STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055918	A. Building B. Wing	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Del Sol Post Acute	16910 Woodruff Ave. Bellflower, CA 90706

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 Based on observation, interview and record review the facility failed to : a.Provide privacy for two of three sampled residents (Resident 44 and Resident 337) by not closing the privacy curtain for Resident 44 and not covering Resident 337's back side while coming back from the shower. b.Not completely covering Resident 70 body after her shower. These deficient practices had the potential for the residents (Resident 44,337 and 70) to experience loss of dignity,self-esteem felt embarrassed and ashamed. Findings: a. During a review of Resident 44's Admission Record, indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with diagnoses that included acute respiratory failure (lungs cannot release enough oxygen into your blood), spastic hemiplegia (neuromuscular condition that causes muscle tightness and involuntary contractions on one side of the body) affecting right dominant side, lack of coordination, type II diabetes mellitus (uncontrolled blood sugar), seizures (sudden uncontrolled burst of electric activity of the brain), dysphagia (difficulty swallowing), gastrostomy (g-tube: surgical opening into the stomach to introduce food and nutrition), retention (continued possession) of urine, manic bipolar disorder (mental health condition that causes extreme mood swings), hypertension (high blood pressure), and vascular dementia (brain damage caused by multiple strokes) with other behavioral disturbances. During a review of Resident 44's Minimum Data Set (MDS), a standardize assessment tool dated 3/27/2024, indicated Resident 2 as cognitively (mental action or process of acquiring knowledge and understanding ability) moderately impaired. The MDS indicated Resident 44 is dependent toilet hygiene, bathing, eating, required maximal assistance or dressing upper (arms, shoulders extremities and lower (legs, hip) extremities, and required moderate assistance on personal hygiene. (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: 055918	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
NAME OF PROVIDER OR SUPPLIER Villa Del Sol Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 16910 Woodruff Ave. Bellflower, CA 90706	

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/11/2024 at 9:38a.m. with Licensed Vocational Nurse 7 (LVN 7), Resident 44 was in bed with his gown up, exposing his briefs. Upon entering the room, LVN 7 did not close the curtains and proceeded to pull Resident 44's gown up where the g-tube was placed, further exposing Resident 44 even more. LVN 7 stated it is important to provide privacy and for resident comfort, and not having the privacy would make the resident embarrassed. During an interview on 4/12/2024 at 10:26a.m. with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated prior to providing patient care, they would close the curtain for privacy as the residents are not supposed to watch each other getting changed. During an interview on 4/12/2024 at 2:35p.m. with Director of Nursing (DON), DON stated privacy curtains should be used as the resident does not want to be exposed and it is important to maintain residents dignity and privacy. DON stated without privacy curtains, the resident would feel violated of their privacy. During a review of the facility's P&P titled, Promoting/Maintaining Resident Dignity, revised 12/19/2022, the P&P indicated all staff member are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. Maintain resident privacy. Each resident will be provided equal access to quality care regardless of diagnosis, severity of condition, or payment source. b. During a review of Resident 70's admission record ,the admission record indicated Resident 70 was admitted to the facility on [DATE] with diagnosis of cerebral infarction (stroke-loss of blood flow to part of the brain), hypertensive heart disease without heart failure (heart problems that occur because of high blood pressure over a long period of time), and acute respiratory failure (when your lungs cannot get enough oxygen into your blood making it difficult to breathe). During a review of Resident 70 's history and physical (H&P) report dated 1/ 30 /2024 , the H&P indicated resident 70 had the capacity to understand and make decisions. During a review of Resident 70's MDS dated [DATE], it indicated the resident requires supervision or touching assistance (helper provides verbal cues and or/ touching/ steadying and or contact guard assistance as resident completes activity) with eating , toileting, and upper body dressing. During an observation and on 4/11/2024 at 09:48 a.m., in the hallway Certified Nursing Assistant 4 (CNA 4) left Resident 70 who was in a shower chair in front of the resident's room . During an interview on 4/11/24 at 10:00 a.m., CNA 4 verified and stated she placed Resident 70 in the hallway and did not know Resident 70's buttocks was not fully covered with the bath blanket. CNA 4 stated the resident should be fully covered and unexposed. During an interview on 4/12/24 at 4:00 p.m., Resident 70 stated she did not feel good and felt embarrassed about her buttocks being exposed. During an interview on 4/12/2024 at 1:00 p.m., with the Director of Nursing (DON), DON stated when taking a Resident 51 to the shower room you must completely cover Resident 51's so body so she will not be exposed to other residents this can affect her dignity and right to privacy. (continued on next page)

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Villa Del Sol Post Acute	16910 Woodruff Ave. Bellflower, CA 90706

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P/P) titled Promoting / Maintaining Resident Dignity Revised October 2022, the P/P indicated, It is the practice of this facility to protect and promote residents rights and treat each resident with respect and dignity as well as care for the each resident in a manner and in an environment , that maintains or enhances resident's quality of life by recognizing each residents individuality. 1.Maintain resident privacy.

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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 46415

Based on observation, interview and record review, the facility failed to ensure one out of three sampled residents (Resident 58) had a functioning call light.

This deficient practice had a potential to result in inability of the resident to obtain care and services as needed.

Findings:

During a review of Resident 58's Admission Record, indicated the resident was admitted on [DATE] with diagnoses that included epilepsy (disorder in which nerve cell activity in the brain is disturbed causing seizures), gastrostomy (g-tube: surgical opening into the stomach to provide nutritional support or decompression), use of anticoagulants (down syndrome (genetic disorder causing developmental and intellectual delay), dysphagia (difficulty swallowing), history of falling, and abnormalities of gait (pattern that you walk) and mobility.

During a review of Resident 58's Minimum Data Set (MDS-, a standardize assessment tool) dated 1/21/2024, indicated Resident 58 as cognitively (mental action or process of acquiring knowledge and understanding ability) severely impaired and does not have any functional impairments on both the right and left upper (arms, shoulders) and lower (hip, legs) extremities.) The MDS indicated Resident 58 is dependent on all aspects of the activities of daily living (ADL: fundamental skills required to independently care for oneself like eating and bathing).

During an interview on 4/10/2024 at 1:52p.m. with Resident 58's family, it was mentioned that the call light button for Resident 58 does not work.

During an observation on 4/10/2024 at 2:40p.m., Resident 58's call light was on the left side of the resident. Resident 58's call light was attached to the pillow and the call light did not look taught or pulled and was resting nicely beside the resident where it could be reached. Upon pressing the call light, the call light button seemed stuck, the button on the call light could not be pressed, and the call light did not turn on or light up outside of the resident's room.

During a concurrent observation and interview on 4/10/2024 at 2:43p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 went to Resident 58 and pressed he call light. LVN 1 stated when the call light it pushed, it would light up outside of the resident's room. LVN 1 stated the call light for Resident 58's light did not light up outside of the resident's room. LVN 1 stated the maintenance will be notified since the call light did not light up and was not working. LVN 1 stated call lights are answered by everyone, and call lights are important as it is a means of communication for the residents since they may not be able to get up. LVN 1 stated if the call light did not work, it would have to be fixed and should be always within reach of the resident. LVN 1 stated if a call light did not work, the resident may be in distress, and no one would know whether the resident needs assistance.

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NAME OF PROVIDER OR SUPPLIER: Villa Del Sol Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 16910 Woodruff Ave. Bellflower, CA 90706	

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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	During a concurrent observation and interview 4/11/2024 at 11:34a.m. with Resident 58's family, the family stated the call light did not work and had the family press the call light. It was noted the call light did not light up outside of the resident's room. The call light was beside Resident 58's left side but it is not functioning During a concurrent observation and interview on 4/11/2024 at 11:37a.m. with Activities Director (AD), the AD pressed the call light and indicated it was not working. AD stated when the call light is pressed, it would light up outside of the resident's room. AD stated the maintenance will be notified since the call light is not working. AD stated it is possible that Resident 58 may need a different call light. During an interview on 4/11/2024 at 3:55p.m. with MS, MS stated he recalled he was notified on 4/10/2023 regarding Resident 58's call light. MS stated he went to the resident's room, and when he pressed the button on the wall, the call light outside of the room did not light up so he thought the call light in the hallway was not working so he replaced the light bulb outside but did not go into the room to check to see if the call light was working. MS stated on 4/10/2024 he did not go into the resident's room and push the call light to check if it was working because family was there During an interview on 4/12/2024 at 2:35p.m. with Director of Nursing (DON), DON stated everyone answers the call light, and if the call light is not working, maintenance will be notified. DON stated if the issue occurred during the night, staffs would write in a binder regarding any issues that needs to be addressed. DON stated call lights are important as that is the residents lifeline and not having a call light would indicate the residents cannot call for assistance when needed. During a review of the facility's P&P titled, Promoting/Maintaining Resident Dignity, revised 12/19/2022, the P&P indicated it is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Each resident will be provided equal access to quality care regardless of diagnosis, severity of condition, or payment source.

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 Based on interview, and record review, the facility staff failed to explain a room change and give notice of room change for one out of three sampled resident's (Resident 337) . This deficient practice had the potential to affect Resident 337's self-esteem and self-worth. Findings: During a review of Resident 337's admission record (face sheet), the face sheet indicated Resident 337 was admitted to the facility on [DATE] with diagnoses of cerebral infarction (stroke-loss of blood flow to part of the brain causing tissue damage), encephalopathy, unspecified (brain disease that alters brain function), and hyperlipidemia (high levels of fat particles in the blood). During a review of Resident 337 's history and physical (H&P) report dated 3/31 /2024, the H&P indicated resident 337 did not have the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS), a comprehensive assessment and care-planning tool dated 4/4/2024, the MDS indicated the resident requires partial/ moderate assistance - helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort with eating, and oral hygiene. During a record review on 4/11/2024 of Resident 337's face sheet, the face sheet indicated Resident 337 was moved from room [ROOM NUMBER] A to room [ROOM NUMBER] A on 4/8/2024. During an interview on 4/11/2024 at 1:36 p.m., with Resident 337 and her sister, Resident 337 stated she was admitted to room [ROOM NUMBER]A on 3/29/2024. Resident 337 stated she was transferred from room [ROOM NUMBER]A to room [ROOM NUMBER]A on 4/8/2024. Resident 337 stated she was not notified that she was moving, or the reason she was moving rooms prior to moving. Resident 337 stated she was scared and did not sleep that night . She stated her dinner tray on 4/8/2024 and breakfast on 4/9/2024 tray was not given to her. She also stated her family was scared when they arrived at the facility and could not find her. Resident 337 stated she felt like she did not have any input on where she would like to go. During an interview and record review on 4/11/2024 at 1:41 p.m., with the Social Service Director (SSD), the SSD verified Resident 337 was transferred from room [ROOM NUMBER]A to room [ROOM NUMBER]A and there was no documentation explaining to Resident 337 why she was transferred. The SSD stated the process is to explain to the resident if they are self-responsible, if not notify the family and get their approval. Document the reason why, notify, dietary and department heads of the resident's new location and then move the resident. The SSD stated when you do not give resident and family notice and an explanation of the transfer the parties can be disappointed, this is bad customer service. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P/P) titled Resident Rights revised 9/22/2022, the P/P indicated, the Resident has a right to treated with respect and dignity, including : The right to receive written notice , including the reason for the change , before the resident's room before the resident's room or roommate in the facility is changed.

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	055918	A. Building B. Wing	04/12/2024

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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 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** 40994 Based on interview and record review, the facility failed to create a resident-centered care plan (a set of instructions for providing individualized care to a resident for an identified area of concern) for the target behavior of withdrawal from activities of interest related to the use of mirtazapine (a medication used to treat mental illness) for one of five residents sampled for unnecessary medications (Resident 74.) The deficient practice of failing to create a resident-centered care plan to address problematic behaviors increased the risk that psychotropic medications (medications that affect brain activities associated with mental processes and behavior) used to manage those behaviors would not be periodically reevaluated as intended. This increased the risk that Resident 74 may have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to psychotropic medications possibly leading to impairment or decline in her mental or physical condition or functional or psychosocial status. Findings: During a review of Resident 74's Admission Record (a document containing a resident's demographic and diagnostic information), dated 4/11/24, the admission record indicated Resident 74 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a disease of the brain that affects memory and mental functioning.) During a review of Resident 74's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 3/7/24, the H&P indicated she did not have the capacity to understand and make decisions. During a review of Resident 74's Order Summary Report (a summary of all currently active physician's orders), dated 4/11/24, the Order Summary Report indicated on 3/15/24, Resident 74's attending physician prescribed mirtazapine 7.5 milligrams (mg - a unit of measure for mass) via gastrostomy tube (g-tube - a tube surgically placed directly into the stomach for residents unable to take food or medications by mouth) at bedtime for depression (a constant feeling of sadness and loss of interest, that interferes with normal daily activities) manifested by withdrawal from activities of interest. A review of Resident 74's available care plans indicated there were no care plans for depression or any behaviors or problems related to withdrawal from activities of interest for which mirtazapine was listed as a targeted intervention. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/11/2024 at 11:10 AM with the Director of Nursing (DON), the DON stated the facility failed to create a resident-centered care plan and define goals of therapy for the use of mirtazapine to treat the target behavior of withdrawal of activities of interest and she could not name any of Resident 74's activities of interest. The DON stated it was important to have problematic behaviors care planned so that non-pharmacological interventions that are resident-specific could be used in addition to medications to manage them. The DON stated the failure to create a care plan addressing Resident 74's problematic behaviors increased the risk that she could have experienced adverse effects related to mirtazapine use, including sedation or drowsiness, which could lead to a diminished quality of life. During a review of the facility's policy (P&P) titled Comprehensive Care Plans, dated 12/19/2022, the P&P indicated It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternate interventions will be documented, as needed . A review of the facility's policy Behavioral Health Services, dated 12/19/22, indicated The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. This process includes, but is not limited to: .MDS and care area assessments . Ongoing monitoring of mood and behavior . care plan development and implementation .

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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 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate treatment and care according to orders, resident’s preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44423

Based on observation, interview and record review, the facility failed to aggressively treat skin breakdown, prevent progression of contact dermatitis (a condition in which the skin becomes red, sore, or inflamed after direct contact with a substance) and promote rapid skin healing process for two of six (6) residents (Resident 22 and Resident 40) by failing to:

1.Implement Documentation of Wound Treatments policy and procedure (P&P) by including Resident 22 and Resident 40's response to the treatment ordered for contact dermatitis.

2.Consult a dermatologist (a medical practitioner specializing in the diagnosis and treatment of skin disorders) for diagnosis and treatment of skin rashes in a timely manner.

3.Inspect all residents in the facility in a timely manner for possible contact and spread of skin rashes.

4.Re-assess treatment interventions for Resident 22 and 40 for non-healing skin rashes.

These failures resulting in intense and persistent scratching and rubbing of the skin and had the potential for skin infections (occur when bacteria infect the skin and sometimes the deep tissue beneath the skin), inability to sleep, feelings of depression and isolation.

Findings:

A. During a concurrent observation and interview on 4/9/2024 at 1:00 p.m. during the initial tour, Resident 22 was observed scratching intensely on both arms, abdomen (stomach) and bilateral (both)breast. Resident 22 stated the rashes are not getting better.

During a review of Resident 22's Admission Record (face sheet) dated 8/12/2016, the Admission Record indicated Resident 22 was admitted to the facility with diagnoses of hypertension (high blood pressure), glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve), contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of the both ankles and morbid obesity (weight is more than 80 to 100 pounds above their ideal body weight).

During a review of Resident 22's Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated 1/23/2024, the MDS indicated Resident 22 was cognitively (a way that relates to thinking, or with conscious mental processes) alert and oriented and able to make daily decisions regarding activities of daily living (ADLs).

During a review of Resident 22's care plan (CP) initiated 1/12/2024, the CP indicated Resident 22 has a scattered skin rash under both breast and lower back. The CP goal indicated Resident 22 will have no complications from the rash and the rash will heal. The CP interventions indicated Resident 22 will avoid scratching, to refer to dermatologist and give medications as ordered by the doctor and monitor/document for effectiveness.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 22's physician orders (PO) dated 1/13/2024, the PO indicated Resident 22 had an order for Hydrocortisone (anti-inflammatory medication used for itching) 2.5% ([%] unit of measurement) topical cream to apply her lateral back (to the side of, or away from, the middle of the body) every day for seven (7) days for a diagnosis of skin dermatitis (a disease that causes inflammation, redness, and irritation of the skin). During a review of Resident 22's Skin Only Evaluation dated 1/30/2024 at 11:17 a.m., the Skin Only Evaluation indicated Resident 22 had generalized contact dermatitis and was evaluated by the wound specialist doctor (health care professionals who have been trained in the care and treatment of all types of wounds [an injury to living tissue caused by a cut, blow, or other impact, typically one in which the skin is cut or broken]). The Skin Only Evaluation indicated Resident 22 treatment order was Hydrocortisone 2.5% to all affected areas for 28 days. During a review of Resident 22's Skin Only Evaluation dated 2/9/2024 at 10:55 a.m., the Skin Only Evaluation indicated Resident 22 continued to have generalized body dermatitis with diffused scattered maculopapular eruptions ([MP] flat or raised red bumps on the skin) and the new treatment order by the wound specialist was to start Hydrocortisone 2.5% with Benadryl (medication used for itching) daily to all affected areas for 28 days. During a review of Resident 22's Skin Only Evaluation dated 3/22/2024 at 10:17 a.m., the Skin Only Evaluation indicated Resident 22 was evaluated by the wound specialist and still had a diagnosis of generalized body dermatitis with diffused scattered MP eruptions on the skin. The Skin Only Evaluation indicated the treatment was changed to miconazole nitrate 2% (antifungal cream) plus hydrocortisone 2.5% cream added with bacitracin ointment topical (antibiotic used to treat skin and eye infections) to affected areas. During a review of Resident 22's Skin Only Evaluation dated 4/5/2024 at 9:39 a.m., the Skin Only Evaluation indicated Resident 22 was evaluated by the wound specialist and still had a diagnosis of generalized body dermatitis. The Skin Only Evaluation indicated the treatment remained the same with miconazole nitrate 2% plus hydrocortisone 2.5% cream added with bacitracin ointment topical to affected areas. During a review of Resident 22's PO dated 2/1/2024, the PO indicated Resident 22 had an order for Hydrocortisone 2.5% topical cream to apply to the body every day for 60 days for a diagnosis of skin dermatitis. During a review of Resident 22's PO dated 3/12/2024, the PO indicated Resident 22 had an order for Hydrocortisone 2.5% topical cream plus Miconazole nitrite (antifungal cream used to treat skin infections) 2% to apply to the generalized body every day for 60 days for a diagnosis of contact dermatitis. During a review of Resident 22's PO dated 4/11/2024, the PO indicated Resident 22 had a new order for a dermatology consultation. During a review of Resident 22's CP initiated 4/11/2024, the CP indicated Resident 22 had generalized body dermatitis. The CP goal indicated Resident 22 will not have further skin breakdown. The CP interventions indicated to monitor skin and notify the doctor of any changes, consult with dermatology on 4/12/2024 and to administer treatment as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 22's progress note dated 4/11/2024, the progress note indicated Resident 22 was diagnosed with Prurigo Nodularis (a chronic inflammatory skin disease where an extremely itchy bumps, symmetrically distributed rash appears most commonly on the arms, legs, the upper back and/or the abdomen) by the dermatologist, 72 days after the initial diagnosis of contact dermatitis was made by the wound specialist. During a concurrent observation and interview on 4/9/2024 at 1:02 p.m. with Resident 22, Resident 22 was observed scratching her arms, stomach, and chest area. Resident 22 stated she has had a rash for a long time, and it is irritating. Resident 22 stated she can take Benadryl), but she does not drink it because it makes her drowsy. Resident 22 stated the staff is aware of her rash and how long it has been there. Resident 22 stated she often wakes up during the night to scratch her body because she itches all over. During a concurrent observation and interview on 4/11/2024 at 11:44 a.m. with the Treatment Nurse (TN) at Resident 22's bedside, the TN stated Resident 22 was being assessed daily for the rash and Resident 22 would show the TN new areas of a rash on her body. The TN stated she was not aware of a new order for a dermatology consult for Resident 22 on 4/11/2024. During a concurrent observation and interview on 4/11/2024 at 11:50 a.m. with Resident 22 and the TN, Resident 22 observed scratching all over and stated she is still itching., especially when she is not completely dried off by staff after bathing. The TN stated, it would be better if Resident 22 saw a dermatologist. During an interview on 4/11/2024 at 12:13 p.m. with Certified Nurse Assistant (CNA 8), CNA 8 stated Resident 22 has a lot of rashes all over her body and they have gotten worse. During an interview on 4/11/2024 at 2:09 p.m. with the Licensed Vocational Nurse (LVN 4), LVN 4 stated Resident 22 rash started in January 2024. LVN 4 stated she did not do a whole-body assessment on Resident 22. LVN 4 stated Resident 22 told her the medication she is receiving for her rashes was not effective. LVN 4 stated she assessed Resident 22 on 4/8/2024 and the rashes were not getting better. During an interview on 4/11/2024 at 3:10 p.m. with the Director of Nurses (DON), the DON stated she is aware that several residents have rashes in Station 2 since January 2024 and that is unusual to have a rash that long. The DON stated Resident 22 has expressed frustration with her current condition with the skin rashes and itching all over. B. During a concurrent observation and interview on 4/11/2024 at 11:50 a.m. with the TN at Resident 40's bedside, Resident 40 was observed with generalized body rash on her chest, arms, stomach and back. Resident 40 was observed scratching his arms vigorously (forcefully and energetically). The TN stated Resident 40 had the rash for a long time and was seen by the wound specialist on 4/5/2024 with no new treatment orders. During a review of Resident 40's Admission Record dated 1/8/2022, the Admission Record indicated Resident 40 was admitted to the facility with diagnosis of anemia (low blood levels), atrial fibrillation (an irregular and often very rapid heart rhythm) and right side hemiplegia (paralysis of one side of the body) following a cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 40's (MDS dated [DATE], the MDS indicated Resident 40 was severely impaired cognitively (a very hard time remembering things, making decisions, concentrating, or learning) and was not able to make decisions for ADLs. During a review of Resident 40's Change of Condition form (COC) dated 1/19/2024, the COC indicated Resident 40 had a skin rash and was diagnosed with generalized body dermatitis. During a review of Resident 40's PO dated 2/21/2024, the PO indicated Resident 40 had an order for Miconazole nitrate 2% cream to apply to generalized body rash. The PO indicated the Miconazole nitrate 2% cream was discontinued on 2/23/2024. During a review of Resident 40's PO dated 2/23/2024, the PO indicated Resident 40 had an order for Permethrin cream 5% (medication used to treat scabies [an infestation of the skin by the human itch mite]) for generalized body dermatitis. During a review of Resident 40's PO dated 2/24/2024, the PO indicated Resident 40 had an order for Triamcinolone Acetonide 0.1% cream medication is used to treat a variety of skin conditions such as eczema, dermatitis, allergies, rash). During a review of Resident 40's Skin Only Evaluation dated 3/22/2024 at 10:08 a.m., and dated 4/5/2024 at 8:36 a.m. the Skin Only Evaluation indicated Resident 40 had generalized body dermatitis. During an interview on 4/11/2024 at 11:55 a.m. with CNA 1, CNA 1 stated Resident 40 had a rash and had it for months on his arms, chest, and abdomen. CNA 1 stated he observed Resident 40 scratching all over his body all the time. During a concurrent interview and record review on 4/11/2024 at 3:10 p.m. with the DON, the DON stated Resident 40 rash is not normal and it could be scabies. The DON stated it is alarming to her that residents have rashes all over their body. The DON stated Resident 40 has not been seen by a dermatologist since January 2024. The DON stated during record review of photos of Resident 40's rash that it showed the rash is not improving. The DON stated it was important for residents' to be comfortable. During a review of the facility job description titled Treatment Nurse dated 2003, the job description indicated the treatment nurse will initiate requests for consultation or referral. The job description indicated the treatment nurse will implement and maintain established policies and procedures relative to skin care treatments. The job description indicated the treatment nurse will identify, manage, and treat specific skin disorders. During a review of the facility P&P titled Skin assessment dated [DATE], the P&P indicated a head-to-toe assessment will be conducted by a licensed or registered nurse upon admission/re-admission, and weekly thereafter or after a change in condition. During a review of the facility P&P titled Documentation of Wound Treatments revised 9/12/2024, the P&P indicated the facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled Provision of Quality Care dated 9/2/2022, the P&P indicated each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. The P&P indicated qualified persons will provide the care and treatment in accordance with professional standards of practice, the resident's care plan, and the resident's choices.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 Based on observation, interview and record review, the facility failed to ensure two of three sampled residents (Resident 51 and Resident 36) was free of accident by: A.Failing to properly position Resident 51 while eating lunch. This deficient practice had the potential for Resident 51 to aspirate (food, drink, or foreign objects are breathed into the lungs) and choke (occurs when the airway is obstructed by food, drink, or foreign objects) on her food. B.Failing to ensure a thorough assessment was conducted to address safety needs during bowel and bladder elimination, for one of three residents (Resident 36), who was legally blind (a person with a visual acuity of 20/200 (even with glasses or contacts, reader can only read the first letter at the top of [NAME] chart [a tool to assess visual acuity]). This deficient practice resulted in lacking safety interventions addressed in the resident's care plan that resulted to Resident 36's fall. Findings: A. During a review of Resident 51's Admission Record, the Admission Record indicated Resident 51 was admitted to the facility on [DATE] with diagnosis of orthostatic hypotension (low blood pressure), bradycardia (slow heart rate), and hyperlipidemia (high levels of fat particles in the blood). During a review of Resident 51 's History and Physical (H&P) report dated 4/1/2024, the H&P indicated Resident 51 can make needs known but cannot make medical decisions. During a review of Resident 51's Minimum Data Set ([MDS] a comprehensive assessment and care screening tool) dated 4/1/2024, indicated the Resident 51 requires substantial / maximal assistance- (helper does more than half the effort) and provides more than half the effort with eating, oral hygiene, and upper body dressing. During a review of Resident 51's Order Summary Report indicated an order for one-to-one feeding assistance (the action of a person feeding another person who cannot feed themselves) with all meals to encourage po intake with supplementation was ordered on 10/27/2023. During an observation and interview on 4/10/2024 at 12:26 p.m., in the dining room Certified Nurse Assistant 7 (CNA 7) was feeding Resident 51 in her wheelchair. Resident 51 was positioned in a low fowlers position (when a resident's head was lowered to a 15-30-degree angle). CNA 7 stated this position was low sometimes Resident 51 was fed in this position to keep her from sliding out of her wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/10/2024 at 1:14 p.m., with Licensed Vocational Nurse 10 (LVN 10), stated a safe eating position for feeding Resident 51 was at 30 degrees and in a Geri chair (a large, padded chair that was designed to help seniors with limited movement). During an interview on 4/12/2024 at 1:41 p.m., Registered Nurse 2 (RN 2) stated when feeding in a wheelchair the resident must be propped up into a sitting position to prevent the risk of choking. During an interview on 4/12/2024 at 1:00 p.m., with the Director of Staff Development (DSD) stated the correct position when feeding Resident 51 was sitting in an upright position. DSD stated if the position was lower Resident 51 can be at risk for aspiration and choking. During a review of the facility's policy and procedure (P&P) titled Meal Supervision and Assistance Date Reviewed /Revised 12/19/ 2022, the P&P indicated, the resident should be positions so his or her head and upper body are as upright as possible with the head tipped slightly forward. If the resident is served his or her meal in bed, use wedges and pillows to achieve a nearly upright position. B.During a review of Resident 36's Admission Record, the Admission Record indicated Resident 36 was admitted to the facility on [DATE], with diagnoses including legal blindness, muscle weakness and difficulty in walking. During a review of Resident's 36's MDS, dated [DATE], the MDS indicated Resident 36 had moderate cognitive impairment (ability to learn, understand, and make decisions), required moderate assistance for all activities of daily living including toilet transfer, walking 10-50 feet, toilet hygiene, upper and lower dressing, and personal hygiene. During a review of Resident 36's care plan titled, Resident at high risk for fall, dated 2/13/2023, the care plan interventions indicated to provide routine rounds and aid go to the bathroom, however, the care plan did not indicate safety interventions for Resident 36 during bowel and bladder elimination. During an interview on 04/09/2024 at 1:46 p.m. with Resident 13, (Resident 36's next bed neighbor), Resident 13 stated Resident 36 had a fall incident earlier today (04/09/2024) at five in the morning when she was awakened of the sound Resident 36 falling. During an interview on 04/09/2024 at 3:05 p.m. with Resident 36's family member (FM) FM stated Resident 36 was completely blind, and FM was worried of Resident 36's safety. FM stated there was no commode at the resident's bedside. FM was worried if a staff does not answer Resident 36's call light promptly at night, Resident 36 would get up and walk to the bathroom and could have not fallen. FM stated Resident 36 could fall again. During an interview on 04/10/2024 at 10:38 a.m., the RN 2 stated Resident 36 was at high risk for fall. RN 2 stated the care plan should have been updated and interventions could have been revised. Resident 36 could have been provided a bedside commode for easy access that Resident 36 could use at night for safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a Concurrent interview and record review on 04/10/2024 at 10:41 a.m., with the MDS coordinator, Resident 36's care plan titled Resident high risk for fall, updated 2/15/2023 was reviewed. MDS coordinator stated, Resident 36's care plan interventions indicated to provide routine rounds and aid go to the bathroom, however, the care plan did not indicate safety interventions during Resident 36's bowel and bladder elimination. During an interview on 04/12/2024 at 10:47 a.m., Resident 36 stated, when she fell on [DATE], Resident 36 was half asleep. Resident 36 stated she put the call light on and had been calling for help, however, no one came and responded to the call light. Resident 36 stated, she got up and walked to the bathroom by herself and fell . During an interview on 04/12/2024 at 11:03 a.m., the DSD stated, since the staff did not answer the call light promptly, if there was an intervention like a bedside commode next to Resident 36's bed, Resident 36 could have used the bedside commode for her bowel and bladder elimination needs and the fall could have been prevented. During a review of the P&P titled, Comprehensive Care Plans, revised 12/19/2022, the P&P indicated, it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. During a review of the P&P titled, Fall Prevention Program, revised 12/28/2023, the P&P indicated, each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The facility utilizes a standardized risk assessment for determining a resident's fall risk.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40994 Based on observation, interview, and record review, the facility failed to accurately account for one dose of a controlled medication (medications with a high potential for abuse) affecting Resident 23 in one of two inspected medication carts (Station 2 Medication Cart.) This deficient practice increased the risk of diversion (any use other than that intended by the prescriber) of controlled medications and that Resident 23 could have received too much or too little medication due to lack of documentation possibly resulting in serious health complications requiring hospitalization . Findings: During an observation and concurrent interview of Station 2 Medication Cart, on 4/10/24 at 1:41 PM, with Licensed Vocational Nurse (LVN) 4, the following discrepancies were found between the Controlled Drug Record (a log signed by the nurse with the date and time each time a controlled substance is given to a resident) and the medication card (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the medication): 1. Resident 23's Controlled Drug Record for hydrocodone/apap (a medication used to treat pain) 5/325 milligrams (mg - a unit of measure for mass) indicated there were 29 doses left, however, the medication card contained 28 doses. LVN 4 stated the missing dose of hydrocodone/apap 5/325 mg for Resident 23 was administered around 11 AM today. LVN 4 stated she failed to sign the Controlled Drug Record at that time because she was distracted by other tasks. LVN 4 stated the facility policy is to sign the Controlled Drug Record immediately after administration to ensure immediate reconciliation of controlled substances. LVN 4 stated this is important to prevent diversion and to ensure residents are not given controlled medications more often than prescribed which could cause medical issues. During a review of the facility's policy (P&P) titled Controlled Substance Administration & Accountability, last revised 6/5/23, the P&P indicated All controlled substances . are accounted for in one of the following ways: . All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided . In all cases, the dose noted on the usage form . must match the dose recorded on the Medication Administration Record (MAR), Controlled Drug Record, or other facility specified form and placed in the patient's medical record . During a record review of the facility's policy Medication Administration, dated 9/2/22, indicated .If a medication is a controlled substance, sign narcotic book .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on interview and record review, the facility failed to ensure a medication regimen review (MRR - an initial or periodic review of a resident's medication regimen to identify and potential problems with medication dosing, interactions, duplications, etc.) was completed and documented upon admission for one of five residents sampled for unnecessary medications (Resident 42.) The failure to ensure Resident 42's medications were reviewed by a pharmacist and document the review in his medical record upon admission increased the risk that he could have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to issues with his medication therapy possibly leading to impairment or decline in his mental or physical condition or functional or psychosocial status. Findings: During a review of Resident 42's Admission Record (a document containing a resident's demographic and diagnostic information), dated 4/11/2024, the Admission Record indicated he was admitted to the facility on [DATE] with diagnoses including: polyarthritis (inflammation of multiple joints) and type 2 diabetes mellitus (a condition characterized by the inability to control blood sugar levels.) During a review of Resident 42's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 3/27/2024, the H&P indicated he had the capacity to understand and make decisions. During a review of Resident 42's Order Summary Report (a summary of all currently active physician's orders), dated, 4/11/2024, the Order Summary Report indicated Resident 42 currently had 29 active medication orders prescribed by his attending physician to manage his multiple health conditions. During a review of Resident 42's clinical record, the clinical record indicated there was no documentation that a pharmacist had performed a review of Resident 42's entire medication profile since his admission to the facility. During a review of Resident 42's Minimum Data Set (MDS - a standardized assessment and care planning tool) Section N (medications), dated 3/30/2024, the MDS did not indicate whether a drug regimen review was completed or if any clinically significant medication issues were identified. During an interview on 4/11/2024 at 10:55 AM, with the Director of Nursing (DON), the DON stated she could not produce any evidence that Resident 42's medication regimen was reviewed by a pharmacist upon admission as required. The DON stated there was no documentation in Resident 42's clinical record indicating an MRR was completed by the pharmacy upon admission. The DON stated because the facility failed to obtain an initial MRR review or follow up with the pharmacy to determine if this resident's medication regimen contained any irregularities, it increased the risk that he could have experienced medical complications related to his drug therapy from an excessive dose, duration, therapeutic duplication, etc . which could possibly lead to hospitalization . (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy (P&P) titled Quality Reporting: Drug Regimen Review, dated 12/19/22, the P&P indicated It is the policy of this facility to document whether a drug regimen review was conducted upon a resident's . admission and throughout the resident's stay, and to document whether any clinically significant medication issues identified were addressed in a timely manner . Documentation of a drug regimen review may be located in various locations and throughout the medical record. Examples include, but are not limited to .A pharmacist may document the review in a designated location such as a medication regimen review form .

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F 0758

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40994

Based on interview and record review, the facility failed to:

1.Ensure mirtazapine (a medication used to treat mental illness) was used for a medical condition diagnosed and documented in the resident's clinical record for one of five residents sampled for unnecessary medications (Resident 74)

2.Monitor and quantify the target behavior of withdrawal from activities of interest and adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to the use of mirtazapine in one of five residents sampled for unnecessary medications (Resident 74)

These deficient practices of failing to ensure psychotropic medications (medications that affect brain activities associated with mental processes and behavior) are only used for documented medical conditions and failing to monitor their use for effectiveness and adverse effects increased the risk that Resident 74 may have experienced adverse effects related to mirtazapine possibly leading to impairment or decline in her mental or physical condition or functional or psychosocial status.

Findings:

During a review of Resident 74's Admission Record (a document containing a resident's demographic and diagnostic information), dated 4/11/2024, the Admission Record indicated she was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a disease of the brain that affects memory and mental functioning.)

During a review of Resident 74's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 3/7/2024, the H&P indicated she did not have the capacity to understand and make decisions and did not identify depression or major depressive disorder (MDD - a mental illness characterized by depressed mood, social withdrawal, and lack of interest in usually enjoyable activities) as a known problem or diagnosis.

During a review of Resident 74's psychiatric progress note, dated 3/14/2024, the psychiatric progress note did not list depression or MDD as a current diagnosis for this resident.

During a review of Resident 74's Order Summary Report (a summary of all currently active physician's orders), dated 4/11/2024, the Order Summary Report indicated on 3/15/2024, Resident 74's attending physician prescribed mirtazapine 7.5 milligrams (mg - a unit of measure for mass) via gastrostomy tube (g-tube - a tube surgically placed directly into the stomach for residents unable to take food or medications by mouth) at bedtime for depression manifested by withdrawal from activities of interest.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055918	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Del Sol Post Acute	16910 Woodruff Ave. Bellflower, CA 90706

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 74's available care plans, there were no care plans for depression, or any behaviors or problems related to withdrawal from activities of interest for which mirtazapine was listed as a targeted intervention. Further review of her care plan for mirtazapine indicated one of the targeted interventions was to monitor for effectiveness and adverse effects. During a review of Resident 74's Minimum Data Set (MDS - a standardized assessment and care planning tool) Section I (active diagnoses), dated 3/8/2024, the MDS Section I did not list depression as an active diagnosis. During a review of Resident 74's MDS Section N (medications), dated 3/8/2024, the MDS Section N indicated she was receiving antidepressant medication therapy regularly and that an indication for it was noted. During a review of Resident 74's Medication Administration Record (MAR - a record of all medications administered and monitoring performed for a resident) between 3/15/2024 and 4/11/2024, the MAR did not indicate the facility staff were monitoring for adverse effects related to the use of mirtazapine and quantifying episodes of Resident 74's behavior of withdrawal from activities of interest per shift. During an interview on 4/11/2024 at 11:10 AM, with the Director of Nursing (DON), the DON stated the facility failed to indicate a clear medical indication for Resident 74's use of mirtazapine. The DON stated initially she thinks it was prescribed for a poor appetite, but ultimately that doesn't make sense to continue when she is fed continuously via a g-tube. The DON stated the order was clarified on 3/16/2024 to indicate it was for depression for withdrawal from activities of interest but there was no record of a diagnosis of depression in the clinical record. The DON stated the psychiatric progress note dated 3/14/2024 does not include a diagnosis of depression in the assessment and the MDS assessment completed on 3/8/2024 does not list depression as a diagnosis for this resident. The DON stated she could not name this resident's activities of interest and the facility failed to create resident-centered care plans and define goals of therapy for this resident's behaviors of withdrawal of activities of interest. The DON stated the facility failed to monitor the behaviors of withdrawal of activities of interest or the adverse effects related to the use of mirtazapine in a meaningful way that would allow a physician to periodically reassess objectively whether the benefits of its continued use outweighed the risks. The DON stated this increased the risk that Resident 74 could have experienced adverse effects related to mirtazapine use, including sedation or drowsiness, which could lead to a diminished quality of life. During a review of the facility's policy (P&P) titled Use of Psychotropic Medication, dated 12/19/22, the P&P indicated Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s) . The indications for use of any psychotropic drug will be documented in the medical record . the resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record .

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%). Eight medication errors out of 30 total opportunities contributed to an overall medication error rate of 26.67 % affecting one of four residents observed for medication administration (Resident 532.) The medication errors noted were as follows: 1.Omitted dose of Symbicort (a medication used to treat breathing problems) 2.Omitted dose of Preservision AREDS2 (a multivitamin supplement) 3.Late administration of aspirin (a medication used to prevent blood clots) 4.Late administration of lisinopril (a medication used to treat high blood pressure) 5.Late administration of gabapentin (a medication used to treat pain) 6.Late administration of vitamin c (a vitamin supplement) 7.Late administration of zinc sulfate (a mineral supplement) 8.Late administration of Eliquis (a medication used to prevent blood clots) The deficient practice of failing to administer medications in accordance with the physician's orders, including any required time frame, increased the risk that Resident 532 may have experienced medical complications possibly resulting in hospitalization . Findings: During a review of Resident 532's Admission Record (a document containing a resident demographic and diagnostic information), dated 4/10/2024, the Admission Record indicated he was admitted to the facility on [DATE] with diagnoses including asthma (a breathing condition characterized by life-threatening inflammation and constriction of the airway) and macular degeneration (an eye disease that causes vision loss.) During a review of Resident 532's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 4/1/2024, the H&P indicated he was unable to make his own medical decisions at this time. During a review of Resident 532's Medication Administration Record (MAR - a record of all active physician orders and medications administered to a resident), for April 2024, the MAR indicated the following medications were due to be administered to Resident 532 at 9:00 AM on 4/10/2024: 1.Pro-Source (a protein supplement) 30 milliliters (ml- a unit of measure for volume) 2.Acidophilus (a probiotic supplement) one capsule (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.Aspirin 81 milligrams (mg - a unit of measure for mass) chewable tablet 4.Lisinopril 10 mg tablet 5.Gabapentin 300 mg capsule 6.Vitamin C liquid 5 ml 7.Zinc Sulfate 50 mg tablet 8.Eliquis 5 mg tablet 9.Symbicort 160-4.5 micrograms (mcg - a unit of measure for mass) inhaler 10.Preservision AREDS2 one tablet During an observation and concurrent interview on 4/10/2024 at 9:43 AM, the licensed vocational nurse (LVN 8) was observed preparing the following medications for Resident 532: 1.Pro-Source (a protein supplement) 30 milliliters (ml- a unit of measure for volume) 2.Acidophilus (a probiotic supplement) one capsule 3.Aspirin 81 milligrams (mg - a unit of measure for mass) chewable tablet 4.Lisinopril 10 mg tablet 5.Gabapentin 300 mg capsule 6.Vitamin C liquid 5 ml 7.Zinc Sulfate 50 mg tablet 8.Eliquis 5 mg tablet LVN 8 stated Resident 532 has a gastrostomy tube (g-tube - a tube surgically placed directly into the stomach for residents unable to take food or medications by mouth) and any medications which were not in liquid form would need to be crushed or opened and mixed with water before administration. During an interview on 4/10/2024 at 10:00 AM, LVN 8 stated Resident 532's Symbicort inhaler was not available in the medication cart, and she would have to contact the pharmacy to order it. During an interview on 4/10/2024 at 10:05 AM, LVN 8 stated Resident 532's Preservision AREDS2 vitamin tablets were not available in the medication cart, and she would have to contact the pharmacy to order them. During an observation on 4/10/2024 at 10:20 AM, LVN 8 was observed beginning the administration of the eight medications listed above one-by-one via Resident 532's g-tube. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/10/2024 at 10:29 AM, LVN 8 was observed completing the administration of the eight medications listed above via Resident 532's g-tube. LVN 8 was not observed administering any other medications to Resident 532 after this time. During an interview on 4/10/2024 at 10:32 AM, LVN 8 stated Resident 532's Preservision AREDS2 vitamins and Symbicort inhaler are unavailable in the cart or anywhere else in the facility so she would be unable to administer them today even though they are scheduled for him. LVN 8 stated the eight medications she administered to Resident 532 today were scheduled for administration at 9:00 AM. LVN 8 stated for medications due at 9:00 AM, the latest they could be administered to be in compliance with the physician's order and facility policy is 10:00 AM. LVN 8 stated all of the medications she administered to Resident 532 today are late today because she was unable to start his medication pass until after 10:00 AM and did not complete it until around 10:30 AM. LVN 8 stated she has around 30 residents to pass medications for every morning including five who have g-tubes and has difficulty passing medications on time consistently due to this workload and the medical acuity of the residents on her unit. LVN 8 stated she wishes that residents with g-tubes could be more evenly distributed around the facility because their medication pass takes significantly longer. During a review of Resident 532's MAR between 4/1/2024 and 4/10/2024, the MAR indicated Symbicort inhaler was administered a total of eight times at 9:00 AM on 4/1, 4/2, 4/3, 4/4, 4/5, 4/6, 4/9, and 4/10/2024, five of which were documented by LVN 8 on 4/4, 4/5, 4/6, 4/9 and 4/10/2024. During a review of Resident 532's MAR between 4/1/2024 and 4/9/2024, the MAR indicated Preservision AREDS2 vitamins were administered a total of 18 times, every day at 9:00 AM and 5:00 PM, four of which were documented by LVN 8 on 4/4, 4/5, 4/6, and 4/9/2024. During an interview on 4/10/2024 at 12:32 PM, LVN 8 stated Resident 532's Symbicort inhaler and Preservision AREDs2 vitamins have never been received from the pharmacy due to an issue with the cost of the medications. LVN 8 stated both medications were scheduled to start for Resident 532 on 4/1/2024 and currently, the facility has failed to resolve the issue with the pharmacy or follow-up with the physician to order an alternative. LVN 8 stated the checkmarks in the MAR with her initials between 4/1/2024 and 4/10/2024 indicated that a medication was successfully administered to a resident. LVN 8 stated she marked the MAR that Symbicort was administered five times at 9:00 AM on 4/4, 4/5, 4/6, 4/9, and 4/10/2024. LVN 8 stated she marked the MAR that Preservision AREDS2 vitamins were administered when they were not four times at 9:00 AM on 4/4, 4/5, 4/6, and 4/9/2024. LVN 8 stated due to her high workload she likely marked them in error because she checked off the resident's entire MAR at the end of the pass and did not check to see which medications were actually administered and which were not. LVN 8 stated if a medication is unavailable, it should not have a checkmark in the MAR. LVN 8 stated if she is unable to complete a medication administration, the MAR should indicate it was not given with a corresponding documentation in the nurses' progress notes explaining the circumstances. LVN 8 stated administering medications late increases the risk that they could be ineffective or could be given too closely to the next dose which could result in medical complications. LVN 8 stated not administering Resident 532's Symbicort for ten days increased the risk that Resident 532's asthma would worsen possibly resulting in breathing issues requiring hospitalization . LVN 8 stated that marking the MAR that medications were administered when they were not creates the risk that Resident 532's physician may increase the dosage on medications that falsely look ineffective increasing the risk that the resident may experience side effects related to their use, resulting in a decreased quality of life. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/10/2024 at 2:32 PM with the Director of Nursing (DON), the DON stated when a medication is unavailable to give, the LVN must notify the pharmacy, the resident's physician, and let her (the DON) know about the missing medication as it will be treated as a medication error. The DON stated none of the LVNs contacted her about missing medications for Resident 532. The DON stated it is unacceptable to sign the MAR that medications were administered when they are not available in the building. The DON stated a medication scheduled for 9:00 AM must be administered to the resident by 10:00 AM to be considered on time. The DON stated not administering medications or administering them late could result in medical complications that could possibly result in hospitalization . A review of the facility's policy Medication Administration, dated 9/2/2022, indicated Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by a physician and in accordance with professional standards of practice . administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician . sign MAR after administered .

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40994 Based on observation, interview, and record review, the facility failed to administer ten doses of Symbicort inhaler (a medication used to treat breathing problems) between 4/1/2024 and 4/10/2024 for one of four residents observed for medication administration (Resident 532.) The deficient practice of failing to administer Symbicort inhaler per the physician's order increased the likelihood that Resident 532 could have developed worsening asthma (a breathing condition characterized by life-threatening inflammation and constriction of the airway) possibly resulting in hospitalization or death. Findings: During a review of Resident 532's Admission Record (a document containing a resident demographic and diagnostic information), dated 4/10/2024, the Admission Record indicated he was admitted to the facility on [DATE] with diagnoses including asthma and macular degeneration (an eye disease that causes vision loss.) During a review of Resident 532's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 4/1/2024, the H&P indicated he was unable to make his own medical decisions at this time. During a review of Resident 532's Medication Administration Record (MAR - a record of all active physician orders and medications administered to a resident), for April 2024, the MAR indicated Symbicort 160-4.5 micrograms (mcg - a unit of measure for mass) inhaler was scheduled to be given every day starting on 4/1/2024 at 9:00 AM for asthma. During an observation and concurrent interview on 4/10/2024 at 9:43 AM, licensed vocational nurse (LVN) 8 was observed preparing the following medications for Resident 532: 1.Pro-Source (a protein supplement) 30 milliliters (ml- a unit of measure for volume) 2.Acidophilus (a probiotic supplement) one capsule 3.Aspirin 81 milligrams (mg - a unit of measure for mass) chewable tablet (a medication used to prevent blood clots) 4.Lisinopril 10 mg tablet (a medication used to treat high blood pressure) 5.Gabapentin 300 mg capsule (a medication used to treat pain) 6.Vitamin C liquid 5 ml (a vitamin supplement) 7.Zinc Sulfate 50 mg tablet (a supplement) 8.Eliquis 5 mg tablet (a medication used to prevent blood clots) (continued on next page)

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F 0760

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

LVN 8 stated Resident 532 has a gastrostomy tube (g-tube - a tube surgically placed directly into the stomach for residents unable to take food or medications by mouth) and any medications which were not in liquid form would need to be crushed or opened and mixed with water before administration.

During an interview on 4/10/2024 at 10:00 AM, LVN 8 stated Resident 532's Symbicort inhaler was not available in the medication cart, and she would have to contact the pharmacy to order it.

During an observation on 4/10/2024 at 10:20 AM, LVN 8 was observed beginning the administration of the eight medications listed above one-by-one via Resident 532's g-tube.

During an observation on 4/10/2024 at 10:29 AM, LVN 8 was observed completing the administration of the eight medications listed above via Resident 532's g-tube. LVN 8 was not observed administering any other medications for Resident 532 after this time.

During an interview on 4/10/2024 at 10:32 AM, LVN 8 stated Resident 532's Symbicort inhaler is unavailable in the cart or anywhere else in the facility so she will be unable to administer it today even though it is scheduled.

During a review of Resident 532's MAR between 4/1/2024 and 4/10/2024, the MAR indicated Symbicort inhaler was administered a total of eight times at 9:00 AM on 4/1, 4/2, 4/3, 4/4, 4/5, 4/6, 4/9, and 4/10/2024, five of which were documented by LVN 8 on 4/4, 4/5, 4/6, 4/9 and 4/10/2024.

During an interview on 4/10/2024 at 12:32 PM, LVN 8 stated Resident 532's Symbicort inhaler has never been received from the pharmacy due to an issue with the cost of the medication. LVN 8 stated the Symbicort was scheduled to start for Resident 532 on 4/1/2024 and currently, the facility has failed to resolve the issue with the pharmacy or follow-up with the physician to order an alternative. LVN 8 stated the checkmarks in the MAR with her initials between 4/1/2024 and 4/10/2024 indicated that a medication was successfully administered to a resident. LVN 8 stated she marked the MAR that Symbicort was administered five times at 9:00 AM on 4/4, 4/5, 4/6, 4/9, and 4/10/2024. LVN 8 stated due to her high workload she likely marked them in error because she checked off the resident's entire MAR at the end of the pass and did not check to see which medications were actually administered and which were not. LVN 8 stated if a medication is unavailable, it should not have a checkmark in the MAR. LVN 8 stated if she is unable to complete a medication administration, the MAR should indicate it was not given with a corresponding documentation in the nurses' progress notes explaining the circumstances. LVN 8 stated not administering Resident 532's Symbicort for ten days increased the risk that Resident 532's asthma will worsen possibly resulting in breathing issues requiring hospitalization . LVN 8 stated that marking the MAR that medications were administered when they were not creates the risk that Resident 532's physician may increase the dosage on medications that falsely look ineffective increasing the risk that the resident may experience side effects related to their use, resulting in a decreased quality of life.

During an interview on 4/10/2024 at 2:32 PM, with the Director of Nursing (DON), the DON stated when a medication is unavailable to give, the LVN must notify the pharmacy, the resident's physician, and let her (the DON) know about the missing medication as it will be treated as a medication error. The DON stated none of the LVNs contacted her about missing medications for Resident 532. The DON stated it is unacceptable to sign the MAR that medications were administered when they are not available in the building. The DON stated not administering medications or administering them late could result in medical complications that could possibly result in hospitalization .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy (P&P)Medication Administration, dated 9/2/2022, the P&P indicated Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by a physician and in accordance with professional standards of practice . administer within 60 minutes prior to or after scheduled time unless otherwise orders by physician . sign MAR after administered .

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40994 44423 Based on observation, interview, and record review the facility failed to: 1.Ensure five expired insulin (a medication used to control high blood sugar) pens and one expired insulin vial were removed from the medication cart affecting Residents 36, 38, 50, and 67 in one of two inspected medication carts (Station 2 Medication Cart). 2.Ensure two unopened insulin pens and one unopened insulin vial were stored in the refrigerator according to the manufacturer's requirements affecting residents 1, 14, and 35 in one of two inspected medication carts (Middle Medication Cart.) 3.Secure a medication in a locked storage area for one of six (6) residents (Resident 22) by leaving Hydrocortisone ([corticosteroid-anti-inflammatory] cream medication used to relieve itching) 2.5 % ([%] unit of measurement) at Resident 22's bedside unattended, without a physician's order. These deficient practices of failing to store medications per the manufacturers' requirements and remove expired medications from the medication carts increased the risk that Residents 1, 14, 35, 36, 38, 50, and 67 could have received medication that had become ineffective or toxic due to improper storage possibly leading to health complications resulting in hospitalization or death. The deficient practice placed Resident 22 at risk for medication errors and had the potential for burning of the skin, purpura (when small blood vessels leak blood under the skin), steroid atrophy (thinning of the skin and results from prolonged use of potent topical steroids) and unsafe medication administration to the wrong resident. Findings: During a concurrent observation and interview on 4/10/2024 at 1:41 PM of Station 2 Medication Cart with licensed vocational nurse (LVN) 4, the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: 1.One opened insulin lispro (a type of insulin) pen for Resident 38 was found labeled with an open date of 3/12/2024. According to the manufacturer's product labeling, open insulin lispro should be used or discarded within 28 days after opening. 2.One opened Lantus insulin (a type of insulin) pen for Resident 67 was found labeled with an open date of 3/12/2024. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the manufacturer's product labeling, open Lantus insulin should be used or discarded within 28 days after opening. 3.One opened insulin lispro pen for Resident 67 was found labeled with an open date of 3/12/2024. According to the manufacturer's product labeling, open insulin lispro should be used or discarded within 28 days after opening. 4.One opened Basaglar insulin (a type of insulin) pen for Resident 36 was found labeled with an open date of 3/11/2024. According to the manufacturer's product labeling, open Basaglar insulin should be used or discarded within 28 days after opening. 5.One opened insulin aspart (a type of insulin) pen for Resident 50 was found labeled with an open date of 3/12/2024. According to the manufacturer's product labeling, open insulin lispro should be used or discarded within 28 days after opening. 6.One opened Admelog insulin (a type of insulin) vial for Resident 36 was found labeled with an open date of 3/12/2024. According to the manufacturer's product labeling, open insulin lispro should be used or discarded within 28 days after opening. LVN 4 stated the insulin for Residents 38, 50, and 67 that were opened on 3/12/2024 expired on 4/9/2024 and the insulin opened for Resident 36 on 3/11/2024 expired on 4/8/2024. LVN 4 stated there is no other insulin in the facility for these residents and they woul have to reorder from the pharmacy for each of them. LVN 4 stated expired insulin could be ineffective at controlling blood sugar levels and administering it to residents could result in medical complications requiring hospitalization . During a concurrent observation and interview on 4/10/2024 at 2:08 PM of the Middle Medication Cart with LVN 1, the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: 1.One unopened Novolin R (a type of insulin) pen for Resident 1 was found in the medication cart stored at room temperature. According to the manufacturer's product labeling, unopened Novolin R pens should be stored in the refrigerator. 2.One unopened Humalog (a type of insulin) pen for Resident 35 was found in the medication cart stored at room temperature. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the manufacturer's product labeling, unopened Humalog pens should be stored in the refrigerator. 3.One unopened Lantus insulin vial for Resident 14 was found in the medication cart stored at room temperature. According to the manufacturer's product labeling, unopened Lantus insulin vials should be stored in the refrigerator. LVN 1 stated the insulin for Residents 1, 14, and 35 are unopened and should be stored in the refrigerator. LVN 1 stated it is not known when these medications were initially stored at room temperature and thus impossible to know when they expire. LVN 1 stated when the pharmacy delivers insulin, it should be stored directly in the refrigerator, not the cart, until they are needed. LVN 1 stated that using ineffective insulin for a resident could cause medical complications due to loss of blood sugar control. During a review of the facility's policy (P&P) titled Storage of Medications, dated April 2008, the P&P indicated Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations of those of the supplier . Medications requiring 'refrigeration' .are kept in a refrigerator with a thermometer to allow temperature monitoring . Outdated, contaminated, or deteriorated medications . are immediately removed from stock, disposed of according to procedures for medication disposal . B.During an observation on 4/9/2024 at 1:00 p.m. during the initial tour, Hydrocortisone medication was found in a cup left on Resident 22's bedside table unattended by licensed staff. During a review of Resident 22's Admission Record (face sheet) dated 8/12/2016, the Admission Record indicated Resident 22 was admitted to the facility with diagnoses of hypertension (high blood pressure), glaucoma (a group of eye diseases that can cause vision loss and blindness by damaging a nerve), contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of the both ankles and morbid obesity (weight is more than 80 to 100 pounds above their ideal body weight). During a review of Resident 22's Minimum Data Set (MDS - a standardized assessment and care-screening tool) dated1/23/2024, the MDS indicated Resident 22 was cognitively (a way that relates to thinking, or with conscious mental processes) alert and oriented and able to make daily decisions regarding activities of daily living (ADLs). During a review of Resident 22's physician orders (PO) dated 3/11/2024, the PO indicated Resident 22 had an order for Hydrocortisone 2.5% topical cream to apply to the body every day for a diagnosis of skin dermatitis (a disease that causes inflammation, redness, and irritation of the skin). During a concurrent observation and interview on 4/9/2024 at 1:02 p.m. with Resident 22 at the bedside, Resident 22 stated, she has a rash all over her body, so she likes to keep the Hydrocortisone cream at her bedside, so she doesn't have to wait for the nurse when she is itching. Resident 22 stated, the licensed nurses know the cream is stored on her bedside table. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Villa Del Sol Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 16910 Woodruff Ave. Bellflower, CA 90706	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/9/2024 with the Licensed Vocational Nurse (LVN 4), LVN 1 stated, medication should not be left at the bedside even if the resident is alert. LVN 4 stated if medication is left at the bedside, a resident could overdose, and the prescribed medication dose is not being monitored by licensed staff. During an interview on 4/9/2024 at 1:07 p.m. with the Treatment Nurse (TN), the TN stated, the medication was left at the bedside because Resident 22 wanted it there and Resident 22 is alert and oriented. The TN stated, if medication is left at the bedside, there should be a physician order for the resident to self-administer the medication and it must be documented in the care plan. During a concurrent interview and record review on 4/9/2024 at 3:01 p.m., the TN stated, there was no physician order for Resident 22 to have medications stored at her bedside. The TN confirmed there was no care plan for self-administration of medication in the electronic medical record (EMR). During an interview on 4/12/2024 at 2:13 p.m. with the Director of Nurses (DON), the DON stated you need a doctor's order to leave medication at the bedside, even if a resident request it. The DON stated an Interdisciplinary Care Team meeting ([IDT] a group of professional and direct care staff that have primary responsibility for the development of a plan for the care and treatment of a patient) must be done to determine if a resident is alert and oriented to leave medications at the bedside. The DON stated it must also be documented in the resident's care plan. The DON stated, if medications are inappropriately left at the resident bedside unattended, another resident could ingest it and it could cause poisoning. During a review of the facility's job description titled Licensed Vocational Nurse, dated 2003, the job description indicated the Licensed Vocational Nurse should prepare and administer medications as ordered by the physician. The job description indication to ensure that prescribed medication for one resident is not administered to another. During a review of the facility policy and procedure (P&P) titled Medication Storage revised 12/18/2022, the P&P indicated it is the policy of the facility to ensure all medications are housed on their premises will be stored in the pharmacy and/or medication rooms The P&P indicated all drugs and biologicals will be store in locked compartments. The P&P indicated during medication pass, medications must be under the direct observation of the person administering medications or locked in the medication cart. During a review of the facility P&P titled Medication Administration revised 9/2/2022, the P&P indicated medications are administered by licensed nurses or other staff who are legally authorized to do so as ordered by the physician and in accordance with professional standards of practice. During a review of the facility P&P titled Resident Self-Administration of Medication revised 12/19/2022, the P&P indicated a resident may only self-administer medications after the facility's interdisciplinary team has determined which medication may be self-administered safely. The P&P indicated bedside medication storage is permitted if the manner of storage prevents access by other residents. The P&P indicated all nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 38740 Based on observation, interview, and record review, the facility failed to follow lunch menu and portion sizes as written for residents on mechanical soft (a type of texture-modified diet for people who have difficulty chewing and swallowing) and pureed (pudding consistency food that does not required chewing) diet. 18 residents on the mechanical soft diet received 3 ounces (oz - a unit of measure of weight) of ground roast beef instead of 4 oz and seven residents on the pureed diet received 3 oz of pureed roast beef instead of 5 1/3 oz per the food portion and serving guide. This deficient practice had the potential to result in meal dissatisfaction, decreased nutritional intake and weight loss. Findings: According to the facility's lunch menu for the mechanical soft and pureed diet on 4/09/2024, the following items will be served: Mechanical soft diet: Roast beef Au Jus Ground (scoop #8 yielding 4 oz); Red potatoes (scoop #8); Savory peas (scoop #8), bread with butter, beverage of choice, brownie. Pureed diet: Roast beef Au Jus pureed (scoop #6 yielding 5 1/3 oz); Red potatoes pureed (scoop #8); savory peas pureed (scoop #12 yielding 2 2/3 oz), pureed bread; beverage of choice, pureed brownie. During an observation of the tray line service for lunch on 4/09/2024, at 11:45AM, for the residents who were on the mechanical soft diet the cook served ground roast beef using scoop #10 yielding 3 oz of ground beef instead of 4 oz per menu and for residents who were on the pureed diet the cook served pureed roast beef using scoop #10 yielding 3 oz of pureed beef instead of using scoop #6 (5 1/3 oz) per menu. During an interview with Cook2 on 4/09/2024, at 12:40PM, Cook2 stated the cooks should follow the spreadsheet (food portion and serving guide) to determine what scoop size to use to serve. During a concurrent interview and review of the spreadsheet (food portion and serving guide) Cook2 stated they made a mistake and used a smaller scoop to serve residents on the pureed diet and residents on the mechanical soft diet. Cook 2 stated they served less protein than the amount stated on the menu to residents on the pureed and mechanical soft diet. During a concurrent interview and review of recipe for the roast beef with the DS on 4/09/2024, at 12:40PM, the DS stated the recipe for the puree and mechanical soft diet is for 3 ounces of meat. Upon further review of the recipe, the DS verified that the recipe indicated to follow the spreadsheet for serving size. During an interview with Registered Dietitian (RD) on 4/09/2024, at 12:45PM, the RD stated that cooks should always follow the spreadsheet for serving and portion guide. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility recipe for Puree fish/Meat/poultry, the recipe indicated for appropriate portion size, refer to spreadsheet. Attractively present on serving plate. During a review of the facility policy (P&P) titled Menu planning Criteria revised 05/20/2020, the P&P indicated, The food and nutritional needs of residents shall be planned to meet the U.S. dietary guide .in order to provide menus that include safe and adequate intake of essential nutrients. During a review of facility spreadsheet for lunch on 4/09/2024, the spread sheet indicated for Mechanical soft diet: Roast beef Au Jus Ground use (scoop #8 yielding 4 ounces (oz.)) and Pureed diet: Roast beef Au Jus pureed use (scoop #6 yielding 5 1/3 ounces (oz.))

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38740 Based on observation, interview, and record review the facility failed to prepare food by methods that conserved texture and appearance. The texture of the pureed (food prepared with a pudding consistency that does not require chewing) diet was lumpy, not smooth with large pieces of pasta present requiring chewing before swallowing. During a taste test the food required chewing and moving around in the mouth before swallowing. This deficient practice had the potential to result in meal dissatisfaction, decreased intake, risk for unplanned weight loss and placed 7 residents on the pureed diet at risk for choking. Findings: During initial facility tour on 4/09/2024 at 8:30AM, the survey team identified complaints about food choices and preferences. During an observation and interview in the kitchen on 4/10/2024 at 11:50AM, Cook1 was taking the temperatures of the lunch menu on the steam table. Cook1 stated the lunch includes vegetable lasagna, mixed zucchini squash and bread. Cook1 stated a portion of the regular lasagna is taken and pureed to serve to the residents on pureed diet. Cook1 stated the blender is used to puree the lasagna. During an observation of the tray line service for lunch at 12:00PM the pureed lasagna looked dry, firm, and not smooth. During the serving of the pureed lasagna there were small chucky pieces of pasta on the plate. During a taste test of a sample tray on 4/10/2024 at 12:28PM, the pureed lasagna was dry, with a lumpy texture. There were some chunky pieces that required chewing and moving around in the mouth before swallowing. During a concurrent interview with the DS, the DS stated the pureed lasagna does not look smooth. The DS said the consistency of the pureed lasagna is chunky and it could be blended more for a smooth finish. During an observation and interview with Cook1 in the kitchen on 4/10/2024 at 12:45PM, Cook1 said the pureed lasagna today was not smooth, it was chunky. Cook1 stated pasta and rice are hard to blend and require more liquid to get a smooth consistency. Cook1 stated he should blend it longer until smooth. Cook1 stated if puree is not smooth and has pieces of noodles it can be choking risk. Cook1 removed the pureed lasagna from the service table and placed it in the blender, added broth and blended longer until smooth. During a review of facility recipe titled Pureed Casseroles, the recipe indicated, remove portions of cooked casserole from regular prepared recipe, place in blender until smooth .ensure mixture achieves smooth, lump free and extremely thick consistency. During a review of the facility policy (P&P) titled Pureed (PU4) revised 09/15/2021, the P&P indicated, this modification is designed for people who have severe chewing and or swallowing problems. Properly pureed foods eliminate the chewing phase .Puree all foods to a smooth, lump-free, extremely thick consistency (not firm or sticky). (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility P&P titled Mechanically altered Diets and Thickened Liquids revised 09/16/2018, the P&P indicated, mechanically altered diet are prepared and served as prescribed by the attending physician and in a form designed to meet individual needs . (Mechanical Soft, Dysphagia Mechanically altered, pureed).

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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 38740

Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and preparation practices when:

1.One large pan of previously prepared creamy salad dressing was stored in the walk-in refrigerator with a use by date of [DATE] exceeding the storage period. One open container of raw liquid eggs was stored together in the same container with six ham sandwiches. Dry powdered milk stored in a large bin with dates [DATE]-[DATE] was expired and one large expired bag of raisin bran cereal with an open date of [DATE] was stored in the dry storage area. Several items in the walk-in freezer were not dated and labeled, one bag of frozen beef patties, one large bag of frozen shrimp and one box of frozen vegetables stored in the walk-in freezer were not covered, open and exposed to freezer environment.

2.One staff working in the dish washing area did not wash hands before removing the clean and sanitized dishes from the dish washer machine.

3.Food brought to residents from outside of the facility, including leftovers stored in the resident food refrigerator were not dated, one coffee creamer stored in the fridge was expired, one plastic bag containing bread and one container of cream were expired.

These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness in 74 out of 81 residents who received food from the facility and residents who had food stored in the resident refrigerator.

Findings:

1.During an observation in the kitchen on [DATE] at 8:30AM, there was one large pan of previously prepared creamy salad dressing with a use by date of [DATE] stored in the walk-in refrigerator.

During a concurrent observation and interview with the Dietary Supervisor (DS), the DS stated the salad dressing was prepared before and should have been discarded.

During an observation in the kitchen on [DATE] at 9:15AM, there were round breaded patties stored in a bag with no label or date, there was a bag with one frozen chicken stored with no label or date, another bag with frozen meat product that looked like chicken stored with no label and date.

During a concurrent observation and interview with the DS on [DATE] at 9:15AM, the DS said the round patties are crab cakes and the meat product is fish not chicken. The DS stated any food taken out of it's original container should be labeled to identify the food product.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same observation and interview with the DS there was one large, opened bag of shrimp, one large, opened bag of hamburger patties and another box of opened, frozen vegetables that were stored in the walk-in freezer, uncovered and exposed to the freezer environment. The DS stated food should be sealed and tightly covered in the freezer to prevent cross contamination. The DS removed the open bags from the freezer. During an observation in the dry storage area on [DATE] at 9:45AM, there was dry powdered milk stored in a large bin with dates [DATE]-[DATE]. There was an open bag of dry raisin bran cereal with an open date of [DATE] stored in the dry storage area. During an interview with the DS on [DATE] at 9:50AM, the DS stated the powdered milk is used for cooking soups and it is also added to cereal. The DS stated the powdered milk is expired and should have been discarded. The DS stated the storage period for open bags of dry cereal is 3 months and the raisin bran cereal was expired. The DS removed the expired food and discarded them. During a review of facility policy (P&P) titled Food Storage revised [DATE] the P&P indicated, Use Use-By dates on all food stored in refrigerators. Expired or outdated food products should be discarded. Foods to be frozen should be stored in airtight containers or wrapped in heavy duty aluminum foil or special laminated papers. Label and date all food items. During a review of facility P&P titled Use by Date Guide revised [DATE], the P&P indicated, cereal, dry ready to eat, opened use by 3 months .Milk nonfat dry opened use by 3 months. During a review of the 2022 U.S. Food and Drug Administration (FDA- a government agency responsible for protecting public health by assuring the safety, efficacy, and security of including human drugs, biological products, and our nation's food supply) Food Code titled Ready to Eat, Time/Temperature control for safety food, Date Marking Code#,d+[DATE].17, the Food Code indicated, Ready to eat, time temperature control for safety food prepared and packaged by food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed, sold, or discarded. During a review of the 2022 FDA Food Code titled Food Storage Containers, Identified with common name of Food Code ,d+[DATE].12, the Food Code indicted Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use .such as cooking oils, flour, herbs, potato flakes .shall be identified with the common name of the food. 2.During an observation in the dishwashing area on [DATE] at 09:30AM, Dietary Aide (DA) 1 was rinsing soiled dishes and loading the dirty dishes in the dish washing machine. DA1 then dipped his hands in a bucket filled with water located inside the manual dishwashing sink next to the dishwashing machine, DA1 shook the excess water off his hands and proceeded to remove the clean and sanitized dishes from the dish machine. DA1 was wearing a disposable apron and moving from the dirty dishes area to the clean area without changing aprons. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with DA1 on [DATE] at 09:35AM, DA1 stated the bucket is filled with sanitizer solution. DA1 then stated he made a mistake and didn't wash his hands before removing clean and sanitized dishes. DA1 stated dipping hands or rinsing in the sanitizer solution is not affective handwashing. DA1 stated handwashing should be done in the handwashing sink with soap and water and then dry the hands with a towel. DA1 stated he was the only one working in the section and he was trying to finish fast and did not follow handwashing procedures. DA1 stated proper handwashing is important to remove dirt and prevent cross contamination of clean dishes. During an interview with the DS on [DATE] at 09:40AM, the DS said there are two staff assigned for the dishwashing area, one staff works on the dirty dishes side and the other works with the clean dishes to makes sure there is no cross contamination of clean dishes. The DS said handwashing should be done in the handwashing sink with soap and water. During a review of facility's policy (P&P) titled, Dishwashing Procedure revised [DATE], the P&P indicated, Either two people are in the dish room, one on dirty side, one on clean side or if one person does both, they must wash their hands between dirty and clean areas. In addition, aprons must be changed between clean and dirty dish machine areas. 3. During an observation in the resident refrigerator located in the resident dining room on [DATE] at 09:31AM, there was one plastic bag that contained bread for residents dated [DATE]. One open container of coffee creamer with a use by date of [DATE] exceeding the storage period, there were muffins and raspberries with no label or date and one container of cream (yogurt consistency) with a use by date of [DATE] expired and stored in the resident refrigerator. During the same observation there was a frozen dinner of roasted chicken stored in the freezer with no label or date. During a concurrent observation and interview with the activity Director (AD) on [DATE] at 09:40AM, the AD stated that all food is stored for 3 days then discarded. The AD stated resident food brought from outside is checked by nurses and then labeled and dated. The AD stated she was responsible for checking the dates and discarding any food item that were more than 3 days old. The AD removed food that exceeded the use by date and food that had no dates from the refrigerator. The AD stated it is important to date food to know when to discard and to make sure residents don't eat bad food. During a review of facility's P&P titled Food from Outside Sources revised [DATE], the P&P indicated, Perishable food should be sealed and dated with a use by date and placed in refrigeration .designate who will be responsible to clean the refrigerators and who will discard outdated or uneaten foods.

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40994

Based on observation, interview, and record review, the facility failed to:

1.Ensure the medication administration record (MAR - a record of all active physician orders and medications administered to a resident) was not falsified by documenting that Symbicort (a medication used to treat breathing problems) was administered eight times between 4/1/2024 and 4/10/2024 when it was unavailable in the facility for one of four residents observed for medication administration (Resident 532.)

2.Ensure the MAR was not falsified by documenting Preservision AREDS2 vitamins (a vitamin supplement for the eyes) were administered 18 times between 4/1/2024 and 4/9/2024 when it was unavailable in the facility for one of four residents observed for medication administration (Resident 532.)

The deficient practice of falsifying Resident 532's medical record to indicate medications were administered when they were unavailable to administer increased the risk that Resident 532 experienced a deterioration of vision, or worsening asthma (a breathing condition characterized by life-threatening inflammation and constriction of the airway) possibly resulting in hospitalization or death.

Findings:

During a review of Resident 532's Admission Record (a document containing a resident demographic and diagnostic information), dated 4/10/2024, the Admission Record indicated he was admitted to the facility on [DATE] with diagnoses including asthma and macular degeneration (an eye disease that causes vision loss.)

During a review of Resident 532's History and Physical (H&P - a record of a comprehensive physician's assessment), dated 4/1/24, the H&P indicated he was unable to make his own medical decisions.

During a review of Resident 532's MAR for April 2024, the MAR indicated Symbicort 160-4.5 micrograms (mcg - a unit of measure for mass) inhaler was scheduled to be given every day at 9:00 AM starting on 4/1/2024 and Preservision AREDS2 vitamin tablets were scheduled to be given twice daily at 9:00 AM and 5:00 PM.

During an observation and concurrent interview on 4/10/2024 at 9:43 AM, licensed vocational nurse (LVN) 8 was observed preparing the following medications for Resident 532:

1.Pro-Source (a protein supplement) 30 milliliters (ml- a unit of measure for volume)

2.Acidophilus (a probiotic supplement) one capsule

3.Aspirin 81 milligrams (mg - a unit of measure for mass) chewable tablet (a medication used to prevent blood clots)

4.Lisinopril 10 mg tablet (a medication used to treat high blood pressure)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5.Gabapentin 300 mg capsule (a medication used to treat pain) 6.Vitamin C liquid 5 ml (a vitamin supplement) 7.Zinc Sulfate 50 mg tablet (a supplement) 8.Eliquis 5 mg tablet (a medication used to prevent blood clots) LVN 8 stated Resident 532 has a gastrostomy tube (g-tube - a tube surgically placed directly into the stomach for residents unable to take food or medications by mouth) and any medications which were not in liquid form would need to be crushed or opened and mixed with water before administration. During an interview on 4/10/2024 at 10:00 AM, LVN 8 stated Resident 532's Symbicort inhaler was not available in the medication cart, and she would have to contact the pharmacy to order it. During an interview on 4/10/2024 at 10:05 AM, LVN 8 stated Resident 532's Preservision AREDS2 vitamin tablets were not available in the medication cart, and she would have to contact the pharmacy to order them. During an observation on 4/10/2024 at 10:20 AM, LVN 8 was observed beginning the administration of the eight medications listed above one-by-one via Resident 532's g-tube. During an observation on 4/10/2024 at 10:29 AM, LVN 8 was observed completing the administration of the eight medications listed above via Resident 532's g-tube. LVN 8 was not observed administering any other medications for Resident 532 after this time. During an interview on 4/10/2024 at 10:32 AM, LVN 8 stated Resident 532's Preservision AREDS2 vitamins and Symbicort inhaler are unavailable in the cart or anywhere else in the facility so she will be unable to administer them today even though they are scheduled for him. During a review of Resident 532's MAR between 4/1/2024 and 4/10/2024, the MAR indicated Symbicort inhaler was administered a total of eight times at 9:00 AM on 4/1, 4/2, 4/3, 4/4, 4/5, 4/6, 4/9, and 4/10/2024, five of which were documented by LVN 8 on 4/4, 4/5, 4/6, 4/9 and 4/10/2024. During a review of Resident 532's MAR between 4/1/2024 and 4/9/2024, the MAR indicated Preservision AREDS2 vitamins were administered a total of 18 times, every day at 9:00 AM and 5:00 PM, four of which were documented by LVN 8 on 4/4, 4/5, 4/6, and 4/9/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055918	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Del Sol Post Acute	16910 Woodruff Ave. Bellflower, CA 90706

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/10/2024 at 12:32 PM, LVN 8 stated Resident 532's Symbicort inhaler and Preservision AREDs2 vitamins have never been received from the pharmacy due to an issue with the cost of the medications. LVN 8 stated both medications were scheduled to start for Resident 532 on 4/1/2024 and currently, the facility has failed to resolve the issue with the pharmacy or follow-up with the physician to order an alternative. LVN 8 stated the checkmarks in the MAR with her initials between 4/1/2024 and 4/10/2024 indicated that a medication was successfully administered to a resident. LVN 8 stated she marked the MAR that Symbicort was administered five times at 9:00 AM on 4/4, 4/5, 4/6, 4/9, and 4/10/2024. LVN 8 stated she marked the MAR that Preservision AREDS2 vitamins were administered when they were not four times at 9:00 AM on 4/4, 4/5, 4/6, and 4/9/2024. LVN 8 stated due to her high workload she likely marked them in error because she checked off the resident's entire MAR at the end of the pass and did not check to see which medications were actually administered and which were not. LVN 8 stated if a medication is unavailable, it should not have a checkmark in the MAR. LVN 8 stated if she is unable to complete a medication administration, the MAR should indicate it was not given with a corresponding documentation in the nurses' progress notes explaining the circumstances. LVN 8 stated not administering Resident 532's Symbicort for ten days increased the risk that Resident 532's asthma would worsen possibly resulting in breathing issues requiring hospitalization . LVN 8 stated that marking the MAR that medications were administered when they were not created the risk that Resident 532's physician may increase the dosage on medications that falsely look ineffective increasing the risk that the resident may experience side effects related to their use, resulting in a decreased quality of life. During an interview on 4/10/2024 at 2:32 PM, with the Director of Nursing (DON), the DON stated when a medication is unavailable to give, the LVN must notify the pharmacy, the resident's physician, and let her (the DON) know about the missing medication as it will be treated as a medication error. The DON stated none of the LVNs contacted her about missing medications for Resident 532. The DON stated it is unacceptable to sign the MAR that medications were administered when they are not available in the building. The DON stated not administering medications or administering them late could result in medical complications that could possibly result in hospitalization . During a review of the facility's policy (P&P) titled Medication Administration, dated 9/2/22, the P&P indicated Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by a physician and in accordance with professional standards of practice . administer within 60 minutes prior to or after scheduled time unless otherwise orders by physician . sign MAR after administered . During a review of the facility's P&P titled Documentation in Medical Record. Dated 9/2/22, the P&P indicated Each resident's medical record shall contain a representation of the experiences of the resident and include enough information to provide a picture of the resident's progress . Principles of documentation include, but are not limited to: Documentation shall be factual, objective, and resident centered . false information shall not be documented .

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	055918	A. Building B. Wing	04/12/2024

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Villa Del Sol Post Acute	16910 Woodruff Ave. Bellflower, CA 90706

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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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46415 Based on observation, interview and record review, the facility failed to observe infection control measures on one of one sampled resident (Resident 2) by failing to perform hand hygiene in between resident contacts. This deficient practice had the potential to transmit infectious microorganisms and increase the risk of infection to the residents. Findings: During a review of Resident 2's Admission Record, indicated the Resident 2 was admitted on [DATE] and was readmitted on [DATE] with diagnoses including multiple sclerosis (chronic disease of the central nervous system), contracture (hardening of muscle) and idiopathic neuropathy (disorder that affects the peripheral nervous system), hypertensive disease (high blood pressure), seizures (sudden uncontrolled burst of electric activity of the brain), unstageable pressure ulcer of sacral region. During a review of Resident 2's Minimum Data Set (MDS a standardize assessment and care screening tool) dated 3/27/2024, indicated Resident 2 as had moderate impairment cognitively (mental action or process of acquiring knowledge and understanding ability) and have functional impairments on both the right side and left side of the upper (arms, shoulders) and lower (hip, legs) extremities. The MDS indicated Resident 2 was dependent on all aspects of the activities of daily living ([ADL] fundamental skills required to independently care for oneself like eating and bathing). During an observation on 4/11/2024 at 12:20p.m., Certified Nursing Assistant 1 (CNA 1) was observed getting a chair from an Enhanced Standard Precaution ([ESP] infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) room that was next to Resident 2's room. CNA 1 was observed not performing hand hygiene prior to entering the neighboring room and proceeded to retrieve a chair from the ESP room. CNA 1 was observed bringing the chair into Resident 2's room and placed it next to Resident 2's bed on the left side with no hand hygiene observed. CNA 1 did not clean the chair prior to putting it right next to residents left side. During an observation on 4/11/2024 at 12:52p.m., CNA 1 sat down next to Resident 2 and was on the process of feeding Resident 2 when Resident 2's roommate requested to have his urinal emptied. CNA 1 stood up, did not perform hand hygiene, put gloves on, and went to assist Resident 2's roommate. During an observation on 4/11/2024 at 1:15 p.m., CNA 1 removed the chair from Resident 2's room and returned the chair back into the neighboring ESP room without performing hand hygiene upon entering and did not clean the chair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/11/2024 at 1:16 p.m. with CNA 1, CNA 1 stated the neighboring room has a resident that has a foley catheter (a drainage port that helps drain using from your bladder) which is the indication for the ESP. CNA 1 stated he took the chair from the neighboring room because there were no other chairs and Resident 2 needed to be fed. CNA 1 stated bringing a chair from another room without disinfecting it can cause cross contamination (physical movement or transfer of harmful bacteria from one person, object or place to another). CNA 1 stated prior to taking the chair from the ESP room, he could have disinfected the chair and get wipes from the nursing station. CNA 1 stated hand hygiene was performed before and after patient care, when touching certain linens, and entering different rooms. CNA 1 stated when he was about to feed Resident 2, he got up, put gloves on and went to empty the neighboring resident's urinal. CNA 1 stated when going from one resident to another resident, he should have washed his hands before putting on gloves. CNA 1 stated improper hand hygiene can cause skin infection that can spread to other nurses and residents. During an interview on 4/11/2024 at 2:23p.m. with Infection Preventionist Nurse (IPN), IPN stated hand hygiene was performed and after entering the room, when their hands were visibly dirty, or when touching high touch surface areas. IPN stated since the ESP were for residents and not for items in the room, staffs gown up only when doing patient care. IPN stated prior to placing an item that was taken from a different room must be disinfected as germs may be on that item. IPN stated hand hygiene was performed to prevent cross contamination, eliminate germs, and must do hand hygiene prior to wearing gloves to assisting the adjacent room. IPN stated improper hand hygiene can increase infection. During an interview on 4/12/2024 at 2:35 p.m. with Director of Nursing (DON), the DON stated hand hygiene should be performed before and after patient care and prior to putting on gloves. The DON stated hand hygiene should be done between each resident care since it was unknown what the resident may have and could result in cross contamination. During a review of the facility's policy and procedure (P&P) titled, Hand Hygiene, revised 12/19/2022, the P&P indicated all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning loves, and immediately after removing gloves. Either soap and water or alcohol-based hand rub (ABHR is preferred) between resident contacts, after handling contaminated objects, before applying and after removing personal protective equipment (PPE), including gloves. During a review of the facility's P&P titled, Infection Prevention and Control Program, revised 12/19/2022, the P&P indicated hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization or soiled or contaminated equipment.

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NAME OF PROVIDER OR SUPPLIER Villa Del Sol Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 16910 Woodruff Ave. Bellflower, CA 90706	

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41699 Based on interview and record review, the facility failed to implement their protocol for Antibiotic Stewardship for one of three sampled residents (Resident 62). Resident 62 was prescribed antibiotic drug without meeting the criteria, before being screen for tooth infection (commonly occur when bacteria invade the pulp and spread to surrounding tissues). This deficient practice had the potential for resident to develop antibiotic resistance (not effective to treat infection) from unnecessary or inappropriate antibiotic use. Findings: During a review of Resident 62's Admission Record (AR), the Admission Record indicated Resident 62 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including peripheral vascular disease (the reduced circulation of blood to a body part other than the brain or heart), heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), and chronic kidney disease (your kidneys are damaged and can't filter blood the way they should). During a review of Resident's 62's Minimum Data Set ([MDS] a standardized assessment and screening tool), dated 2/23/2024, the MDS indicated Resident 62 had no cognitive impairment (ability to learn, understand, and make decisions) and requires substantial assistance for toilet hygiene, shower, lower body dressing and putting on and taking off footwear. During a review of Resident 62's medication administration record dated 4/2024 indicated Resident 62 started taking clindamycin HCL (an antibiotic that fights bacteria in the body) oral capsule 150 mg (unit of measurement) on 4/6/2024, Resident 62 to take one capsule by mouth four times daily for swelling times ten days. During a concurrent interview and record review (RR) on 04/11/2024 at 12:54 p.m., the infection preventionist (IP) stated that blood works should have been ordered and done so that it can be useful to determine if there was really a tooth infection. The IP stated that giving unnecessary antibiotic puts the resident high risk for antibiotic resistance and high risk for clostridium difficile (a germ [bacterium] that causes diarrhea and colitis [an inflammation of the colon]). RR indicated there was no blood works done and indicated Resident 62 does not meet the requirement for tooth infection because the facility was just basing it on pain and swelling. During an interview on 04/11/2024 at 1:13 p.m., the director of nurses (DON) stated that it is a must for all infection and resident must undergo blood works or any form of testing to make sure resident does not use any antibiotic for nothing and to make sure the antibiotic the resident is taking is sensitive to the bacteria or the causative agent and it prevents from developing antibiotic resistance and prevent clostridium difficile. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Policy and Procedure (P&P) titled, Antibiotic Stewardship Program, revised 12/19/2022, the P&P indicated, it is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. Nursing staff shall assess residents who are suspected to have an infection and complete an SBAR form prior to notifying the physician. Laboratory testing shall be in accordance with current standards of practice. 46415

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44423 Based on interview, and record review the facility failed to offer the pneumonia (PNA) (an infection of the lungs) vaccinations (medication to prevent a particular disease) for two of six sampled residents (Resident 8 and Resident 48). This deficient practice placed Resident 8 and Resident 48 at a higher risk of acquiring and transmitting pneumonia to other residents in the facility. Findings: A. During a review of Resident 8's Admission Record, the Admission Record indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including dementia (a condition characterized by progressive or persistent loss of intellectual functioning), chronic obstructive pulmonary disease ([COPD] a condition involving constriction of the airways and difficulty or discomfort in breathing), and anemia (low blood levels). During a review of the Minimum Data Set ([MDS] a comprehensive assessment and care screening tool) dated 3/8/2024, the MDS indicated Resident 8 was severely impaired cognitively (hard time remembering things, making decisions, concentrating, or learning) and was not able to make decisions for activities of daily living (ADLs). During a review of Resident 8's Medical Record dated 2/18/2021, indicated Resident 8 refused to receive the pneumonia vaccine and was not offered the pneumonia vaccine in 2022, 2023 or 2024. During an interview on 4/11/2024 at 9:18 a.m. with the Infection Preventionist (IP), the IP stated the pneumonia vaccine was usually offered with the flu vaccine, but Resident 8 was not offered the pneumonia vaccine this year. The IP stated she did not follow up with Resident 8 to see if he wanted the pneumonia vaccine. The IP stated it was important for Resident 8 to receive the pneumonia vaccine to prevent him from getting pneumonia disease and the symptoms wouldn't be so severe. The IP stated the pneumonia vaccine should be offered to residents once a year. The IP stated Resident 8 was not offered the pneumonia vaccine by the facility since 2019. B. During a review of Resident 48's Admission Record, the Admission Record indicated Resident 48 was admitted to the facility on [DATE], with diagnoses including schizophrenia (a serious mental condition of a type involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and muscle weakness. During a review of the MDS dated [DATE], the MDS indicated Resident 48 was severely impaired cognitively and was not able to make decisions for activities of daily living (ADLs). During a review of Resident 48's Medical Record (MR) dated 2/18/2021, indicated Resident 48 refused to receive the pneumonia vaccine on 3/22/2022 and was not offered the pneumonia vaccine in 2023 and 2024. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/11/2024 at 9: 22 a.m. with the IP, the IP stated the pneumonia vaccine was usually offered with the flu vaccine but Resident 48 was not offered the pneumonia vaccine this year. The IP stated she did not follow up with Resident 48 to see if she wanted the pneumonia vaccine. The IP stated it was important for Resident 48 to receive the pneumonia vaccine to prevent her from getting pneumonia disease and the symptoms wouldn't be so severe. The IP stated the pneumonia vaccine should be offered to residents once a year. The IP stated Resident 48 was not offered the pneumonia vaccine by the facility since 2021. During an interview on 4/12/2024 with the Director of Nurses (DON), the DON stated the IP reviews the resident's history for the pneumonia vaccine and it was not given, it should be offered to the residents. The DON stated if a resident refuses the pneumonia vaccine, it should be offered by the facility three times and then documented. The DON stated if a resident was offered to a resident in 2016 or 2019, it should be re-offered by the facility. The DON stated it was important for residents over [AGE] years old to get the pneumonia vaccine to decrease the risk of respiratory infections, like pneumonia. During a review of the facility policy and procedure (P&P) titled Pneumococcal Vaccine Series dated 12/19/2022, the P&P indicated it was the facility policy to offer our residents, staff, and volunteer workers immunization against pneumococcal disease in accordance with current CDC ([Centers for Disease Control] the nation's leading science-based, data-driven, service organization that protects the public's health) guidelines and recommendations. The P&P indicated each resident will be offered a pneumococcal immunization unless it is medically contraindicated, or the resident has already been immunized.