daily and was immobile (not able to move or be moved) or required 2-person assistance in his ability to get to the bathroom/transfer to a toilet/commode/urinal, adjust clothing and wipe etc.</p> <p>(continued on next page)</p>		

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<p>F 0656</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 4/9/2025 at 2:16 PM with MDS Nurse 1 (MDSN 1), Resident 245's medical chart was reviewed. MDSN 1 stated Resident 245 did not have a care plan for self-care functional levels and bowel incontinence. MDSN 1 stated there should have been a care plan for Resident 245's bowel incontinence and ADL assistance to include interventions such as monitoring for any skin breakdown, repositioning and goals to give quality of life, dignity and prevent bed sores. MDSN also stated staff cannot provide the right care of the resident without a care plan.</p> <p>During a concurrent observation and interview on 4/7/2025 at 8:45 AM with Certified Nursing Assistant 5 (CNA 5), at Resident 245's bedside, CNA 5 was observed cleaning, changing the diaper and Resident 245's clothes after a bowel movement. Resident 245 was observed with no participation during his diaper change. CNA 5 stated he has worked with Resident 245 before and Resident 245 needed assistance with showers, putting on clothes, and B&B care.</p> <p>During an interview on 4/9/2025 at 1:26 PM with CNA 6, CNA 6 stated Resident 245 is not able to provide care to himself from his legs down and not able to help much and above the waist. CNA 6 stated Resident 245 is total assistance with incontinent care after bowel movements and diaper changes.</p> <p>During an interview of 4/9/2025 1:48 PM with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 245 is dependent on staff during hygiene care like brushing teeth, combing hair, and B&B care. LVN 2 stated, Resident (Resident 245) ambulates very little and needs a lot of assistance with transferring to /from his wheelchair. LVN 2 stated care plans are needed for residents to address any issues.</p> <p>During an interview on 4/10/2025 at 11:21AM with the Director of Nursing (DON), the DON stated there should be a care plan for Resident 245's bowel incontinence and ADL function based on an assessment to develop interventions and monitor if the interventions are effective or need revisions. DON stated if care plans are not initiated, staff would not know the plan [of care] or interventions in place to provide the resident with appropriate care.</p> <p>During a review of the facility's Policy & Procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 8/24/2023, the P&P indicated the comprehensive care plan will be developed within seven (7) days from completion of the MDS assessment, all goals and interventions from the current baseline care plan will be included in the resident's care plan and additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152</p> <p>Based interview and record review, the facility failed to ensure the dental care plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs) was reviewed and revised for one (1) of 19 residents (Resident 28) after the completion of the Minimum Data Set (MDS - a resident assessment tool) on 2/19/2025 and based on the assessed needs of the resident as indicated in the facility's policy.</p> <p>This failure had the potential for Resident 28 to receive inappropriate care and/or inadequate services, negatively affecting Resident 28's well-being.</p> <p>Findings:</p> <p>During a review of Resident 28's Admission Record, the Admission Record indicated Resident 28 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (inability to move one side of the body), dysphagia (difficulty swallowing foods or liquids) following cerebral infarction (also known as a stroke; refers to damage to the tissues in the brain due to a loss of oxygen to the area), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>During a review of Resident 28's MDS, dated [DATE], the MDS indicated Resident 28 with moderately impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 28 was dependent (helper does all effort needed to complete activity) with oral hygiene, toileting hygiene, personal hygiene, dressing and bathing. The MDS also indicated Resident 28 had no natural teeth or tooth fragment(s).</p> <p>During a review of Resident 28's Oral/Dental Health Problems care plan, dated 9/27/2024, the care plan indicated Resident 28 had a broken upper denture ridge with a staff intervention for Resident 28 to refrain from using the upper denture until fixed.</p> <p>During a review of Resident 28's Dental Progress Notes, dated 10/24/2024, the Progress Notes indicated a full upper denture was repaired and delivered to Resident 28.</p> <p>During a review of Resident 28's Long Term Care Evaluation, dated 3/31/2025, the Long-Term Care Evaluation indicated Resident 28 has upper and lower dental appliances.</p> <p>During an interview on 4/10/2025 at 10:16 AM with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated she was assigned to Resident 28 on 4/10/2025. CNA2 stated Resident 28 wears upper and lower dentures every day. CNA 2 stated Resident 28 stated she cleaned and put a top and bottom denture in the resident's mouth that morning (4/10/2025).</p> <p>During an interview on 4/10/2025 at 10:21 AM with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated she has provided care to Resident 28 and he wears both top and bottom dentures.</p> <p>(continued on next page)</p>		

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<p>F 0657</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 4/10/2025 at 11:30 AM with the Director of Nursing (DON), Resident 28's medical chart was reviewed. The DON stated Resident 28's medical chart did not indicate a revised care plan which reflected the fixed upper denture. The DON stated the care plan should have been revised once Resident 28's dentures were fixed to update current interventions to reflect the resident's current condition.</p> <p>During a review of the facility's Policy & Procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 8/24/2023, the P&P indicated the comprehensive care plan will be periodically reviewed and revised by IDT after each assessment (including MDS assessments) as required, at the onset of new problems, change of condition, to address changes in behavior and care and other times as appropriate or necessary. The P&P also indicated additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152</p> <p>Based on observation, interview and record review, the facility failed to apply Geri sleeves (protective sleeves that prevent tearing, bruising, and abrasions of the skin) for one (1) of two (2) sampled residents (Resident 4) as indicated on the physician's order.</p> <p>This failure had the potential for Resident 4 to acquire additional skin tears (traumatic wounds caused by friction when the upper layer of the skin becomes torn from the underlying layers) to the arms and a lack of services to attain or maintain his highest practicable physical well-being.</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record, the Admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure (a sudden condition in which not enough oxygen passes from the lungs into the blood), muscle weakness, and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 3/10/2025, the MDS indicated Resident 4 with moderately impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 4 with partial/moderate assistance (helper does less than half the effort needed to complete the activity) with oral, toileting and personal hygiene, dressing and bathing and supervision or touching assistance (helper provides verbal cues, touching/steadying and/or contact guard assistance during activity) with eating.</p> <p>During a review of Resident 4's Change in Condition Evaluation, dated 3/15/2025, the Evaluation indicated Resident 4 was observed scratching both forearms causing skin tears to both forearms with scant (very little) bleeding noted.</p> <p>During a review of Resident 4's Physician Order, dated 3/17/2025, the order indicated, Application of bilateral upper extremity Geri sleeves at all times, may remove during hygiene care for skin maintenance, wound management and skin breakdown everyday shift.</p> <p>During a review of Resident 4's Skin Tear Right Forearm care plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs), created 3/15/2025, the care plan indicated if skin tear occurs, treat per facility protocol, identify potential causative factors and eliminate/resolve when possible and inform/instruct staff of causative factors and measures to prevent skin tears.</p> <p>During a concurrent observation and interview on 4/9/2025 at 3:50 PM with Licensed Vocational Nurse 2 (LVN 2) at Resident 4's bedside, Resident 4 was observed lying in bed without Geri sleeves on to the resident's left or right forearms. LVN 2 was observed checking Resident 4's bedside and closet for either Resident 4's Geri sleeves. LVN 2 stated Resident 4 does not have on his Geri sleeves on, and she was unable to find them in the resident's room. LVN 2 stated Resident 4 scratches himself and wears the Geri sleeves to both arms to prevent skin tears. LVN 2 stated, per the physician's order, Resident 4 should have been wearing the Geri sleeves.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/9/2025 at 3:56 PM with the Director of Nursing (DON), the DON stated Resident 4 has an order to wear Geri sleeves at all times and the order should be followed. The DON stated Resident 4 has skin tears to his left and right forearm, has fragile skin, and he tends to scratch. The DON also stated if Resident 4 refused to wear the gerisleeves, staff should explain the risks and benefits to the resident three (3) times, notify the family, physician, and create a care plan for the refusal.</p> <p>During a review of the facility's Policy & Procedure (P&P) titled, Medication - Administration, revised 1/1/2012, the P&P indicated medications and treatments will be administered as prescribed.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636</p> <p>Based on observation, interview, and record review, the facility failed to provide two (2) of three (3) sampled residents (Residents 37 and 43) on dialysis (a lifesaving treatment for residents with kidney failure) treatment, a safe and appropriate care in accordance with the facility's policy by failing to ensure:</p> <p>1a. Resident 37's fluid intake was restricted to 1200 milliliters (ml, unit of volume) per day as indicated on the physician's orders and care plan.</p> <p>1b. A current Interdisciplinary Team (IDT, group of healthcare professionals from diverse fields who work in a coordinated manner toward a common goal for the resident) meeting was conducted for Resident 37's fluid restriction noncompliance.</p> <p>2. Resident 43's fluid intake was restricted to 1000 ml per day as indicated on the physician's order and care plan.</p> <p>This deficient practice had the potential to result in overloading (harmful amount of fluid in the body) Resident's 37 and 43 with fluid which could cause complications such as swelling, high blood pressure, shortness of breath, and pulmonary edema (an accumulation of fluid in the lungs).</p> <p>Findings:</p> <p>1. During a record review of Resident 37's Admission Record, the Admission Record indicated Resident 37 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses including but not limited to end stage renal disease (ESRD, advanced stage kidney failure), dependence on renal dialysis, type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel) with diabetic chronic kidney disease (a serious complication of diabetes where the kidneys are damaged due to persistently high blood sugar levels), and hypertensive chronic kidney disease (high blood pressure caused by damage to the kidneys).</p> <p>During a record review of Resident 37's Minimum Data Set (MDS, a resident assessment and tool), dated 2/20/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated Resident 37 required substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, shower/bathing self, chair/bed-to-chair transferring, toilet transferring and walking ten feet. The MDS also indicated Resident 37 received hemodialysis.</p> <p>During a record review of Resident 37's Physician Order Summary, dated 2/13/2025, the order indicated for Fluid Restriction = 1200 ml/day; Dietary: 600 ml; Nursing: 11-7: 100 ml; 7-3: 300 ml; 3-11: 200 ml every shift for ESRD (No water pitcher at bedside).</p> <p>During a record review of Resident 37's Intake and Output and Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment) for the month of March 2025, the record indicated Resident 37 received over 1200 ml on the following days:</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 3/3/2025 (1500 ml), 3/4/2025 (1280 ml), 3/5/2025 (1380 ml), 3/6/2025 (1280 ml), 3/7/2025 (1500 ml), 3/9/2025 (1380 ml), 3/10/2025 (1390 ml), 3/11/2025 (1280 ml), 3/12/2025 (1220 ml), 3/13/2025 (1280 ml), 3/14/2025 (1800 ml), 3/16/2025 (1400 ml), 3/17/2025 (1280 ml), 3/18/2025 (1280 ml), 3/21/2025 (1600 ml), 3/22/2025 (1280 ml), 3/23/2025 (1480 ml), 3/25/2025 (1400 ml), 3/26/2025 (1440 ml), 3/28/2025 (1500 ml), 3/29/2025 (1320 ml), 3/30/2025 (1240 ml), and 3/31/2025 (1480 ml) (23 out of 31 days).</p> <p>During a record review of Resident 37's Intake and Output and MAR for the month of April 2025, the record indicated Resident 37 received over 1200 ml on the following days:</p> <p>- 4/2/2025 (1390 ml), 4/3/2025 (1280 ml), 4/4/2025 (1320 ml), 4/5/2025 (1500 ml), 4/7/2025 (1480 ml), and 4/8/2025 (1280 ml) (6 out of 9 days).</p> <p>During a record review of Resident 37's care plan, revised 3/9/2024, the care plan indicated Resident 37 had renal insufficiency related to end stage renal disease. Fluid Resident of 1200 ml/day. The staff interventions were to encourage resident to comply with fluid restriction, discuss risk of noncompliance including fluid overload, and to notify the physician.</p> <p>During a record review of Resident 37's care plan, revised 1/24/2025, the care plan indicated Resident 37 had a potential fluid deficit related to fluid restriction for diagnosis of ESRD, noncompliant with fluid restriction, getting water by herself from water dispenser despite multiple reminders to comply with fluid restriction, and family brought resident's own pitcher. The staff interventions were to ensure fluid restriction of 1200 ml/day and to monitor vital signs as ordered/per protocol and record.</p> <p>During an observation on 4/7/2025 at 12:04 PM in Resident 37's room, Resident 37 was sitting in her wheelchair with a personal cup on top of her bedside table.</p> <p>During a concurrent interview and record review on 4/9/2025 at 2:19 PM with Registered Nurse Supervisor 1 (RNS 1) of Resident 37's Intake and Output and MAR for March 2025 and April 2025, RNS 1 stated Resident 37 received a fluid intake which exceeded the physician's order of fluid restriction of 1200 ml/day for multiple days for the month of March 2025 and April 2025. RNS 1 stated when Resident 37 received too much fluids there could be an overflow of fluids in the body. RNS 1 stated complications that could result from fluid overload were congestion, shortness of breath, and a decrease in oxygen saturation (a decrease in the amount of oxygen in the blood).</p> <p>During a concurrent interview and record review on 4/9/2025 at 4 PM with RNS 1 of Resident 37's care plan, RNS 1 stated Resident 37 was noncompliant with the physician's order for fluid restriction. RNS 1 stated one of the care plan interventions was to notify the physician of Resident 37's noncompliance for fluid restriction.</p> <p>During a concurrent interview and record review on 4/9/2025 at 4:10 PM with RNS 1 of Resident 37's nursing progress notes and change of condition (COC, tool used by health care professionals when communicating about critical changes in a resident's status), RNS 1 stated the physician was not notified of Resident 37's noncompliance in March 2025 and April 2025 as indicated in the care plan.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent follow up interview and record review on 4/9/2025 at 4:35 PM with RNS 1 of Resident 37's IDT notes, RNS 1 stated the last IDT meeting for Resident 37's noncompliance was discussed with the physician on 7/3/2024. RNS 1 stated there was no current physician notification of Resident 37's noncompliance.</p> <p>During an interview on 4/10/2025 at 11:45 AM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 37 is able to verbalize her needs. CNA 1 stated Resident 37 drank what the kitchen had placed onto her food trays. CNA 1 stated she was aware Resident 37 had a fluid restriction. CNA 1 stated CNA 1 would sometimes get extra water for Resident 37 to drink when Resident 37 would request for it.</p> <p>During an interview on 4/10/2025 at 12:01 PM with Resident 37, Resident 37 stated the nursing staff gave her water every 2 to 3 hours. Resident 37 stated she was not able to get out of bed to get the water by herself from the dining room. Resident 37 stated most of the time, she would have to ask the staff for water, and staff would bring the water for her. Resident 37 stated the nursing staff did not talk to her about her fluid restriction when they brought in water for her. Resident 37 stated she was aware she had a fluid restriction but was not informed by the staff when they brought in water requested by her.</p> <p>During a concurrent review of Resident 37's last IDT meeting, dated 2/6/2025 and interview on 4/10/2025 at 2:12 PM with the Director of Nursing (DON), the DON stated Resident 37's noncompliance to fluid restriction was not and should have been discussed. The DON stated Resident 37's noncompliance should have been addressed during the IDT meeting so the family and the whole team could be aware of Resident 37's fluid restriction noncompliance. During a concurrent review of the policy and procedure (P&P) with the DON, the DON stated if the resident continued to be noncompliant, the IDT would meet with the resident and his/her family to discuss risks and benefits.</p> <p>2. During a record review of Resident 43's Admission Record, the Admission Record indicated Resident 43 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses including but not limited to metabolic encephalopathy (abnormalities of water, electrolytes, vitamins, and other chemicals that adversely affect the brain function), ERSR, dependence on renal dialysis, and type 2 diabetes mellitus with diabetic chronic kidney disease.</p> <p>During a record review of Resident 43's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was intact. The MDS indicated Resident 43 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for personal hygiene, rolling left and right, sit to lying, sit to standing, and toilet transferring. The MDS also indicated Resident 43 was on dialysis.</p> <p>During a record review of Resident 43's physician ordered, dated 1/20/2025, the order indicated for fluid restriction: 1000 ml/day = Dietary: 360 ml + Nursing: 640 ml (11-7:100 ml; 7-3: 340 ml; 3-11: 200 ml) (no water pitcher at bedside) every shift for ESRD on hemodialysis monitor fluid intake (ml) provided by nursing per shift.</p> <p>During a record review of Resident 43's care plan, revised 1/20/2025, the care plan indicated Resident 43 had a potential nutritional problem related to fluid restriction. The staff interventions were to ensure fluid restriction of 1000 ml/day with 360 ml provided from dietary and 640 ml provided from nursing, provide diet as ordered, and to monitor intake and record every meal.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a record review of Resident 43's Intake and Output and MAR for the month of March 2025, the record indicated Resident 43 received over 1000 ml on the following days:</p> <p>- 3/1/2025 (1440 ml), 3/2/2025 (1120 ml), 3/4/2025 (1740 ml), 3/5/2025 (1200 ml), 3/6/2025 (1200 ml), 3/7/2025 (1200 ml), 3/8/2025 (1200 ml), 3/9/2025 (1500 ml), 3/10/2025 (1640 ml), 3/11/2025 (1740 ml), 3/12/2025 (1140 ml), 3/14/2025 (1320 ml), 3/15/2025 (1740 ml), 3/16/2025 (1640 ml), 3/17/2025 (1640 ml), 3/18/2025 (1540 ml), 3/19/2025 (1180 ml), 3/20/2025 (1120 ml), 3/21/2025 (1640 ml), 3/22/2025 (1110 ml), 3/24/2025 (1120 ml), 3/25/2025 (1190 ml), 3/26/2025 (1040 ml), 3/27/2025 (1590 ml), 3/28/2025 (1440 ml), 3/29/2025 (1560 ml), 3/30/2025 (1480 ml), and 3/31/2025 (1740 ml) (28 out of 31 days).</p> <p>During a record review of Resident 43's Intake and Output and MAR for the month of April 2025, the record indicated Resident 43 received over 1000 ml on the following days:</p> <p>- 4/1/2025 (1120 ml), 4/2/2025 (1360 ml), 4/3/2025 (1740 ml), 4/4/2025 (1180 ml), 4/5/2025 (1640 ml), 4/7/2025 (1040 ml), 4/8/2025 (1540 ml), and 4/9/2025 (1440 ml) (eight out of nine days).</p> <p>-</p> <p>During an observation on 4/7/2025 at 12:43 PM in Resident 43's room, Resident 43 was lying down in bed with bedside table with the food tray to the right side of the bed.</p> <p>During a concurrent interview and record review on 4/9/2025 at 2:52 PM with RNS 1 of Resident 43's Intake and Output and MAR for March 2025 and April 2025, RNS 1 stated Resident 43 received a fluid intake which exceeded the physician's order of fluid restriction of 1000 ml/day for multiple days for the month of March 2025 and April 2025. RNS 1 stated when Resident 43 received too much fluids, there could be an overflow of fluids in the body. RNS 1 stated complications that could result from fluid overload were congestion, shortness of breath, and a decrease in oxygen saturation.</p> <p>During an interview and record review on 4/9/2025 at 2:59 PM with RNS 1 of Resident 43's care plan, RNS 1 stated nursing staff did not and should have ensured Resident 43's fluid restriction of 1000 ml/day with 360 ml being provided from dietary and 640 ml being provided from nursing as indicated on the care plan.</p> <p>During an interview on 4/10/2025 at 11:02 AM with the Director of Nursing (DON), the DON stated when dialysis residents are placed on fluid restrictions it is to avoid fluid overload. The DON stated dialysis residents are not able to excrete excess fluids, therefore the residents received dialysis treatment to excrete the toxins from their body. The DON stated fluid overload complications could result in shortness of breath, cough, congestion and a presence of edema (swelling caused by too much fluid trapped in the body's tissues). The DON stated with fluid overload, residents could experience a change of condition and respiratory distress.</p> <p>During a record review of the facility's Policy and Procedure (P&P) titled, Dialysis Care, revised 1/1/2012, the policy indicated as follows:</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- If the resident does not comply with his or her care plan, the facility will document this noncompliance with following care plan and make the necessary adjustments, including providing additional education to the resident. If the resident continues to be noncompliant, the IDT will meet with the resident and his/her family to discuss risks and benefits.</p> <p>- For residents who are alert, able to understand instructions, able to verbalize needs and ambulatory, but are noncompliant to his/her fluid restriction, the following protocol applies:</p> <p>i. The Nursing Staff will advise the resident of the risk and benefits of adherence to the physician's order regarding fluid restriction.</p> <p>ii. The Nursing Staff will notify the attending physician about resident's noncompliance to the fluid restriction.</p> <p>- Fluid Restrictions:</p> <p>i. Dialysis residents are given fluid based on the fluid restriction as ordered by the physician.</p> <p>ii. The Nursing and Dietary Staff will carefully organize the division and distribution of fluid.</p> <p>During a record review of the facility's P&P titled, Intake and Output, revised 2/27/2025, the policy indicated the facility will record intake and output as ordered by the physician and per regulations.</p> <p>During a record review of the facility's P&P titled, Dialysis Management, revised 1/25/2024, the policy indicated diet and fluid restrictions will be followed as ordered.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152</p> <p>Based on observation, interview and record review, the facility failed to administer medications as indicated on facility policy for three (3) of four (4) sampled residents (Resident 245, 4 and 11), by failing to administer:</p> <ol style="list-style-type: none"> 1. Resident 245's cyclobenzaprine (a muscle relaxer that treats muscle spasms) between 7 AM and 9 AM. 2. Resident 4's bethanechol (medication that stimulates the bladder to urinate), metoprolol (medication that lowers blood pressure), verquvo (medication that reduces risks of death or hospitalization with heart failure), eliquis (medication that reduces blood clotting), entresto (medication that reduces stress on the heart and strengthens the heart's pumping action) between 8 AM and 10 AM. 3. Resident 11's amlodipine (medication to lower blood pressure) and clopidogrel (medication that prevents blood platelets from sticking together) between 8 AM and 10 AM. <p>This deficient practice had the potential to result in adverse reactions (an undesired harmful effect resulting from a medication or other intervention) to Residents 245, 4, and 11.</p> <p>Findings:</p> <p>1. During a review of Resident 245's Admission Record, the Admission Record indicated resident 245 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), gastro esophageal reflux disease (GERD - chronic digestive disease where the contents of the stomach refluxes and irritates the esophagus) and fusion of thoracic spine (a surgical procedure where two or more bones in the mid-back are joined together to eliminate movement between them).</p> <p>During a review of Resident 245's Minimum Data Set (MDS- a resident assessment tool), dated 4/5/2025, the MDS indicated Resident 245 with moderately impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 245 was dependent (helper does all effort needed to complete activity) with toileting hygiene and dressing, partial/moderate assistance (helper does less than half the effort needed to complete the activity) with oral hygiene and required supervision or touching assistance (helper provides verbal cues, touching/steadying and/or contact guard assistance during activity) with eating.</p> <p>During a review of Resident 245's Order Summary Report, the Report indicated an order for cyclobenzaprine HCl oral tablet 10 milligrams (mg- a unit of mass or weight equal to one thousandth of a gram), give 10 mg by mouth 3 times a day for muscle spasm.</p> <p>During an observation on 4/9/2025 at 9:25 AM with Licensed Vocational Nurse 2 (LVN 2) at Resident 245's bedside, LVN 2 was observed administering Cyclobenzaprine 10mg to Resident 245.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 245's Medication Admin Audit Report, dated 4/9/2025, the Report indicated scheduled time of 8 AM for cyclobenzaprine 10 mg and documented administration time of 9:28 AM.</p> <p>2. During a review of Resident 4's Admission Record, the Admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included obstructive and reflux uropathy (a blockage and backwards flow of urine), hypertensive heart disease (heart problems caused by consistently high blood pressure), and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 with moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 4 required partial/moderate assistance with oral, toileting and personal hygiene, dressing and bathing and supervision or touching assistance with eating.</p> <p>During a review of Resident 4's Order Summary Report, the Report indicated the following orders:</p> <p>a. Bethanechol chloride 25 mg, give 25 mg by mouth 4 times a day for urine retention (inability to completely empty the bladder).</p> <p>b. Metoprolol tartrate 25 mg, give 25mg by mouth two (2) times a day for hypertension (HTN - high blood pressure), hold if SBP less than 110 or pulse less than 60.</p> <p>c. Verquvo 2.5 mg, give one (1) tablet by mouth 2 times a day for heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs).</p> <p>d. Eliquis 2.5 mg, give 2.5 mg by mouth 2 times a day for atrial fibrillation (AFib - irregular, often rapid heart rate that can cause poor blood flow, leading to blood clots, stroke, or heart failure).</p> <p>e. Entresto 24-26 mg, give 1 tablet by mouth in the morning for congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) hold if systolic blood pressure (SBP - maximum pressure in the arteries during one heartbeat) less than 110.</p> <p>During an observation on 4/9/2025 at 10:21 AM with LVN 2 at Resident 4's bedside, LVN 2 was observed administering bethanechol 25 mg, metoprolol 25 mg, verquvo 2.5 mg, eliquis 2.5 mg and entresto 24-26 mg to Resident 4.</p> <p>During a review of Resident 4's Medication Admin Audit Report, dated 4/9/2025, the Report indicated scheduled times of 8 AM for verquvo 2.5mg, bethanechol 25 mg, metoprolol 25 mg and 9 AM for eliquis 2.5 mg and entresto 24-26 mg, with documented administration times of 10:26 AM for all medications.</p> <p>3. During a review of Resident 11's Admission Record, the Admission Record indicated Resident 11 was admitted to the facility on [DATE] with diagnoses included chronic kidney disease (CKD - longstanding disease of the kidneys leading to renal failure) stage 3, atherosclerotic heart disease (blockage of blood supply to the heart muscle due to buildup of plaque in the arteries) and essential hypertension (abnormal high blood pressure that is not the result of a medical condition).</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11 with moderately impaired cognitive patterns for daily decision making. The MDS indicated Resident 11 required partial/moderate assistance with eating, oral hygiene and substantial/maximal assistance with toileting, personal hygiene and bathing.</p> <p>During a review of Resident 11's Order Summary Report, the Report indicated an order for amlodipine besylate oral tablet 10 mg, give 10 mg by mouth one time a day for hypertension, hold if SBP less than 110 and an order for clopidogrel bisulfate oral tablet 75mg, give 75mg by mouth in the morning for coronary artery disease (CAD - a narrowing or blockage of your coronary arteries).</p> <p>During an observation on 4/9/2025 at 10:43 AM at Resident 11's bedside, LVN 2 observed administering amlodipine 10 mg and Clopidogrel 75 mg to Resident 11.</p> <p>During a review of Resident 11's Medication Admin Audit Report, dated 4/9/2025, the Report indicated scheduled times of 9 AM for amlodipine 10 mg and 9 AM for clopidogrel 75 mg and documented administration time of 10:52 AM for both for amlodipine 10 mg and clopidogrel 75 mg.</p> <p>During an interview on 4/9/2025 at 7:57 AM with LVN 2, LVN 2 stated the facility process for medication administration is to watch and follow the six (6) rights of medication: right resident, right dose, right time, right medication, right route and right of refusal.</p> <p>During an interview on 4/10/2025 at 3:11 PM with LVN 2, LVN 2 stated the time frame for medication administration is between 1 hour before and 1 hour after the scheduled time. LVN 2 stated it is important to make sure meds are given on time so that residents are not receiving double doses of the medications.</p> <p>During an interview on 4/10/2025 at 3:27 PM with the Director of Nursing (DON), the DON stated per facility policy, the medication administration window is 1 hour before and 1 hour after [scheduled time] and the medication administration times need to be followed for consistency and accurate monitoring of the medication's effect to the resident.</p> <p>During a review of the facility Policy & Procedure (P&P) titled, Medication- Administration, revised 1/1/2012, the P&P indicated medications will be administered as prescribed, medications may be administered one hour before or after the scheduled medication administration time, and nursing staff will keep in mind the seven rights of medication when administering medication: right medication, right amount, right resident, right time, right route, right to know what the medication does and right to refuse the medication.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152</p> <p>Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five (5) percent (%). Eight (8) medication errors (the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order/ manufacturer's specifications/accepted professional standards and principles) out of 26 opportunities (observed administered medications) for error, which yielded a facility medication error rate of 30.77% for three (3) of four (4) sampled residents (Residents 245, 4 and 11) observed during medication administration (med pass). The medication errors were as follows:</p> <ol style="list-style-type: none"> 1. Resident 245's cyclobenzaprine (a muscle relaxer that treats muscle spasms) was not administered between 7 AM and 9 AM. 2. Resident 4's bethanechol (medication that stimulates the bladder to urinate), metoprolol (medication that lowers blood pressure), verquvo (medication that reduces risks of death or hospitalization with heart failure), eliquis (medication that reduces blood clotting), entresto (medication that reduces stress on the heart and strengthens the heart's pumping action) were not administered between 8 AM and 10 AM. 3. Resident 11's amlodipine (medication to lower blood pressure) and clopidogrel (medication that prevents blood platelets from sticking together) were not administered between 8 AM and 10 AM. <p>These failures have the potential to result in adverse reactions (an undesired harmful effect resulting from a medication or other intervention) to Residents 245, 4 and 11.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 245's Admission Record, the Admission Record indicated Resident 245 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), gastro esophageal reflux disease (GERD - chronic digestive disease where the contents of the stomach refluxes and irritates the esophagus) and fusion of thoracic spine (a surgical procedure where two or more bones in the mid-back are joined together to eliminate movement between them). <p>During a review of Resident 245's Minimum Data Set (MDS - a resident assessment tool), dated 4/5/2025, the MDS indicated Resident 245 with moderately impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 245 was dependent (helper does all effort needed to complete activity) with toileting hygiene and dressing, partial/moderate assistance (helper does less than half the effort needed to complete the activity) with oral hygiene and required supervision or touching assistance (helper provides verbal cues, touching/steadying and/or contact guard assistance during activity) with eating.</p> <p>During a review of Resident 245's Order Summary Report, the Report indicated an order for cyclobenzaprine HCl oral tablet 10 milligrams (mg - a unit of mass or weight equal to one thousandth of a gram), give 10 mg by mouth 3 times a day for muscle spasm.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 4/9/2025 at 9:25 AM with Licensed Vocational Nurse 2 (LVN 2) at Resident 245's bedside, LVN 2 was observed administering cyclobenzaprine 10mg to Resident 245.</p> <p>During a review of Resident 245's Medication Admin Audit Report, dated 4/9/2025, the Report indicated scheduled time of 8 AM for cyclobenzaprine 10 mg and documented administration time of 9:28 AM.</p> <p>2. During a review of Resident 4's Admission Record, the Admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included obstructive and reflux uropathy (a blockage and backwards flow of urine), hypertensive heart disease (heart problems caused by consistently high blood pressure), and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 with moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 4 required partial/moderate assistance with oral, toileting and personal hygiene, dressing and bathing and supervision or touching assistance with eating.</p> <p>During a review of Resident 4's Order Summary Report, the Report indicated the following orders:</p> <ul style="list-style-type: none"> a. Bethanechol chloride 25 mg, give 25 mg by mouth 4 times a day for urine retention (inability to completely empty the bladder). b. Metoprolol tartrate 25 mg, give 25 mg by mouth two (2) times a day for hypertension (HTN - high blood pressure), hold if SBP less than 110 or pulse less than 60. c. Verquvo 2.5 mg, give one (1) tablet by mouth 2 times a day for heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs). d. Eliquis 2.5 mg, give 2.5 mg by mouth 2 times a day for atrial fibrillation (AFib - irregular, often rapid heart rate that can cause poor blood flow, leading to blood clots, stroke, or heart failure). e. Entresto 24-26 mg, give 1 tablet by mouth in the morning for congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) hold if systolic blood pressure (SBP-maximum pressure in the arteries during one heartbeat) less than 110. <p>During an observation on 4/9/2025 at 10:21 AM with LVN 2 at Resident 4's bedside, LVN 2 was observed administering bethanechol 25 mg, metoprolol 25 mg, verquvo 2.5 mg, eliquis 2.5 mg and entresto 24-26 mg to Resident 4.</p> <p>During a review of Resident 4's Medication Admin Audit Report, dated 4/9/2025, the Report indicated scheduled times of 8 AM for verquvo 2.5 mg, bethanechol 25 mg, metoprolol 25 mg and 9 AM for eliquis 2.5 mg and entresto 24-26 mg, with documented administration times of 10:26 AM for all medications.</p> <p>(continued on next page)</p>		

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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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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. During a review of Resident 11's Admission Record, the Admission Record indicated Resident 11 was admitted to the facility on [DATE] with diagnoses included chronic kidney disease (CKD - longstanding disease of the kidneys leading to renal failure) stage 3, atherosclerotic heart disease (blockage of blood supply to the heart muscle due to buildup of plaque in the arteries) and essential hypertension (abnormal high blood pressure that is not the result of a medical condition).</p> <p>During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11 with moderately impaired cognitive patterns for daily decision making. The MDS indicated Resident 11 required partial/moderate assistance with eating, oral hygiene and substantial/maximal assistance with toileting, personal hygiene and bathing.</p> <p>During a review of Resident 11's Order Summary Report, the Report indicated an order for amlodipine besylate oral tablet 10 mg, give 10mg by mouth one time a day for hypertension, hold if SBP less than 110 and an order for clopidogrel bisulfate oral tablet 75 mg, give 75 mg by mouth in the morning for coronary artery disease (CAD- a narrowing or blockage of your coronary arteries).</p> <p>During an observation on 4/9/2025 at 10:43 AM at Resident 11's bedside, LVN 2 observed administering amlodipine 10 mg and Clopidogrel 75 mg to Resident 11.</p> <p>During a review of Resident 11's Medication Admin Audit Report, dated 4/9/2025, the Report indicated scheduled times of 9 AM for amlodipine 10 mg and 9 AM for clopidogrel 75 mg and documented administration time of 10:52 AM for both for amlodipine 10 mg and clopidogrel 75 mg.</p> <p>During an interview on 4/9/2025 at 7:57 AM with LVN 2, LVN 2 stated the facility process for medication administration is to watch and follow the six (6) rights of medication: right resident, right dose, right time, right medication, right route and right of refusal.</p> <p>During an interview on 4/10/2025 at 3:11 PM with LVN 2, LVN 2 stated the time frame for medication administration is between 1 hour before and 1 hour after the scheduled time. LVN 2 stated it is important to make sure meds are given on time so that residents are not receiving double doses of the medications.</p> <p>During an interview on 4/10/2025 at 3:27 PM with the Director of Nursing (DON), the DON stated per facility policy, the medication administration window is 1 hour before and 1 hour after [scheduled time] and the medication administration times need to be followed for consistency and accurate monitoring of the medication's effect to the resident.</p> <p>During a review of the facility Policy & Procedure (P&P) titled Medication- Administration, revised 1/1/2012, the P&P indicated medications will be administered as prescribed, medications may be administered one hour before or after the scheduled medication administration time, and nursing staff will keep in mind the seven rights of medication when administering medication: right medication, right amount, right resident, right time, right route, right to know what the medication does and right to refuse the medication.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>47362</p> <p>Based on observation, interview, and record review, the facility failed to ensure three (3) of 3 dumpsters (a movable waste container designed to be brought and taken away) were closed and not overflowing, in accordance with the facility's Policy and Procedure (P&P) titled, Waste Management.</p> <p>This deficient practice had a potential to attract vermin (animals that are believed to be harmful, carry diseases such as rodents, parasitic worms, or insects), pests (any living thing that has a negative effect on humans), and wildlife (undomesticated animal species) and may cause disease and other health issues to residents, staff, and the community.</p> <p>Findings:</p> <p>During an observation on 4/7/2025 at 7:34 AM at the west side of the facility building, 3 dumpsters located outside the facility building, near the facility entrance and parking area were observed overflowing with empty boxes and clear plastic bag containing kitchen trash.</p> <p>During a concurrent observation of the 3 dumpsters outside the facility and interview on 4/7/2025 at 7:54 AM with the Dietary Service Supervisor (DSS), the DSS stated dumpsters were overflowing with empty boxes and kitchen trash.</p> <p>During an interview on 4/9/2025 at 1:24 PM with DSS, the DSS stated all kitchen trash was thrown in the dumpsters outside. DSS stated the dumpsters were not supposed to be overflowing and it should be closed properly because it could attract rodents, flies and insects and could cause sickness like vomiting, diarrhea, and/ or stomach flu.</p> <p>During an interview on 4/9/2025 at 1:46 PM with the Director of Nursing (DON), the DON stated trashcans are supposed to be fully closed and not overflowing for the safety of the staff and residents to reduced cross contamination.</p> <p>During a record review of the facility's P&P titled, Waste Management, revised 4/21/2022, the P&P indicated to reduces risk of contamination from regulated waste (waste contaminated with blood, body fluids, or other potentially infectious materials, requiring specific handling and disposal due to the potential risk of infection) and maintain appropriate handling and disposable of all waste. The P&P under the procedure indicated food waste will be placed in covered garbage and trash cans</p>		

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678</p> <p>Based on interview and record review, the facility failed to accurately document the site of blood pressure measurement for one of 19 sampled residents (Resident 20), for consistent monitoring and clinical interpretation.</p> <p>This deficient practice had the potential to affect the accuracy of clinical assessments and medical management of Resident 20.</p> <p>Findings:</p> <p>During a review of Resident 20's Admission Record, the Admission Record indicated Resident 20 was admitted on [DATE] with diagnosis of End Stage Renal Disease (ESRD- Condition in which the kidneys cease functioning on a permanent basis leading to the need for regular course of long-term dialysis or kidney transplant to maintain life) and required hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).</p> <p>During a review of Resident 20's Order Summary, dated 3/9/2025, indicated no Blood Pressure checks, no blood draw on left arm as appropriate, dialysis (hemodialysis) access site: Left Arm.</p> <p>During a review of Resident 20's Minimum Data Set (MDS - a resident assessment tool), dated 3/20/2025, the MDS indicated Resident 20 had moderate cognitive (ability to think, reason, and make decisions) impairment for skills for daily decision making. The MDS indicated Resident 20 required set up or clean up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) to eat, partial assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) for oral hygiene, upper body dressing, personal hygiene, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed transfer. The MDS indicated Resident 20 maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) for toileting, showering, lower body dressing, and putting on/taking off footwear.</p> <p>During a review of Resident 20's Weights and Vitals Summary, indicated the licensed vocational nurse 1 (LVN 1) documented blood pressure checks for Resident 20, were performed on the left arm on 2/5/2025, 2/15/2025, 2/19/2025, 2/20/2025, 3/15/2025, 3/22/2025, and 4/3/2025.</p> <p>(continued on next page)</p>		

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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>During an interview on 4/09/2025 at 1:39 PM with LVN 1, LVN 1 stated she made a mistake while documenting the site for blood pressure check for Resident 20 on the dates she documented the site on the left arm on 2/5/2025, 2/15/2025, 2/19/2025, 2/20/2025, 3/15/2025, 3/22/2025, and 4/3/2025. LVN 1 stated Resident 20 has an arteriovenous (direct connection between a patient's artery and vein) shunt (a passage or device that redirects blood or fluid from one are of the body to another) on his left arm where he gets hemodialysis, therefore no blood draws, and no blood pressure checks should be taken on the left arm. LVN 1 stated if the blood pressure was checked on the same side as the AV shunt, it could cause harm to the resident such as damage to the AV shunt which is necessary to use during dialysis to filter out wastes from the body and prevent them resident from accumulating fluids in the body which would cause worsening of the resident's condition. LVN 1 stated she should have reviewed her documentation prior to finalizing to ensure accuracy of her documentation and avoid any assumptions and misinterpretations by clinical staff.</p> <p>During an interview on 4/10/2025 at 8:30 AM with Resident 20 in Resident 20's room, Resident 20 stated the licensed nurses only take blood pressure checks on his right arm never on his left arm.</p> <p>During an interview on 4/10/2025 at 8:53 AM with the Director of Nursing (DON), the DON stated principles of good nursing documentation include accuracy, completeness, and legibility. The DON stated it is important to document accurately to ensure that the facility staff can monitor residents and to avoid assumptions and opinions, such as the assumption that Resident 20's blood pressure reading was checked on the left arm, where his AV shunt was placed.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Completion and Correction, dated 1/12012, indicated the facility will work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation. The P&P also indicated entries will be complete, legible, descriptive, and accurate and if an error needs to be corrected, draw one line through the entry, designate the entry as an error, and initial next to the change.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>44636</p> <p>Based on observation, interview, and record review, the facility staff failed to obtain an accurate water temperature reading and ensure the water used to wash two loads of soiled linens in two (2) of 2 washing machines had the correct temperature in accordance with the facility policy.</p> <p>This deficient practice had the potential to compromise infection control measures to eliminate disease causing bacteria, germs, and viruses on linens which could get residents sick and potentially spread infection in the facility.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 4/9/2025 at 9:27 AM in the laundry room with Laundry 1 (LD 1), LD 1 stated LD 1 did not check the thermometer for the water temperature in the washing machine. LD 1 stated there were 2 loads of white linens currently being washed in washing machines 1 and 2.</p> <p>During a concurrent observation and interview on 4/9/2025 at 9:34 AM with Maintenance Supervisor (MS), MS stated the thermometer to check for the water temperature of the washing machine was broken. MS stated the reading on the thermometer was between 70-80 degrees Fahrenheit (F). MS stated the water heater was turned off and was not heating the water for the washing machine. MS stated the water heater was set at 140 degrees F therefore the temperature for the washing machine should be at 140 degrees F. MS stated the water temperature reading when checked manually was between 72-74 degrees F. MS stated there are two loads of laundry being washed and one load has already been washed. MS stated the water temperature for the washing machines was not and should have been at 140 degrees F. MS stated when washing linens, the water should be set at a high temperature. MS stated washing the two loads of laundry at 72 degrees F does not kill the bacteria on the linens.</p> <p>During a concurrent observation and interview on 4/9/2025 at 9:44 AM with LD 2, LD 2 stated the washing machine thermometer currently indicated water temperature at 130 degrees F which was acceptable. LD 2 stated the load of laundry from the washing machine which contained linens such as fitted sheets, pillowcases, and flat sheets were taken out from the washing machine and were transferred into the dryer. LD 2 stated, at 9 AM today (4/9/2025), LD 2 had checked but did not log the water temperature reading of 146 degrees F from the thermometer.</p> <p>During an interview on 4/10/2025 at 9:27 AM with the Administrator (ADM), the ADM stated the washing machines were low temperature washing machines and the temperatures should be between 120-160 degrees F when washing laundry.</p> <p>During an interview on 4/10/2025 at 10:06 AM with the Infection Prevention Nurse (IPN), IPN stated the washing machines should be set at the hottest available temperature to kill the bacteria and pathogens on the laundry. IPN stated the bacteria from the laundry would not be eradicated when washing them at a low temperature. IPN stated all the residents used the linens and as a result, these linens could transmit pathogens to other residents in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a record review of the facility's policy and procedure titled, Laundry - Sorting, Washing, & Drying, revised 1/1/2012, the policy indicated when washing the laundry sheets and pillowcases, the hottest available water is used, along with the correct setting on the machine, and the correct amount of detergent for the load.</p>

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>44636</p> <p>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.</p> <p>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.</p> <p>Findings:</p> <p>During a review of the facility's room waiver (a legal document which allows to give up certain legal rights or claims), dated 4/7/2025, the waiver indicated that these rooms did not meet the requirements for 80 square feet per bed. The room waiver also indicated these rooms had adequate space for nursing care, and the health and safety of the residents occupying these rooms are not in jeopardy. The room waiver further indicated these rooms were in accordance with the needs of the residents and would not have an adverse effect on the residents' health and safety or impede the ability of any resident to attain his or her practical well-being. The room waiver showed the following:</p> <table border="1"> <thead> <tr> <th>Room #</th> <th>Room Sq. Ft.</th> <th>Number of beds</th> </tr> </thead> <tbody> <tr> <td>24</td> <td>230.84</td> <td>3</td> </tr> <tr> <td>26</td> <td>221.56</td> <td>3</td> </tr> <tr> <td>28</td> <td>217.74</td> <td>3</td> </tr> <tr> <td>44</td> <td>234.4</td> <td>3</td> </tr> </tbody> </table> <p>During an interview with the Administrator (ADM) on 4/7/2025 at 10:20 AM, the ADM stated 4 resident rooms (rooms 24, 26, 28, and 44) did not meet the minimum requirement of 80 sq. ft. per resident in multiple resident rooms. The ADM submitted a room wavier for these resident rooms.</p> <p>During observations on 4/7/2025 from 7:30 AM to 4:35 PM, rooms 24, 26, 28, and 44 did not meet the minimum requirement of 80 sq. ft. per resident. The residents in these rooms were able to maneuver their wheelchairs easily and ambulated inside the rooms without difficulty. The nursing staff had enough space to provide care to the residents in the room. The rooms had space for beds, bedside tables, nightstands, and other medical equipment.</p> <p>During interview with residents residing in rooms 24, 26, 28 and 44 both individually and collectively from 4/7/2025 to 4/10/2025, the residents did not express any concerns regarding the size of their rooms and stated they had enough space to move around freely.</p> <p>(continued on next page)</p>			Room #	Room Sq. Ft.	Number of beds	24	230.84	3	26	221.56	3	28	217.74	3	44	234.4	3
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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During interviews with nursing staff assigned to rooms 24, 26, 28 and 44 from 4/7/2025 to 4/10/2025, the staff stated they were able to work and provide care to the residents in those rooms without issues/difficulty moving around. The staff stated there was enough space for them to provide care to residents and provide the residents with privacy and dignity.</p> <p>During a review of the facility's submitted room waiver request letter, the letter indicated a request for the waiver to be granted on the condition that there was ample room to accommodate wheelchairs and other medical equipment, as well as space for mobility and movement of ambulatory residents. It also indicated that there was adequate space for nursing care, and the health and safety code of residents occupying these rooms were not in jeopardy. These rooms were in accordance and do not have an adverse effect on the residents' health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being.</p> <p>During multiple observations made to rooms 24, 26, 28, and 44 from 4/7/2025 to 4/10/2025, the room sizes of the above rooms did not adversely affect the residents' health and or safety.</p> <p>The department is recommending approval of the room waiver for rooms 24, 26, 28, and 44, as requested by the facility.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44636</p> <p>Based on observation, interview, and record review, the facility failed to ensure the call light (a visible and audible alarm activated by a call button) for one of 19 of sampled residents (Resident 3) was within reach as indicated on care plan and facility's policy.</p> <p>This failure had the potential to result in the inability for Resident 3 to obtain necessary care and services which could result to harm/injury to the resident.</p> <p>Findings:</p> <p>During a record review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] with the diagnoses including but not limited to metabolic encephalopathy (abnormalities of water, electrolytes, vitamins, and other chemicals that adversely affect the brain function), chronic obstructive pulmonary disease (COPD, disease that causes obstructed airflow from the lungs), and cerebral infarction (a stroke, damage to tissue in the brain due to loss of oxygen to the area).</p> <p>During a record review of Resident 3's Minimum Data Set (MDS, a resident assessment and tool), dated 2/28/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was moderately impaired. The MDS indicated Resident 3 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for toileting hygiene, shower/bathing self, personal hygiene, sit to standing, and chair/bed-to-chair transferring.</p> <p>During a record review of Resident 3's care plan, revised 8/12/2024, the care plan indicated Resident 3 was at risk for falls related to impulsive behavior, trying to be independent beyond ability, and poor safety judgment. The staff interventions were to ensure Resident 3's call light was within reach and encourage the resident to use it for assistance as needed, and to keep frequently used items within easy reach.</p> <p>During an observation on 4/7/2025 at 9:42 AM in Resident 3's room, Resident 3 was lying in bed and the call light was observed on the floor on the right side of the bed.</p> <p>During a concurrent observation and interview on 4/7/2025 at 9:48 AM in Resident 3's room with Restorative Nursing Assistant 1 (RNA 1), RNA 1 stated Resident 3's call light was on the floor and needed to be placed on the bed next to Resident 3.</p> <p>During an interview on 4/10/2025 at 11:02 AM with the Director of Nursing (DON), the DON stated residents' call lights should be placed within reach. The DON stated the call light should not be on the floor because the resident may need to call for assistance. The DON stated residents' needs may not be addressed promptly when the call lights are not placed within their reach.</p> <p>During a record review of the facility's policy and procedure titled, Communication - Call System, revised 1/1/2012, the policy indicated call cords will be placed within the resident's reach in the resident's room.</p>		

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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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47362</p> <p>Based on observation, interview, and record review the facility failed to maintain safe, clean, comfortable sanitary and home like environment for one (1) of (3) three sampled residents (Resident 56) for the environment care area by failing to ensure the linen bin was not overflowing in Room A.</p> <p>This deficient practice caused an unsanitary environment and had a potential for residents to be placed at risk for serious illness and/ or injury.</p> <p>Findings:</p> <p>During a review of Resident 56's Admission Record, the Admission Record indicated Resident 56 was initially admitted to the facility on [DATE] with diagnosis which included history of falling, adult failure to thrive (adults whose independence is declining), bed confinement status (unable to get up from bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair).</p> <p>During a review of Resident 56's Minimum Data Set (MDS, a resident assessment tool), dated 3/21/2025, the MDS indicated Resident 56 cognitive skills (processes of thinking and reasoning) for daily decision making was severely impaired (never/rarely made decisions).</p> <p>During an observation on 4/7/2025 at 9:44 AM in Room A (Resident 56's room), linen bin was observed to be overflowing with used white linen and not lined with plastic lining.</p> <p>During observation in Room A and interview on 4/9/2025 at 1:57 PM with the Director of Nursing (DON), the DON stated Resident 56's linen bin on Room A does not have plastic lining, and it was left open and overflowing with used linen. The DON stated the linen bins were supposed to be closed, lined with plastic lining and not overflowing to provide clean environment to the resident.</p> <p>During interview on 4/9/2025 at 3:47 PM with the Registered Nurse Supervisor (RNS), the RNS stated the linen bin needs to have plastic lining and is not supposed to be overflowing with used linen and needs to be fully closed for infection control purposes. RNS also stated it can possibly spread bacteria that can cause sickness like stomachache, skin problem, and diarrhea to the resident.</p> <p>During a record review of the facility's Policy and Procedure (P&P) titled Resident Room and Environment revised date 1/1/2012, the P&P indicated purpose to provide residents with safe, clean comfortable, and homelike environment. The P&P also indicated the facility staff aim to create personalized, homelike atmosphere, paying attention to the cleanliness and order.</p>		