STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056104	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Villa Health Care Center	9028 Rose Street 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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on observation, interview and record review, the facility failed to develop and implement a policy for use of, sensor alarm pads (a device that alerts staff when a resident moves or leaves their bed or chair) and to ensure consistent monitoring of the use of the sensor alarm pads for the bed and chair, for one of three sampled residents (Resident 26) while the sensor alarm pads were utilized. This deficient practice had the potential to place Resident 26 at risk for decline in physical functioning, reduced mobility, and loss of dignity due to the unmonitored use of sensor alarm pads. Findings: During a review of Resident 26's Admission Record, the Admission Record indicated Resident 26 was originally admitted on [DATE] with a re-admitted on 3/22/2025 with diagnoses of chronic obstructive pulmonary disease ([COPD], a chronic lung disease causing difficulty in breathing), hypertension ([HTN], high blood pressure), dementia (a progressive state of decline in mental abilities), and atrial fibrillation ([A-Fib], (a condition that causes irregular and fast heartbeat in the heart). During a review of Resident 26's History and Physical (H/P) dated 3/25/2025, the H/P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 26's Minimum Data Set ([MDS], a resident assessment tool) dated 3/26/2025, the MDS indicated Resident 26 was severely cognitively (ability to make decisions of daily living) impaired and required moderate assistance (helper does less than half the effort) on self-care abilities such as eating, required maximal assistance (helper does more than half the effort to complete the task) with oral hygiene, toileting hygiene, shower/bathe, upper and lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 26 required maximal assistance with mobility such as rolling left and right, sitting to lying position, lying to sitting on side of bed, bed to chair transfers, and toilet transfers. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 26's Order Summary Report, the Order Summary Report indicated, sensor pad alarm while in bed to alert staff when Resident 26 is trying to get out of bed unassisted, informed consent obtained by medical doctor from responsible party, ordered on 3/22/2025. The Order Summary Report indicated sensor pad alarm in wheelchair to alert staff when Resident 26 is trying to get out of wheelchair unassisted informed consent obtained by medical doctor from responsible party ordered on 3/22/2025. During a review of Resident 26's Medication Administration Record ([MAR], used to document medications taken by the resident) for April 2025, there was missing documentation for April 5th during the nocturnal shift, April 14th during night shift, April 21st during night and nocturnal shift to monitor the resident when the sensor alarm pads were in use. During an observation on 4/21/2025 at 10:47 a.m., in Resident 26's room, Resident 26 was resting in bed with eyes closed. There was a box attached to the bed with a wire attached to the box connect to the alarm pad underneath Resident 26 who as resting in bed. During a concurrent interview and record review on 4/23/2025 at 2:59 p.m., with the MDS Coordinator (MDSC), Resident 26's MAR for April 2025 was reviewed. The MDSC stated staff should be monitoring the residents and the sensor alarm pads every shift to make sure the sensor alarms pads were still there and if the sensor alarm pads were working properly. The MDSC stated if the monitoring was not done every shift or as needed, the residents could be at risk for falls. The MDSC stated monitoring should be done every shift to make sure residents are safe and it should have been documented in the MAR. The MDSC stated if it was not documented, the monitoring was not done. The MDSC stated not aware if there was a policy for sensor alarm pads being utilized. During an interview on 4/24/2025 at 3:20 p.m. with the Director of Nursing (DON), the DON stated sensor alarm pads should be monitored every shift. The DON stated the importance of monitoring the residents and the sensor alarm pads was to make sure the sensor alarm pads were functioning and in place. The DON stated monitoring of the sensor alarm pads should be done every shift and documented to make sure the sensor alarm pads were serving their purpose of alerting staff [NAME] Resident 26 tried to get up unassisted. The DON stated high fall risk residents will fall if monitoring was not done every shift or as needed. The DON stated there was no policy and/or procedure for the bed and chair sensor alarm pads being utilized for residents and that there should be a policy for bed and chair sensor alarm pads since it was an intervention being used for fall risk residents. The DON stated a policy, and procedure was how the facility would monitor and document interventions being done with residents and if the interventions are effective. The facility did not have a policy regarding use of bed and chair alarms.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 49130 Based on observation, interview and record review the facility failed to ensure four out of five sampled residents' (Resident 14 and Resident 21, Resdent 28 amd 12)'s Minimum Data Set ([MDS], a resident assessment tool) was coded appropriately when: a.Resident 14's MDS was not coded correctly in the bladder and bowel portion. b.Resident 21's MDS was not coded correctly in the active diagnosis portion. c. Resident 28's MDS was not coded correctly to reflect Resident 28 had Bed sensor alarm (a safety device a pressure sensitive pad use to detect when a resident leaves their bed) and chair sensor alarm(a safety device a pressure sensitive pad use to detect when a resident leaves their bed). d.Resident 12's MDS was not coded correctly to reflect a diagnosis of bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) The deficient practice resulted in an inaccurate depiction of Resident 14, Resident 21, Resident 28, and Resident 12's current health status. Findings: a.During a review of Resident 14's Admission Record, the Admission Record indicated Resident 14 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including asthma (a chronic respiratory disease characterized by inflammation and narrowing of the airways, making breathing difficult), hypertension ([HTN], high blood pressure), atrial fibrillation ([A-Fib], (a condition that causes irregular and fast heartbeat in the heart), and hyperlipidemia (too much fat particles in the blood). During a review of Resident 14's history and physical (H/P) dated 4/6/2025, the H/P indicated Resident 14 had the capacity to understand and make decisions. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 14's MDS dated [DATE], the MDS indicated Resident 14 had intact cognitive (thinking process) skills and was independent (resident completes the activity by themselves with no assistance from a helper) with self-care abilities such as eating, required supervision (helper provides verbal cues as resident completes the task) with oral hygiene, personal hygiene, and upper body dressing, required moderate assistance (helper does less than half the effort completing task) with toileting hygiene, lower body dressing, and putting on/taking off footwear and maximal assistance (helper does more than half the effort) with shower/bathe. The MDS indicated Resident 14 required supervision during mobility such as rolling left and right, sit to lying position, and lying to sitting on side of bed, required moderate assistance with sit to stand position, bed to chair transfer, toilet transfers, shower transfers, and walking 10 to 50 feet. The MDS indicated Resident 14 was always incontinent with urinary continence (loss of voluntary control of urination) and occasionally incontinent with bowel continence (loss of voluntary control of bowl movements). During a review of Resident 14's Bowel and Bladder Evaluation dated 2/15/2025, the Bowel and Bladder evaluation indicated Resident 14 as incontinent. During a concurrent observation and interview on 2/4/2025 at 10:23 a.m., with Resident 14 in her room, Resident 14 was resting in bed watching television. Resident 14 stated she was not incontinent. Resident 14 stated she could not ambulate to the bathroom without assistance because she just had surgery on her right hip. During a concurrent interview and record review on 4/23/2025 at 4:03 p.m., with the MDS Coordinator (MDSC), the MDS dated [DATE] and the Bowel and Bladder Evaluation dated 2/15/2025 was reviewed. The MDSC nurse stated the resident was alert and oriented and could tell staff if she needed to go to the restroom, so she was not incontinent. The MDSC nurse stated the MDS should have been coded as always continent because the resident was alert and oriented and knows when she needed to go to the restroom. The MDSC nurse stated the MDS assessment was coded incorrectly. The MDSC nurse stated if the MDS was not coded correctly, the plan of care for the resident would not be appropriate for the resident. b.During a review of Resident 21's Admission Record, the Admission Record indicated Resident 21 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including HTN, high blood pressure), hyperlipidemia (too much fat particles in the blood), diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), and glaucoma (a group of eye diseases that damage the optic nerve, which connects the eye to the brain, leading to vision loss). During a review of Resident 21's H/P dated 2/27/2025, the H/P indicated Resident 21 had the capacity to understand and make decisions. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 21's MDS dated [DATE], the MDS indicated Resident 21 had moderate cognitive impairment and required assistance with set up or clean up (helper sets up or cleans up while resident completes the activity), required moderate assistance (helper does less than half the effort while resident completes the task) with self-care abilities such as eating and required maximal assistance (helper does more than half the effort completing task) with oral hygiene, and personal hygiene, as dependent (helper does all of the effort while resident does none of the effort to complete the task) with upper body dressing, with toileting hygiene, shower/bathe, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 21 required maximal assistance with mobility such as rolling left and right, sit to lying position, lying to sitting on side of bed, and bed to chair transfers, was dependent on sit to stand position, toilet transfers, and shower transfers. The MDS indicated Resident 21 was taking an antidepressant medication (medications used to treat depression [a persistent mood disorder characterized by feelings of sadness, loss of interest, and a range of physical and cognitive symptoms that significantly interfere with daily life]). Resident 21 did not have a mood disorder diagnosis in the active diagnoses portion of the MDS. During a review of Resident 21's psychiatric (relating to mental illness or its treatment) consult note dated 3/3/2025, the psychiatric consultation note indicated Resident 21 had a documented history of major depressive disorder, and continued to exhibit symptoms of major depressive disorder. The psychiatric consultation notes also indicated diagnoses of adjustment disorder (a mental health condition characterized by an excessive emotional or behavioral reaction to a specific stressful event or life change). During a review of Resident 21's psychologist consultation note dated 3/6/2025, the psychologist consultation note indicated that Resident 21 was diagnosis with adjustment disorder with depressed mood as evidence by reported emotional and behavioral response to medical conditions, functional limitations, increased need for assistance and rehab placement. During a review of Resident 21's Order Summary Report, the Order Summary Report indicated sertraline (medication used to treat depression) oral tablet (pill) 100 milligram ([mg], unit of measurement) give one tablet by mouth one time a day for depression manifested by verbalization of feeling depressed, informed consent obtained by medical doctor from Resident 21 ordered on 2/26/2025. During a concurrent interview and record review on 4/23/2025 at 3:18 p.m. with MDS Coordinator (MDSC), the MDS dated [DATE] and psychologist consultation note dated 3/6/2025 was reviewed. The MDSC nurse stated MDS assessment should have been coded to indicate that Resident 21 had a depressed mood disorder because she was seen by psychology and psychiatry consult that stated resident was diagnose with adjustment disorder with depressed mood and was taking an antidepressant medication. The MDSC stated the importance of ensuring the MDS assessment was accurate was to make sure Resident 21's care plans were based on an accurate MDS that reflected the diagnoses of the resident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/24/2025 at 4:15 p.m., with the Director of Nursing (DON), the MDS assessment dated [DATE] for Resident 14, Bowel and Bladder evaluation dated 2/15/2025, the MDS assessment dated [DATE] for Resident 21, the psychologist consultation note dated 3/6/2025 for Resident 21 were reviewed. The DON stated the MDS assessment for Resident 14 was inaccurate because Resident 14 was continent and stated the MDS assessment was coded that Resident 14 was incontinent. The DON stated the importance of accurate assessment of the MDS was to meet the needs of the residents, to provide the proper care needed for the residents, and to maintain their functioning status. The DON stated the MDS assessment for Resident 21 was also not accurate as the MDS assessment for active diagnosis section, there should have been a diagnosis of mood disorder because Resident 21 was taking an antidepressant medication for depress mood. The DON stated the psychologist consultation note indicated that the resident had a diagnosis of adjustment disorder with depressed mood and the MDS assessment should have indicated that Resident 21 had some type of depressed mood disorder. The DON stated the MDS assessment needed to be accurate to reflect Resident 14's and Resident 21's diagnoses and health status so the facility can give person centered care. c.Based on observation, interview, and record review, the facility failed to ensure the assessment entries on the Minimum Data Set (MDS- an assessment and care screening tool) related to Bed sensor alarm (a safety device a pressure sensitive pad use to detect when a resident leaves their bed) and chair sensor alarm(a safety device a pressure sensitive pad use to detect when a resident leaves their bed) was accurately documented for one of three randomly selected residents (Resident 28) This deficient practice had the potential to negatively affect Resident 28's plan of care and delivery of necessary care and services. Findings: During a review of Resident 28's Admission Record, the Admission Record indicated, Resident 28 was initially admitted to the facility on ,d+[DATE]/ 2021 and last admission was on 3/27/2025 with diagnoses including hemiplegia and hemiparesis (muscle weakness or partial paralysis not being able to move a body part) following cerebral infarction (brain tissue dies due to lack of blood flow) affecting the right dominant side. HTN and abnormalities in gait (walking) and mobility ((moving). During a review of Resident 28's MDS dated [DATE], the MDS indicated Resident 28 had significant cognitive impairment. The MDS indicated Resident 28 required partial moderate assistance (helper lifts or holds trunk or supports trunk or limbs but provides less than half the effort) with eating, oral hygiene, upper body dressing, personal hygiene and needs help on indoor mobility. During a record review of Resident 28's Order Summary Report (OSR), as of 3/27/2025 the OSR indicated an order for sensor pad alarm on bed to alert staff when trying to get out of bed unassisted and on 3/27/2025 an order for sensor alarm pad in wheelchair to alert staff when trying to get out of wheelchair unassisted. During a concurrent interview and record review on 4/23/2025 at 3:31 p.m., with the MDSC nurse, the MDSC nurse stated Resident 28 had a sensor bed pad alarm and a sensor bed alarm. The MDSC nurse stated she did not document the sensor pad alarm and the sensor bed alarm in Resident 28's MDS. The MDSC nurse stated the sensor bed alarm and sensor chair alarm was a form of restraint (when a patient avoids moving or repositioning themselves in a chair of bed due to fear of triggering the alarm). The MDSC nurse stated documenting sensor pad alarms helps in making sure it is used appropriately. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/24/2025 at 3:00 p.m., with the DON, the DON stated bed sensor alarms and chair sensor alarms should be documented in section P of the MDS. The DON stated if the assessment is not correct it does not reflect what the resident is getting, and the facility was not keeping Resident 28 safe. The DON stated if the chair and bed alarm is not documented or monitored it may not serve its purpose and the resident may still fall. d.During a review of Resident 12's Admission Record (a document containing demographic and diagnostic information), dated 4/22/2025, the admission record indicated Resident 12 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but not limited to, schizophrenia (a mental illness that is characterized by disturbances in thought) and depression (a mood disorder characterized by persistent sadness and loss of interest in activities). During a review of Resident 12's Minimum Data Set MDS (MDS - a federally mandated resident assessment tool), dated 3/31/2025, the MDS indicated Resident 12's cognition was intact. The MDS indicated Resident 12 was independent for Activities of Daily Living (ADLs) such as eating, needed supervision level assistance from the facility staff for oral hygiene, upper body dressing, lower body dressing and personal hygiene, moderate assistance for toileting, showering and putting on/taking off footwear. The MDS did not indicate a medical diagnosis for bipolar disorder. During a review of Resident 12's Order Summary Report (a list of all currently active medical orders), dated 4/22/2025, the order summary report indicated the following physician order: Aripiprazole (a medication used to treat mental conditions such as depression and bipolar disorder) Oral Tablet 15 milligrams ([mg] a unit of measurement for mass), give 1 tablet by mouth one time a day for bipolar disorder manifested by (m/b) sudden mood change, order date 9/24/2024, start date 9/25/2024. During a review of Resident 12's psychiatry initial evaluation and consultation notes, dated 1/10/2025, 3/3/2025 and 2/5/2025, the documents respectively indicated, The patient, with a documented history of major depressive disorder and bipolar disorder, underwent an initial 45-minute, and 16-minute psychiatry evaluations. The documents indicated diagnoses of Major Depressive Disorder (MDD) and bipolar disorder, and no diagnosis of schizophrenia was documented. During a review of Resident 12's Medication Administration Record ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 4/1/2025 to 4/22/2025, 3/1/2025 to 3/31/2025 and 2/1/2025 to 2/28/2025, the MAR indicated aripiprazole 15 mg was documented as administered every day for bipolar disorder. During an interview on 4/23/2025 at 3:30 p.m. with the Minimum Data Set Coordinator (MDSC), the MDSC stated Resident 12's MDS indicated diagnoses of schizophrenia and depression. MDSC stated facility staff would look at the psychiatry evaluation to verify the accuracy of the diagnoses in MDS, but she was not sure how the diagnoses were entered for Resident 12 because MDSC was not at the facility when they were entered. MDSC stated there was an inaccuracy of assessments and there was a possibility that the care plans would not be according to what was necessary for the resident's care. MDSC stated there could be side effects from unnecessary use of psychotropic medications for elderly residents which could cause unwanted side effects, such as cognitive impairment and increased risk for falls. MDSC stated the medications should have been prescribed only if there was a valid diagnosis. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 4/24/2025 at 10:40 a.m. with the psychiatry nurse practitioner (NP) 1, NP 1 stated Resident 12 had medical diagnoses of bipolar disorder and depression based on her evaluation of the resident. NP 1 stated Resident 12 did not have a diagnosis of schizophrenia. NP 1 stated, I do not believe that the MDS stating schizophrenia is accurate. During an interview on 4/24/2025 at 12:20 p.m. with the Director of Nursing (DON), DON stated when she checked Skilled Nursing Facility (SNF) 1's records, Resident 12's admitting diagnoses were bipolar disorder, depression and anxiety. DON stated the hospital's admission records, dated 09/2024 and 03/2024, did not have any diagnoses. DON stated there was an inaccuracy in diagnoses in Resident 12's MDS because MDS indicated diagnoses of schizophrenia and no bipolar disorder, whereas psychiatry evaluation indicated bipolar disorder and no schizophrenia. DON stated the inaccurate record of medical diagnoses would affect resident's treatment plan. DON stated the resident might not be getting treatment with the right medications causing negative impact on resident's cognition and behaviors. During a review of the facility's policy and procedure (P/P) titled Resident Assessment and Associated Processes, dated 12/2023, indicated it is the policy of this facility that resident's will be assessed and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment of each resident and will be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health status, and strengths and needs will be identified comprehensive assessment includes the completion of the MDS MDS data is signed/stored electronically in the clinical health record and is readily and easily accessible to all professionals who need to review the information in order to provide care to the resident. 49573

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45777 49573 Based on observation, interview and record review the facility failed to develop a care plan for two of three sampled residents (Resident 28 and Resident 29) when : a. Resident 28 had an order for a bed sensor alarm (a safety device a pressure sensitive pad use to detect when a resident leaves their bed) and a chair sensor alarm (a safety device a pressure sensitive pad used to detect when a resident tries to get up from the chair) b. Resident 29 refusing to get out of bed and attend activities for three days . Findings: During a review of Resident 28's Admission Record, the Admission Record indicated Resident 28 was originally admitted on [DATE] with a re-admitted on 3/22/2025 with diagnoses including chronic obstructive pulmonary disease ([COPD], a chronic lung disease causing difficulty in breathing), hypertension ([HTN], high blood pressure), dementia (a progressive state of decline in mental abilities), and atrial fibrillation ([A-Fib], (a condition that causes irregular and fast heartbeat in the heart). During a review of Resident 28's History and Physical (H/P) dated 3/25/2025, the H/P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 28's Minimum Data Set ([MDS], a resident assessment tool) dated 3/26/2025, the MDS indicated Resident 28 was severely cognitivly (ability to make decisions of daily living) impaired, and required moderate assistance (helper does less than half the effort) on self-care abilities such as eating, required maximal assistance (helper does more than half the effort to complete the task) with oral hygiene, toileting hygiene, shower/bathe, upper and lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 28 required maximal assistance with mobility such as rolling left and right, sitting to lying position, lying to sitting on side of bed, bed to chair transfers, and toilet transfers. During a review of Resident 28's Order Summary Report, the Order Summary Report indicated; sensor pad alarm (a device, typically a pressure-sensitive pad, used to alert facility staff when a resident moves or leaves their bed or chair unassisted) in bed to alert staff when Resident 28 was trying to get out of bed unassisted, informed consent obtained by medical doctor from responsible party ordered on 3/22/2025. The Order Summary Report indicated sensor pad alarm in wheelchair to alert staff when trying to get out of wheelchair unassisted informed consent obtained by medical doctor from responsible party ordered on 3/22/2025. During a review of Resident 28's comprehensive care plan dated 3/13/2025, the comprehensive care plan did not indicate a care plan addressing Resident 26's use of bed and chair sensor alarm pads in place. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/21/2025 at 10:47 a.m., in Resident 28's room, Resident 28 was resting in bed with eyes closed. There was a box attached to the bed with a wire attached to the box underneath Resident 28. During a concurrent interview and record review on 4/23/2025 at 2:59 p.m. with the MDS Coordinator (MDSC), Resident 28's the Order Summary Report and comprehensive care plan dated 3/13/2025 were reviewed. The MDSC stated sensor alarm pads should have been care planned, to monitor the effectiveness of the sensor alarm pads. The MDSC stated there should have been interventions in place to make sure the sensor alarm pads were effective in alerting staff and keeping Resident 28 safe from falling. The MDSC stated if the interventions in the care plan were not effective, the interventions could be reassessed, and new interventions would be added. The MDSC stated a comprehensive care plan should be a focused individualized care plan, and how staff should be caring for the residents based on the interventions being done on the floor. The MDSC stated the comprehensive care plan did not have a focus for the sensor alarm pads and to guide staff on how to care for Resident 28's pad alarms. During a concurrent interview and record review on 4/24/2025 at 3:20 p.m. with the Director of Nursing (DON), Resident 28's comprehensive care plan dated 3/13/2025 was reviewed. The DON stated sensor alarm pads should have been care planned. The DON stated the importance of having a comprehensive care plan was that it was a plan of care on how facility staff will be providing care to the residents. The DON stated there should have been a separate care plan for sensor alarm pads to monitor the effectiveness of the sensor alarm pads and its functioning purpose. DON stated the comprehensive care plan should make sure the residents still have a need for the sensor alarm pads. b.During a review of Resident 29's Admission Record, the Admission Record indicated, Resident 29 was initially admitted to the facility on [DATE] and last admission was on 1/29/2025 with diagnoses including cerebral infarction (brain tissue dies due to lack of blood flow) due to blockage of a blood vessel in the brain, essential (primary) Hypertension (high blood pressure) and muscle weakness (generalized). During a record review of Resident 29's H&P, the H&P indicated Resident 29 did not have the capacity to understand and make decisions. During a review of Resident 29's MDS dated [DATE] , the MDS indicated, Resident 29 was dependent (resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity) with shower/ bath, toilet hygiene, eating , lower body dressing, putting on and taking off footwear and substantial/ maximum assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with chair/ bed -to chair transfer. During a record review of Resident 29's Order Summary Report (OSR), as of 3/27/2025 the OSR indicated an order dated 3/26/2025 for skilled physical therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) every day, 5 times per week for 4 weeks. PT may include therapeutic exercises, therapeutic activities, neuromuscular (relating to nerves and muscles) re-education , wheelchair management, gait training , manual therapy and patient caregiver education and training. (continued on next page)

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Rose Villa Health Care Center	9028 Rose Street Bellflower, CA 90706

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of resident 29's care plan dated 1/30/2025 the care plan indicated Resident 29 had a pressure ulcer (injury to skin and underlying tissue due to unrelieved pressure) or potential for pressure ulcer development, theinterventions were for Resident 29 to get out of bed unless contraindicated. During an interview on 4/23/2025 at 10:30 a.m., with Certified Nurse Assistant 2 (CNA 2), CNA 2 stated Resident 29 had refused to get up for the past three days , CNA 2 stated resident 29 never get out of bed. CNA 2 stated when a resident refuses to get out of bed she reports the refusal to her charge nurse. CNA 2 stated it is important to get the resident out of bed to prevent beds sores. During an interview on 4/23/2025 at 10:36 a.m., with Licensed Vocational Nurse (LVN 1) , LVN 1 stated he was aware Resident 29 did not want to get out of bed and when a resident refuses multiple times a plan of correction is done, and the doctor is called. LVN 1 stated there must be a care plan so the nurses can focus on the resident's problem. During an interview on 4/ 24/2025 at 3:00 p.m., with the Director of nursing (DON), the DON stated the bed sensor alarm and wheelchair sensor alarm for Resident 28 should have a separate sectionin the care plan so staff can focus where nurses can monitor the placement of the sensor alarm and if it is functioning. The DON stated CNA's notify the LVN when Resident 29 refuses to get out of bed and the LVN charts it and notifies the doctor and family, and then care plan it. The DON stated it was important to do a care plan for Resident 29 refusing to get out of bed and must be reflective to meet the residents needs so that we can refer them to the right DON stated it is important the resident gets out of bed to improve their sensory stimulation. During a review of the facility's policy and procedure (P/P) titled, Comprehensive Person-Centered Care Plan, dated 12/2023, indicated the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person- centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment the facility IDT will develop and implement a comprehensive person-centered, culturally-competent, and trauma-informed care plan for each resident within seven (7) days of completion of the Resident Minimum Data Set (MDS) and will include resident's needs identified in the comprehensive assessment, any specialized services as a result of PASARR recommendation, and resident's goals and desired outcomes, preferences for future discharge and discharge plan.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 12) who was incontinent (unable to voluntarily control retention of urine or feces in the body) of bowel and bladder, was provided a retraining and/or toileting program (a structured approach to help individuals regain or improve control over their bowel and bladder functions), to regain the resident's normal bowel and bladder function as much as possible. This failure had a potential to result in Resident 12's inability to regain control of bowel and bladder function and can lead to a loss of dignity. Findings: During a review of Resident 12's Admission Record, the Admission Record indicated, Resident 12 was initially admitted to the facility on [DATE] and last re-admission was on 9/24/2024 with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), overactive bladder (a bladder has a strong urge to pass urine even when your bladder isn't really full), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 12's History and Physical (H&P), dated 9/27/2024, the H&P indicated, Resident 12 was alert and oriented. During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool), dated 3/31/2025, the MDS indicated Resident 12 required moderate assistance (Helper does less than half the effort) from one staff for transfer, toileting hygiene, shower/bathe self, supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and /or contact guard assistance as resident completes activity) from one staff for bed mobility, dressing, personal hygiene, and independent for eating. The MDS indicated, Resident 12's cognition (The mental process of thinking, learning, remembering, being aware of surroundings, and using judgment) was intact. During an interview on 4/21/2025, at 10:46 a.m., with Resident 12, in Resident 12's room, Resident 12 stated, she did not want to talk about her incontinence issue because it made her feel embarrassed. During a concurrent interview and record review on 4/23/2025, at 3:48 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 12's MDS, dated [DATE] and 3/31/2025 were reviewed. The MDS, dated on 9/30/2024, indicated, Resident 12 was frequently incontinent for urine, occasionally incontinent for bowel, and was not on a bowel and bladder toileting program. The MDS, dated on 3/31/2024, indicated, Resident 12 was frequently incontinent for urine, occasionally incontinent for bowel, and was not on bowel and bladder toileting program. MDSC stated, Resident 12 was a candidate for bowel and bladder retraining program, but the facility did not have the program currently. MDSC stated, she believed that Resident 12 would benefit from bowel and bladder retraining program to promote highest functional ability. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/2025, at 4:11 p.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated, Resident 12 had few episodes of incontinence, but she was continent most of the time. CNA 1 stated, Resident 12 was not in the bladder and bowel retraining program and there was no set schedule for toileting for Resident 12. During an interview on 4/23/2025, at 4:18 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, Resident 12 was a candidate for the retraining program and would benefit from the retraining program. LVN 2 stated, she was not sure of a bowel and bladder retraining program at the facility. During an interview on 4/24/2025, at 3:21 p.m., with the Director of Nursing (DON), the DON stated, Resident 12 was a candidate for the retraining program and should be in the program. The DON stated, the facility's policy and procedure for the retraining program was outdated and should be revised. The DON stated, she should have provided an in-service (staff training and education) to staff regarding the facility's bowel and bladder retraining program. The DON stated, the staff should screen the resident for bowel and bladder function and place the resident in a retraining program if the resident (general) is screened as a possible candidate. The DON stated, the bowel and bladder retraining program was important to preserve current level of function and promote achieving highest functional level for Residenrt 12. During a review of Resident 12's Bowel and Bladder Evaluation, dated 9/26/2024, the Bowel and Bladder Evaluation indicated, Resident 12 was a possible candidate and scored 12 (score 0-4 good candidate, 5-8 likely candidate, 9-12 possible candidate, 13-16 unlikely candidate, 17-20 not a candidate). During a review of Resident 12's Bowel and Bladder Evaluation, dated 3/31/2025, the Bowel and Bladder Evaluation indicated, Resident 12 was a possible candidate and scored 12. During a review of Resident 12's Care Plan (CP), dated from 9/2024 to 4/2025, the CP indicated, there was no care plan regarding bowel and bladder retraining program. During a review of Resident 12's Order Summary Report (OSR), dated 4/24/2025, the OSR indicated, there was no order to place Resident 12 in the retraining program. (continued on next page)

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F 0690 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, Bowel and Bladder Retraining, revised 5/2007, the P&P indicated, POLICY: It is the policy of this facility that bowel and bladder retraining will be provided for residents with the potential to benefit from such a program. When medically appropriate. bowel and bladder retraining is the preferred treatment option for incontinence. PURPOSE: Achieve as nearly normal filling and emptying of bladder as possible. To re-train incontinence residents in bladder and bowel control when medically feasible. Advantages for resident: I. Regain confidence and self-esteem. 2. Less skin breakdown and odor. 3. Cooperation with activities and ambulation. Assessment Process: 1. Complete assessment form. 2. Record database for three (3) days by stating: INC. - CONT. - DRY every two (2) hours around the clock on Elimination Diary Form. 3. On the fourth (4) day, determine if bowel and bladder retraining is appropriate. 4. If not appropriate. document on original Bowel and Bladder Retraining Assessment Form; or if appropriate, initiate formal program by placing forms in B&B notebook. 5. Document decision on original Bowel and Bladder Retraining Assessment Form. 6. Notify licensed nurse through Nursing Communication 24-hour Report Book. 7. Place copy of original assessment in B&B notebook. 8. Address bowel and bladder retraining on resident's care plan . 10. Each incontinent resident must be assessed for potential successful bowel and bladder retraining. Before a formalized bowel and bladder retraining program is initiated, a physician's order must be obtained.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 17) received multivitamins with minerals in accordance with physician orders during medication administration. This deficient practice had the potential to result in weakness and fatigue due to low levels of vitamins and minerals for Resident 17. Findings: During a review of Resident 17's Admission Record (a document containing demographic and diagnostic information), dated 4/22/2025, the admission record indicated Resident 17 was originally admitted to the facility on [DATE] and readmitted on [DATE]. During a review of Resident 17's History and Physical, dated 2/2/205, the document indicated Resident 17 had the capacity to understand and make decisions. During a review of Resident 17's Minimum Data Set MDS (MDS - a federally mandated resident assessment tool), dated 1/28/2025, the MDS indicated Resident 17's cognition was moderately impaired. The MDS indicated that Resident 17 needed maximal assistance from facility staff for Activities of Daily Living (ADLs) such as eating, oral hygiene, toileting hygiene, showering, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During an observation on 4/22/2025 between 10:11 a.m. and 10:36 a.m., Licensed Vocational Nurse (LVN) 2 prepared and administered nine medications as listed below to be administered for Resident 17 but did not include multivitamins with minerals. 1. One tablet of amlodipine (a medication used to treat high blood pressure) 5 milligrams ([mg] a unit of measurement for mass) 2. One tablet of chlorthalidone (a medication used to reduce the amount of water in the body and to treat high blood pressure) 25 mg 3. One tablet of methimazole (a medication used to treat high thyroid) 5 mg 4. One tablet of propranolol (a medication used to treat high blood pressure) 10 mg 5. One tablet of bupropion (a medication used to treat depression) extended release (XL) 150 mg 6. One tablet of thiamin (vitamin B1) (a vitamin used to treat low level of vitamin B1) 100 mg 7. One tablet of vitamin C (a vitamin used to treat low level of vitamin C) 500 mg 8. One tablet of hydrocodone-acetaminophen (a combination medication used to treat pain) 5-325 mg (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of medication reconciliation and review of Resident 17's Order Summary Report (a document containing a summary of all active physician orders), dated 4/22/2025, the document indicated, but not limited to, the following medications: Multiple Vitamins-Minerals Tablet, give 1 tablet by mouth one time a day for supplement, order date 4/22/2025, start date 4/23/2025 Multivitamin-Minerals Oral Tablet, give 2 tablets by mouth one time a day for supplement, order date 1/24/2025, start date 1/25/2025 During a review of Resident 17's Medication Administration Record ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 4/1/2025 to 4/30/2025, the multivitamin with minerals was not documented as administered. During a review of Resident 17's care plan report, creation date of 1/24/2025, the note indicated, has nutritional problem or potential nutritional problem related to diagnosis of status post fall, leukocytosis (a medical condition with high number of white blood cells in the blood), altered level of consciousness and mild anterior wedge compression fracture with history of chronic back pain .hypertension (HTN - high blood pressure), arthritis (inflammation of the joints), atrial fibrillation (irregular heart beat and rhythm). During an interview on 4/22/2025 at 2:14 p.m. with LVN 2, LVN 2 stated she forgot to administer multivitamins with minerals to Resident 17 on 4/22/2025. LVN 2 stated Resident 17 could feel lethargic or weak due to possible low levels of vitamins and minerals. During an interview on 4/23/2025 at 4:53 p.m. with the Director of Nursing (DON), DON stated facility nurse should have given multivitamins with minerals to Resident 17 per physician order for it to be effective for the resident's health. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 2012, the P&P indicated, Medications are administered as prescribed in accordance with written orders of the attending physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49130 Based on observation, interview, and record review, the facility failed to ensure Resident 11's multivitamin liquid bottle indicated a manufacturer expiration date in accordance with manufacturer's specifications and facility's policy and procedures (P&P) titled, Medication Storage dated 2012 and Medication Ordering and Receiving from Pharmacy Provider, Medications Brought to Care Center by Resident or Family Member, dated 2012 in one of one inspected medication room (Station 1 Medication Room). This deficient practice had the potential to result in Resident 11 receiving multivitamin liquid that had become expired, ineffective, or toxic due to improper labeling and/or storage possibly leading to adverse effects from the multivitamin. Findings: During a review of Resident 11's Admission Record (a document containing demographic and diagnostic information), dated [DATE], the admission record indicated Resident 11 was admitted to the facility on [DATE] with diagnoses including but not limited to, tinea unguium (fungal infection of the nails), alcohol abuse and cognitive communication deficit. During a review of Resident 11's History and Physical, dated [DATE], the document indicated Resident 11 did not have the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set MDS (MDS - a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 11's cognition was severely impaired. The MDS indicated the Resident 11 needed supervision level assistance from the facility staff for Activities of Daily Living (ADLs) such as eating, moderate assistance for oral hygiene, upper body dressing and personal hygiene, and maximal assistance for toileting hygiene, showering, lower body dressing and putting on/taking off footwear. During a concurrent observation and interview on [DATE] at 11:32 a.m. with Licensed Vocational Nurse (LVN) 3 in Station 1 Medication Room, there was a dark-brown colored bottle with a manufacturer label that indicated, Marry Ruth's Liquid Morning Multivitamin Hair Growth stored in the medication refrigerator. The liquid multivitamin bottle did not indicate a manufacturer expiration date. LVN 3 stated she could not find the expiration date on the bottle that had facility's handwritten label indicating Resident 11's first name, room number and an open date of [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on [DATE] at 12:11 p.m. with the Director of Nursing (DON), DON tried to remove the facility's handwritten labels from the liquid multivitamin bottle to find the manufacturer expiration date. DON stated she was not able to find the expiration date for Resident 11's liquid multivitamin bottle. DON stated it was important to have an expiration date to determine if the multivitamin was still safe and effective to be administered to Resident 11. DON stated liquid multivitamin was Resident 11's home medication that she brought to the facility to be taken for hair growth. DON was not able to indicate where Resident 11's liquid multivitamin was sourced from. During an interview on [DATE] at 12:37 p.m. with LVN 4, LVN 4 stated Resident 11 brought the sealed bottle of liquid multivitamin. LVN 4 stated Resident 11's liquid multivitamin did not have an expiration date and without an expiration date, it would be difficult to know how long Resident 11 had the product. LVN 4 stated it would not be safe or effective to administer liquid multivitamin intended for hair growth to Resident 11. During a review of Resident 11's Order Summary Report (a document containing a summary of all active physician orders), dated [DATE], the document indicated, but not limited to, the following medication: Multivitamin Oral Liquid (Multiple Vitamins with Minerals), give 30 milliliters ([mL] a unit of measurement for volume) by mouth one time a day for multivitamin and hair growth, order date [DATE], start date [DATE] During a review of Resident 11's nursing progress notes, dated [DATE], the document indicated a note, MD was made aware of new order for [NAME] Ruth's multivitamin plus hair growth oral liquid (30 mL). Discontinue order for multivitamin/minerals tablets. During a review of Resident 11's Medication Administration Record ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated [DATE] to [DATE], the multivitamin oral liquid was documented as administered 15 times from [DATE] to [DATE]. During a review of the facility's P&P titled, Medication Ordering and Receiving from Pharmacy Provider, Medications Brought to Care Center by Resident or Family Member, dated 2012, the P&P indicated, Medications brought into the care center by a resident or family member are used only upon written order by the resident's attending physician, after the contents are verified, and if the packaging meets the state, federal, and pharmacy's guidelines. Other unauthorized medications are not accepted by the care center. During a review of the facility's P&P titled, Medication Storage, dated 2012, the P&P indicated, Medications and biologicals are stored properly, following manufacturer's recommendations or those of the supplier to maintain their integrity and to support safe administration. The provider pharmacy dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices established by the United States Pharmacopeia (USP).

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49573 Based on observation, interview, and record review, the facility failed to ensure an accurate medical diagnosis was documented for one of three sampled residents (Resident 21), by failing to ensure Resident 21's diagnoses of adjustment disorder with depressed mood a specific type of adjustment disorder where the dominant symptoms are those associated with depression, such as low mood, tearfulness, and feelings of hopelessness, in response to a stressful event or life change was reflected. This deficient practice had the potential to negatively impact the provision of necessary care and services and portray an inaccurate reflection of resident receiving care in the facility. Findings: During a review of Resident 21's Admission Record, the Admission Record indicated Resident 21 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypertension ([HTN], high blood pressure), hyperlipidemia (too much fat particles in the blood), diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), and glaucoma (a group of eye diseases that damage the optic nerve, which connects the eye to the brain, leading to vision loss). During a review of Resident 21's history and physical (H/P) dated 2/27/2025, the H/P indicated Resident 21 has the capacity to understand and make decisions. During a review of Resident 21's Minimum Data Set ([MDS], a resident assessment tool) dated 3/25/2025, the MDS indicated Resident 21 had moderate cognitive (thinking process) impairment and required set up or clean up assistance (helper sets up or cleans up while resident completes the activity) with self-care abilities such as eating, required moderate assistance (helper does less than half the effort while resident completes the task) with oral hygiene, and personal hygiene, required maximal assistance (helper does more than half the effort completing task) with upper body dressing and was dependent (helper does all of the effort while resident does none of the effort to complete the task) with toileting hygiene, shower/bathe, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 21 was taking an antidepressant medication. The MDS did not have the mood disorder diagnosis listed in the active diagnoses section of the MDS. During a review of Resident 21's psychiatric (relating to mental illness or it's treatment) consult note dated 3/3/2025, the psychiatric (medical doctor who specializes in mental health, including substance use disorders and prescribed a medication and administer medical treatments for mental health disorders) consultation note indicated Resident 21 had a documented history of major depressive disorder (mood disorder characterized by persistent sadness, loss of interest or pleasure, and other symptoms that interfere with daily life), continued to exhibit symptoms of major depressive disorder. The psychiatric consultation notes also indicated diagnosis of adjustment disorder. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 21's psychologist (a professional who practices psychology and studies mental states, perceptual, cognitive, emotional, and social processes and behavior) consultation note dated 3/6/2025, the psychologist consultation note indicated that Resident 21 was diagnosed with adjustment disorder with depressed mood as evidenced by reported emotional and behavioral response to medical conditions, functional limitations, increased need for assistance and rehab placement. During a concurrent interview and record review on 4/23/2025 at 3:18 p.m., with the MDS Coordinator (MDSC), Resident 21's admission record, MDS assessment dated [DATE], and the psychologist consultation note dated 3/6/2025 were reviewed. The MDSC stated there should have been a diagnosis of mood disorder in Resident 21's admission records medical diagnosis information. The MDSC stated the importance of maintaining accurate diagnoses information for Resident 21 was to make sure Resident 21 was receiving care based on care plan, to monitor resident safety, and to monitor episode of depression. MDSC stated there should be communication with the psychologist and/or psychiatrist doctor and that if there are any changes in the resident diagnosis and treatment, the facility can make sure diagnosis are accurate and any irregularities can be corrected. MDSC stated there should be a medical diagnosis of a mood disorder before any medication was ordered. During a concurrent interview and record review on 4/24/2025 at 4:15 p.m., with the Director of Nursing (DON), Resident 21's admission record, MDS assessment dated [DATE], psychologist consultation note dated 3/6/2025 was reviewed. The DON stated Resident 21 had adjustment disorder with depressed mood and the admission record medical diagnosis information should have indicated that resident has some type of depressed mood disorder. The DON stated the importance of having accurate medical diagnosis information was that it is a reflection of the resident, to make sure it reflects the resident in the clinical chart to meet their needs and to prevent confusion. The DON stated the admission record medical diagnosis information needed to be accurate to reflect the resident so facility can refer to psychology and/or psychiatry consult as needed if the resident has a mental illness/disorder so the plan of care can be effective in treating the resident. During a review of the facility's policy and procedure (P/P) titled Resident Assessment and Associated Processes, dated 12/2023, the P/P indicated it was the policy of this facility that resident's will be assessed, and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment of each resident an accurate comprehensive assessment will be made of the resident's needs, strengths, goals, life history and preferences each individual who completes a portion of the assessment will electronically sign and certify the accuracy of that portion of the assessment, as well as the date the data was obtained.

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Rose Villa Health Care Center	9028 Rose Street Bellflower, CA 90706

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on observation. interview and record review, the facility failed to implement infection control measures by failing to ensure: A. Resident 148's visitor was wearing Personal Protective Equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) while the visitor (Vistor 1) was assisting the resident. B. To place Resident 148 in Contact Isolation (a preauction that is used for patients with diseases caused by bacteria and viruses that are spread through direct and indirect contact) due to possible clostridium difficile (C. diff- a highly contagious bacteria that causes severe diarrhea) infection while waiting for lab result. This failure had the potential to result in compromised infection control measures to prevent the potential spread of infection among residents, staff, and visitors. Findings: During a review of Resident 148's Admission Record, the Admission Record indicated, Resident 148 was admitted to the facility on [DATE] with diagnoses including pneumonia (an infection/inflammation in the lungs), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 148's History and Physical (H&P), dated 4/21/2025, the H&P indicated, Resident 148 had fluctuating ability to make medical decisions. During a review of Resident 148's Minimum Data Set (MDS - a resident assessment tool), dated 4/25/2025, the MDS indicated Resident 148 required moderate assistance (Helper does less than half the effort) from one staff for oral hygiene, toileting hygiene, shower/bathe self, dressing, personal hygiene, bed mobility, transfer, and supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and /or contact guard assistance as resident completes activity) from one staff for eating. A. During a concurrent observation and interview on 4/21/2025, at 11:35 a.m., with Resident 148's Visitor 1 in Resident 148's room, Visitor 1 was sitting next to Resident 148's bed without wearing PPE such as a mask, gown, and gloves. Visitor 1 placed her handbag on Resident 148's bed and assisted Resident 148 to reposition by pulling her shoulder towards the left side and placing a pillow behind her. There was an Enhanced Barrier Precaution (EBP- an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities) signage placed on the foot of Resident 148's bed board. The visitor stated, she did not see the EBP signage because it was not placed in a visible place and the staff did not explain anything about wearing PPE. (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//21/2025, at 11:30 a.m., with Certified Nurse Assistant (CNA) 2 in Resident 148's room, CNA 2 stated, she did not see the EBP signage because it was placed on the foot of the bed board. CNA 2 stated, it was not placed in a visible place such as outside of the entrance near the isolation cart and the color of the signage blended to color of the foot board. CNA 2 stated, the staff and visitors should wear PPE when providing care or touching Resident 148 who was placed on EBP isolation to prevent spreading of infection and cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another). CNA 2 stated, she should have educated and offered the visitor PPE. During an interview on 4/24/2025, at 9:10 a.m., with the Infection Preventionist Nurse (IPN), the IPN stated, anyone who had high contact (touching) such as bathing, touching, changing, hygiene care, and repositioning a resident who was on EBP isolation should wear PPE to prevent cross contamination and spreading infection. The IPN stated, this would apply to the visitors as well. The IPN stated, Resident 148 was diagnosed with pneumonia and staff should have ensured Visitor 1 was wearing a mask. The IPN stated, EBP signage should be placed in a visible place. During a review of Resident 148's Care Plan (CP), initiated and revised on 4/21/2025, the CP Focus indicated, Resident 148 had community acquired pneumonia. The CP Interventions indicated to Place enhanced barrier precautions and monitor for signs and symptoms of pneumonia. During a review of the facility's Policy and Procedure (P&P) titled, IPCP Standard and Transmission-Based Precautions, revised 3/2024, the P&P indicated, Procedure: Enhanced Barrier Protection {EBP}: used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. a. PPE: The use of gown and gloves for high-contact resident care activities is indicated . c. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: i. Dressing, ii. Bathing/showering, iii. Transferring, iv. Providing hygiene, v. Changing linens, vi. Changing briefs or assisting with toileting, vii. Device care or use . 6. Implementation: a. The facility will implement a system to alert staff, residents and visitors that a resident is on TBP: i. Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves). ii. For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves .e. Provide education to residents and visitors as needed. B. During an observation and interview on 4/24/2025, 9:16 a.m., with Resident 148 in her room, there was no isolation signage placed. There was no isolation cart near the entrance. Resident 148 stated, she had diarrhea more than five times yesterday and the nurse collected the stool sample. During a concurrent observation and interview on 4/24/2025, at 9:28a.m., with Licensed Vocational Nurse (LVN) 5 in a hallway near Resident 148's room, LVN 5 was passing medications and came out of the resident 148's room. LVN 5 performed hand hygiene by using sanitizer and did not clean hands with soap and water. LVN 5 stated, Resident 148 was not on any isolation because EBP was discontinued. LVN 5 stated, she got the report from night shift regarding Resident 148 had diarrhea, but she did not know that she had more than five times. LVN 5 stated, if the resident had multiple diarrheas, the resident should be placed on contact isolation that required wearing PPE upon entering the room and washing hands with soap and water while waiting for the lab result to protect the resident and staff themselves from C-diff. (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 4/24/2025, at 9:36 a.m., with IPN, IPN stated, if the resident had diarrheas more than three times a day, the nursing staff should have placed the resident in contact isolation and wearing PPE before entering the room. IPN stated, the nursing staff should have washed hands with soap and water when finishing providing care per the policy. IPN stated, the nursing staff might jeopardize safety of other residents by not placing Resident 148 on contact isolation and not perform hand hygiene with soap and water. During an interview on 4/24/2025, at 3:21 p.m., with Director of Nursing (DON), DON stated, all staff and visitors needed to follow isolation precaution, and staff should educate the visitors regarding precaution and PPE. DON stated, the staff should place contact isolation for Resident 148 while waiting for lab result to prevent further spreading infection. During a review of Resident 148's Care Plan (CP), initiated and revised on 4/23/2025, the CP Focus indicated, Resident 148 had diarrhea. The CP Interventions indicated, give anti-diarrheal medication and encourage fluid intake, but there was no intervention for contact isolation precaution. During a review of the facility's Policy and Procedure (P&P) titled, IPCP Standard and Transmission-Based Precautions, revised 3/2024, the P&P indicated, Policy: Transmission-Based Precautions are the second tier of basic infection control and used in addition to Standard Precautions for patients who are or may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Procedure: 2. Contact Precautions are used with a known infection that is spread by direct or indirect contact with the resident or the resident's environment. (e.g. MDROs). Note: Contact precautions/isolation are required for patients with MDROs with: o Draining wounds or secretions/excretions that cannot be covered and contained, o Acute diarrhea . b. Personal protective equipment {PPE): i. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. ii. [NAME] PPE upon room entry, then doff and properly discard PPE and perform hand hygiene before exiting the patient room to contain pathogens.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46537 Based on interview and record review, the facility failed to implement the antibiotic stewardship program (the effort to ensure that [antibiotics - medicines that fight bacterial infections in people and animals] are used only when necessary and appropriate) for two of four sampled residents (Resident 148 and Resident 14) as evidenced by: A. Failing to identify the indication of use and assess Infection Surveillance (an active reassessment of an antimicrobial prescription 48-72 hours after first administration) of Zosyn (a prescription drug that's used to treat or prevent certain infections intravenously) for Resident 148. B. Failing to implement Infection Surviellance of daptomycin (medication used to treat infection) for Resident 14. This deficient practice had the potential for resident to develop antibiotic resistance (not effective to treat infection) from unnecessary or inappropriate antibiotic use. Findings: A. During a review of Resident 148's Admission Record, the Admission Record indicated, Resident 148 was admitted to the facility on [DATE] with diagnoses including pneumonia (an infection/inflammation in the lungs), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 148's History and Physical (H&P), dated 4/21/2025, the H&P indicated, Resident 148 had fluctuating ability to make medical decisions. During a review of Resident 148's Minimum Data Set (MDS - a resident assessment tool), dated 4/25/2025, the MDS indicated Resident 148 required moderate assistance (Helper does less than half the effort) from one staff for oral hygiene, toileting hygiene, shower/bathe self, dressing, personal hygiene, bed mobility, transfer, and supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and /or contact guard assistance as resident completes activity) from one staff for eating. During a review of Resident 148's Order Summary Report (OSR), dated 4/24/2025, the OSR indicated, give Zosyn intravenous solution 4-0.5 milligram (mg)/100 milliliter (ml) every eight hours for pneumonia for two days was ordered on 4/21/2025 and completed on 4/23/2025. During a review of Resident148's Care Plan (CP), initiated and revised on 4/21/2025, the CP Focus indicated, Resident 148 had community acquired pneumonia. The CP Interventions indicated, give medications as ordered and monitor/document for side effects and effectiveness. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/24/2025, at 9:36 a.m., with the IPN, Resident 148's Infection Surveillance, dated 4/21/2025 was reviewed. The Infection Surveillance indicated, there was no documentation and was left blank. The IPN stated, Resident 148 received Zosyn (mediction used to treat infection) through Intravenous (IV) therapy from the General Acute Care Hospital (GACH) prior to admission to the facility and Resident 148 continued to receive the Zosyn at the facility.The IPN stated, she did not do Infection Surveillance (equivalent to Antibiotic Time Out) assessment. The IPN stated, she was not sure if Zosyn antibiotic administration for Resident 148 met McGeer's Criteria (criteria used to determine appropriate use of antibiotics). The IPN stated, Zosyn administration for Resident 148 was completed yesterday, and she (IPN) should have done Infection Surveillance assessment to see if Zosyn was indicated because unnecessary use of antibiotics could lead to develop antibiotic resistance. During a concurrent interview and record review on 4/24/2025, at 4:21 p.m., with the Director of Nursing (DON), Resident 148's Infection surveillance, dated 4/24/2025 was reviewed. The Infection Surveillance indicated, McGeer's Criteria was not met for Zosyn. The DON stated, she completed the Infection Surveillance assessment and realized Resident 148's condition did not meet McGeer's criteria for recieving Zosyn, but the Zosyn was given already. The DON stated, all antibiotics should be assessed, monitored, and evaluated for the indication and duration of the therapy to prevent unnecessary use of antibiotics that could develop resistance, and unnecessarily suffer from adverse reaction and side effects. B. During a review of Resident 14's Admission Record, the Admission Record indicated Resident 14 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including asthma (a chronic respiratory disease characterized by inflammation and narrowing of the airways, making breathing difficult), hypertension ([HTN], high blood pressure), atrial fibrillation ([A-Fib], (a condition that causes irregular and fast heartbeat in the heart), and hyperlipidemia (too much fat particles in the blood). During a review of Resident 14's H&P dated 4/6/2025, the H&P indicated has the capacity to understand and make decisions. During a review of Resident 14's MDS dated [DATE], the MDS indicated Resident 14 had intact cognitive skills and was independent (resident completes the activity by themselves with no assistance from a helper) with self-care abilities such as eating, required supervision (helper provides verbal cues as resident completes the task) with oral hygiene, personal hygiene, and upper body dressing, required moderate assistance (helper does less than half the effort completing task) with toileting hygiene, lower body dressing, and putting on/taking off footwear and maximal assistance (helper does more than half the effort) with shower/bathe. The MDS indicated Resident 14 required supervision mobility such as rolling left and right, sitting to lying position, and lying to sitting on side of bed, required moderate assistance with sit to stand position, bed to chair transfer, toilet transfers, shower transfers, and walking 10 to 50 feet. During a review of Resident 14's Order Summary Report, the Order Summary Report indicated daptomycin intravenous ([IV], existing or taking place within, or administered into, a vein or veins) solution reconstitute 850 milligram ([mg], unit of measurement) intravenously one time a day for right hip wound MRSA ([Methicillin-resistant Staphylococcus aureus], infection caused by a type of bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections) infection for 35 days ordered on 4/4/2025. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 14's Infection Surveillance dated 4/4/2025, the Infection Surveillance indicated the surveillance by body system indicated other infections such as right hip surgical wound infection with antibiotic treatment daptomycin 850 mg IV one time a day started on 4/5/2025 and that infection preventionist note meets criteria for infection. The Infection Surveillance also indicated infection preventionist note that Resident 14 was currently on daptomycin 850 mg IV one time a day. During a review of the Antibiotics Stewardship binder, the Antibiotic Stewardship binder indicated a list of all the residents in the facility that were receiving antibiotics with the reason for antibiotic use, the start date, the end date and the signs and symptoms or testing residents had done. Resident 14 was not on the list of residents who were receiving antibiotics in the facility. During a review of Resident 14's care plan dated 4/6/2025, the care plan indicated interventions such as monitor/document/report to medical doctor as needed for signs and symptoms of infection at the site such as drainage, inflammation, swelling, redness and warmth. The care plan also indicated to give medication as ordered and monitor/document for effectiveness, side effects, monitor/document/report to medical doctor as needed for signs and symptoms of MRSA infection such as inflammation around the wound sites, drainage, lethargy, headache, increased heart rate, urinary tract infections, and toxic shock syndrome. During an observation on 2/4/25 at 10:23 a.m., of Resident 14 in her room, Resident 14 was resting in bed watching television. Resident 14 stated she had revision surgery on her right hip replacement on 3/25/2025. Resident 14 stated she was getting antibiotics through her PICC (peripherally inserted central catheter, a long, thin tube inserted into a vein in the arm and threaded up to a larger vein near the heart) line on right upper arm. During a concurrent interview and record review on 4/24/2025 at 11:33 a.m., with the IPN, the Order Summary Report, antibiotics stewardship binder, and Infection Surveillance dated 4/4/2025 were reviewed. The IPN stated Resident 14 was started on daptomycin 850 mg intravenously one time a day for right hip wound MRSA infection for 35 days. The IPN stated she was aware that Resident 14 was on IV antibiotics, but that Resident 14 was not monitored in the antibiotics stewardship binder for residents who are on antibiotics. The IPN stated residents that are not being monitored while receiving antibiotics may experience adverse effects, the medication might not be affective anymore and residents might get another infection.The IPN stated the Infection Surveillance was done when Resident 14 was started on the antibiotic, but another assessment was not done after to see if the medication was effective, if it needed to be continued and no monitoring was done. During a concurrent interview and record review on 4/24/2025 at 4:50 p.m. with the DON, the Infection Surveillance dated 4/4/2025 was reviewed. The DON stated there was no monitoring done for Resident 14 while the on antibiotic. The DON stated Resident 14 was first assessed on 4/4/2025 when the antibiotic was ordered but there have been no other assessments done after to see if the antibiotic was still required. The DON stated there was no monitoring in place to see if there was still a need for the antibiotic. The DON stated the importance of monitoring residents on antibiotics was to see if the antibiotics were working, and to monitor any signs or symptoms if the antibiotics was still needed. The DON stated the IPN should have followed up with the doctor for prolonged use of the antibiotic because the resident can develop resistance to the antibiotic. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P/P) titled, Antibiotic Stewardship, dated 12/2023, indicated is the policy of this facility to implement an Antibiotic Stewardship Program (ASP) that is incorporated in the overall Infection Prevention and Control Program which will promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use . review data, monitor and summarize antibiotic use from pharmacy data, such as the rate of new starts, types of antibiotics prescribed summarize antibiotic resistance patterns based on laboratory data incorporate monitoring of antibiotic use, including the frequency of monitoring/review, report on number of antibiotics prescribed and the number of residents treated each month, assess residents for any infection using McGeer's criteria, require antibiotic orders to include the indication, dose, and duration . facility may consider antibiotic time-out (TO) practices. A time-out can be considered a stop order of an antibiotic when a diagnostic test or symptoms of resident do not support the diagnosis of infection. These practices include improving the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection, optimizing the use of diagnostic testing, and implementing an antibiotic review process, also known as an antibiotic time-out, for all antibiotics prescribed in the facility . IP or designee will be responsible for infection surveillance and [NAME] tracking. IP or designee will collect and review data. During a review of the facility's Policy and Procedure (P&P) titled, Antibiotic Stewardship, revised 12/2023, the P&P indicated, Policy :It is the policy of this facility to implement an Antibiotic Stewardship Program (ASP) that is incorporated in the overall Infection Prevention and Control Program which will promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. This policy has the potential to limit antibiotic resistance in the post-acute care setting, while improving treatment efficacy and resident safety, and reducing treatment-related costs. This policy will include basic elements about antibiotic resistance and opportunities for improvement. Procedure: 1. Leadership: a. The team may consist of the Medical Director, Administrator, Director of Nursing, Infection Preventionist, Pharmacy Consultant and Laboratory Representative. b. The team will: o Review data, monitor and summarize antibiotic use from pharmacy data, such as the rate of new starts, types of antibiotics prescribed, or days of antibiotic treatment per 1,000 resident days o Summarize antibiotic resistance patterns based on laboratory data, for example, the last 18 months; and/or o Track measures of outcome surveillance related to antibiotic use (e.g. C. difficile, MRSA, and/or CRE) o Incorporate monitoring of antibiotic use, including the frequency of monitoring/review o Report on number of antibiotics prescribed and the number of residents treated each month o Assess residents for any infection using McGeer's criteria. o Require antibiotic orders to include the indication, dose, and duration . 4. Action: a. Facility may consider antibiotic time-out (TO) practices. o A time-out can be considered a stop order of an antibiotic when a diagnostic test or symptoms of resident do not support the diagnosis of infection. oThese practices include improving the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection, optimizing the use of diagnostic testing, and implementing an antibiotic review process, also known as an antibiotic time-out, for all antibiotics prescribed in the facility. Antibiotic reviews provide clinicians with an opportunity to reassess the ongoing need for and choice of an antibiotic when the clinical picture is clearer and more information available. 5. Tracking: a. IP or designee will be responsible for infection surveillance and [NAME] tracking. b. IP or designee will collect and review data. B. [NAME] Resident 14 49573