STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056218	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bell Convalescent Hospital	4900 E. Florence Ave Bell, CA 90201

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P), titled Administering Medications, which indicated medications were to be administered in accordance with prescriber orders and within one hour of their prescribed time for one of three sample residents (Resident 19). This deficient practice resulted in Resident 19 being administered Hydrocodone-Acetaminophen (Norco - a medication to relieve moderate to severe pain) 3 hours earlier than the prescribed time. Findings: During an observation on 7/10/2024 at 9:58 a.m., in front of Resident 19's room, LVN 5 retrieved a bubble pack of Norco from the medication cart. LVN 5 removed one tablet from the bubble pack and placed the tablet in a medicine cup. LVN 5 went inside of Resident 19's room to administer the resident Norco for pain. A review of Resident 19's Admission Record, dated 11/29/2023, indicated Resident 19 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 19's diagnoses included convulsions (sudden, irregular movement of a limb of the body), hemiplegia (inability to move one side of the body) and hemiparesis (weakness to move one side of the body) following cerebrovascular disease (relating to the brain and its blood vessels) affecting the left non-dominant side. A review of Resident 19's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 4/24/2024 indicated Resident 19 was moderately impaired with cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 19 had impairment on one side of the upper extremities and impairment on both sides of the lower extremities. The MDS further indicated Resident 19 required a helper for all efforts related to toileting and bathing. A review of Resident 19's' History and Physical (H&P), dated 12/5/2023, indicated Resident 19 did not have the capacity to understand and make decisions. (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: 056218	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024

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Bell Convalescent Hospital	4900 E. Florence Ave Bell, CA 90201

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 19's care plan with a focus of Resident at risk for alterations in pain and comfort related to contractures on both knees and chronic leg pain, initiated on 11/8/2023 and revised 12/26/2023 indicated pain would be controlled to Resident 19's level of comfort and the resident would not have any interruptions in normal activities due to pain. The staff's interventions included to assess Resident 19's pain level as needed, and give meds as ordered. A review of Resident 19's Order Summary Report, dated 6/3/2024, indicated to administer Norco Oral Tablet 5-325 MG, 1 tablet by mouth, every 12 hours as needed for moderate pain. A review of Resident 19's Medication Administration Record (MAR), dated 7/10/2024, indicated Resident 19 received Norco at 12:50 a.m. for a pain level of seven out of ten (7/10), indicating severe pain. The MAR indicated LVN 5 did not document the 9:58 a.m. dose administration. During an interview on 7/11/2024 at 4:21 p.m., with the Director of Nursing (DON), the DON stated the licensed nurses must know the medications and the five rights (right drug, right dose, right time, right route, and right patient) when administering medications to the residents. A review of the facility's policy and procedure (P&P) titled, Administering Medications, revised April 2019, indicated medications are administered in accordance with prescribers' orders, including any required time frame. The P&P indicated medications are administered within one hours of their prescribed time, unless otherwise specified. The P&P indicated the individual administering the medication would initials the resident's MAR on the appropriate line after giving each medication and before giving the next ones. The P&P indicated the medication along with the date and time the medication was administered, the dosage and the route of administration would be recorded in the resident's medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056218	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Bell Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 4900 E. Florence Ave Bell, CA 90201	

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to administer supplemental oxygen as ordered by the physician for one of two sampled residents (Resident 5). This deficient practice created the potential for Resident 5 to suffer from oxygen toxicity (lung damage that happens from breathing in too much extra [supplemental] oxygen, and can cause coughing, trouble breathing, and, in severe cases, death). Findings: A review of Resident 5's Admission Record indicated Resident 5 was admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 5's admitting diagnoses included heart failure (when the heart muscle doesn't pump blood as well as it should), asthma (a chronic lung disease affecting people of all ages), and respiratory failure (condition in which your blood doesn't have enough oxygen or has too much carbon dioxide). A review of Resident 5's Minimum Data Set (MDS; a comprehensive assessment and care planning tool) dated 6/24/2024, indicated Resident 5 had impaired short-term memory (ability to recall events from the last 5 minutes) and mild cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 5 required substantial to maximal assistance from staff for eating, brushing her teeth, repositioning herself from left to right while in bed, and to move from a lying to a sitting position. During an observation on 7/11/2024 at 12:39 PM, at Resident 5's bedside, Resident 5 was observed wearing a nasal cannula (a thin, flexible tube that wraps around your head, typically hooking around your ears, that delivers oxygen) delivering supplement oxygen at a rate of four (4) liters per minute (L/min; a unit of oxygen delivery rate). During a concurrent observation, interview, and record review, on 7/11/2024 at 12:50 PM, with the Director of Nursing (DON), at Resident 5's bedside, Resident 5's physician orders dated 7/1/2024 were reviewed. Resident 5's oxygen delivery system was observed. The DON stated Resident 5 was receiving oxygen at a rate of four (4) L/min, and stated Resident 5's physician orders indicated Resident 5 was supposed to receive oxygen at two (2) L/min. A review of the facility policy and procedure (P&P) titled Oxygen Administration , dated 10/2010, indicated the purpose of the P&P was to provide guidelines for safe oxygen administration, and indicated staff were supposed to verify and review the physician's orders for oxygen administration. The P&P further indicated staff were supposed to adjust the oxygen delivery device to ensure the proper flow of oxygen was being administered. A review of the facility P&P titled Policy and Procedure on Physician Orders , undated, indicated it was the facility's policy to provide care and services in accordance with physician orders.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P), titled Pain Assessment to ensure effective pain management assessment was conducted for one of three sampled resident (Resident 19), by: 1. Licensed Vocational Nurse (LVN 5) failing to promptly address Resident 19's pain, when the resident verbalized, he was in pain. 2. LVN 5 failing to use a standard pain assessment scale to determine Resident 19's pain level. 3. LVN 5 failing to ensure the licensed nurse further assessed Resident 19's pain to determine the location, frequency, quality, intensity, and duration of pain. 4. LVN 5 failing to document Resident 19's administration of Hydrocodone-Acetaminophen (Norco - a medication to relieve moderate to severe pain). 5. LVN 5 failing to ensure Resident 19 was assessed and re-evaluated for pain before administering more pain medications. These deficient practices caused Resident 19 to experience pain that interfered with his activities of daily living and had the potential to result in Resident 19 experiencing unrelieved pain. Findings: A review of Resident 19's Admission Record, dated 11/29/2023, indicated Resident 19 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 19's diagnoses included convulsions (sudden, violet, irregular movement), hemiplegia (inability to move one side of the body) and hemiparesis (partial inability to move one side of the body) following cerebrovascular disease (relating to the brain and its blood vessels) affecting the left non-dominant side. A review of Resident 19's Minimum Data Set (MDS - a standardized resident assessment care screening tool), dated 4/24/2024 indicated Resident 19 was moderately impaired with cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 19 had impairment on one side of the upper extremities and impairment on both sides of the lower extremities. The MDS further indicated Resident 19 required a helper for all efforts related to toileting and bathing. A review of Resident 19's' History and Physical (H&P), dated 12/5/2023, indicated Resident 19 did not have the capacity to understand and make decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056218	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER: Bell Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE: 4900 E. Florence Ave Bell, CA 90201	

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/10/2024 at 9:38 a.m., with LVN 5 and Resident 19, LVN 5 was observed taking Resident 19's blood pressure during the morning medication pass. LVN 5 asked Resident 19 why he refused his shower and Resident 19 replied that he was having pain. LVN 5 completed Resident 19's blood pressure reading and proceeded back to the medication cart to prepare the resident's routine morning medications. LVN 5 placed the medications in a medicine cup and took them back into the room. LVN 5 handed the cup to Resident 19 and stated, Here are our medications. When Resident 19 was asked if he knew what medications he was taking, the resident replied Norco. LVN 5 stated No, these are your regular medications. Resident 19 stated, I need something for pain, I thought this was my pain medication. Give me everything, I need Tylenol and all my medications. I am having pain! LVN 5 asked Resident 19 where he was having pain. Resident 19 stated in his left leg. LVN 5 proceeded to the medication cart. LVN 5 took out a bubble pack and placed one tablet of Norco in a medication cup. At 9:58 a.m., LVN 5 administered the Norco to Resident 19. LVN 5 immediately returned back to medication cart. LVN 5 was asked if she knew what Gabapentin was used for, and LVN 5 replied she was not sure, but she believed Gabapentin was a pain medication and ordered for Resident 19's leg pain. LVN 5 stated that she did not know Resident 19's pain level because she did not ask. LVN 5 stated that she gave the Norco without asking Resident 19's pain level because the nurses always gave Resident 19 Norco for pain. LVN 5 stated that she should have asked the resident's pain level before administering Norco. LVN 5 stated that she should have given Tylenol before giving Norco and she should have checked to see if the Gabapentin worked before giving additional medications for pain. LVN 5 stated that it was important to know if the pain level was mild, moderate, or severe. LVN 5 stated if the pain was severe and the pain medication did not work, staff were to call the doctor. LVN 5 stated We have to ask the pain level to avoid medication errors. A review of Resident 19's care plan with a focus of Resident at risk for alterations in pain and comfort related to contractures on both knees and chronic leg pain, initiated on 11/8/2023 and revised 12/26/2023, indicated pain would be controlled to Resident 19's level of comfort and Resident 19 would not have any interruptions in normal activities due to pain. The staff interventions included to assess Resident 19's pain level as needed, observe for pain, provide comfort measures as needed and provide diversional activities and non-medications interventions which included positioning, relaxation therapy, progressive relaxations, bathing, heat and cold application and muscle stimulation as needed. A review of Resident 19's Order Summary Report, dated 6/3/2024, indicated an active order dated 12/4/2024 to monitor pain every shift with the pain scale. A review of Resident 19's Order Summary Report, dated 6/3/2024, indicated an active order dated 12/4/2024 for Acetaminophen (Tylenol - a medication to relieve mild to moderate pain) 325 milligrams (MG, unit of measurement). The order indicated to give 2 tablets by mouth every six hours as needed for pain. A review of Resident 19's Order Summary Report, dated 6/3/2024, indicated an active order dated 12/4/2024 for Norco Oral Tablet 5-325 MG. The order indicated to give 1 tablet by mouth every 12 hours as needed for moderate pain. A review of Resident 19's Order Summary Report, dated 6/3/2024, indicated an active order dated 12/4/2024 for Gabapentin Oral Capsule (a medication used to treat nerve pain). The order indicated to give 300 MG by mouth two times a day for pain on the lower extremities. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bell Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 4900 E. Florence Ave Bell, CA 90201	

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 19's Medication Administration Record (MAR), dated 7/10/2024, indicated Resident 19 received Norco at 12:50 a.m., for a pain level of seven out of ten (7/10), indicating severe pain. A review of Resident 19's Pain Assessment Scale dated 7/10/2024 and timed at 9:50 a.m., indicated Resident 19 was assessed by LVN 5. The pain assessment scale indicated Resident 19 had a pain level of three out 10 (3/10), indicating mild pain. A review of Resident 19's MAR dated 7/10/2024, indicated LVN 5 did not document the administration of Norco at 9:58 a.m., as observed during the morning medication pass. During an interview on 7/11/2024 at 4:21 p.m., with the Director of Nursing (DON), the DON stated that all licensed nurses should know the medications they were giving to the residents and the nurses should always ask the residents their pain level. The DON stated, If you don't ask the resident their pain level, you will not know if you are relieving the resident's pain. A review of the facility's undated policy and procedure (P&P) titled, Pain Assessment, indicated pain would be assessed and recorded each time that vital signs are recorded for each resident. The P&P indicated a standard Pain Assessment Scale would be used to determine pain levels of each resident and for residents with complaints of pain, further assessment would be completed by licensed nurses to determine the nature, quality, intensity, and effects of pain. A review of the facility's P&P titled, Administering Medications, revised April 2019, indicated medications are administered in accordance with prescribers' orders, including any required time frame. The P&P indicated medications are administered within one hours of their prescribed time, unless otherwise specified. The P&P indicated the individual administering the medication would initials the resident's MAR on the appropriate line after giving each medication and before giving the next ones and records in the resident's medical record, the date and time the medication was administered, the dosage and the route of administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056218	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bell Convalescent Hospital	4900 E. Florence Ave Bell, CA 90201

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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 - Many

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47286

Based on observation, interview, and record review, the facility failed to ensure infection prevention and control was maintained when the following occurred:

1. Enhanced barrier precautions (EBP; an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] that employs targeted gown and glove use during high contact resident care activities) were not implemented for 15 of 16 residents who met EBP-implementation criteria (Residents 2, 3, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 18).

2. Facility failed to report three new cases of Covid-19 (an acute disease caused by a coronavirus, capable of progressing to severe symptoms, including death, especially in older people and those with underlying health conditions) to the local health department on 6/21/2024 and 6/24/2024 (Laundry Staff [LS] 1, Licensed Vocational Nurse [LVN] 1, and Resident 5), prior to closing an outbreak (the occurrence of more cases of disease than expected in a given area or among a specific group of people over a particular period of time.) at the facility.

These deficient practices created the risk for avoidable spread of infection to all facility residents and staff and placed vulnerable facility residents at risk of suffering severe illness and/or death.

Findings:

1. a. A review of Resident 2's Admission Record indicated Resident 2 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 2's admitting diagnoses included dysphagia (difficulty or discomfort in swallowing).

A review of Resident 2's physician orders, dated 9/23/2023, indicated Resident 2 received enteral feeding through a gastrostomy tube (GT; a tube inserted through the belly that brings nutrition directly to the stomach).

b. A review of Resident 3's Admission Record indicated Resident 3 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 3's admitting diagnoses included dysphagia and benign prostatic hyperplasia (BPH; a non-cancerous condition in which the prostate gland [a small organ located below the bladder] is larger than normal).

A review of Resident 3's Minimum Data Set (MDS; a comprehensive assessment and care-planning/care-screening tool), dated 4/17/24, indicated Resident 3 had a GT for nutrition and an unhealed pressure ulcer (an injury that breaks down the skin and underlying tissue).

c. A review of Resident 6's Admission Record indicated Resident 6 was admitted to the facility on [DATE]. Resident 6's admitting diagnoses included chronic kidney disease (CKD; a gradual loss of kidney function over time).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 6's MDS, dated [DATE], indicated Resident 6 had an indwelling urinary catheter (a tube that is inserted into and remains in the bladder that drains urine into a bag outside the body). d. A review of Resident 7's Admission Record indicated Resident 7 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 7's admitting diagnoses included dysphagia. A review of Resident 7's MDS, dated [DATE], indicated Resident 7 had a GT for administration of artificial nutrition. e. A review of Resident 8's Admission Record indicated Resident 8 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE]. Resident 8's admitting diagnoses included dysphagia and the presence of a GT. A review of Resident 8's MDS, dated [DATE], indicated received artificial nutrition via GT. f. A review of Resident 9's Admission Record indicated Resident 9 was admitted to the facility on [DATE]. Resident 9's admitting diagnoses included dysphagia, presence of GT, and BPH. A review of Resident 9's MDS, dated [DATE], indicated Resident 9 had a GT for administration of artificial nutrition. g. A review of Resident 10's Admission Record indicated Resident 10 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 10's admitting diagnoses included presence of a GT and dysphagia. A review of Resident 10's MDS, dated [DATE], indicated Resident 10 had a GT for administration of artificial nutrition. h. A review of Resident 11's Admission Record indicated Resident 11 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE]. Resident 11's admitting diagnoses included presence of a GT and failure to thrive (weight loss of more than 5%, decreased appetite, poor nutrition, and physical inactivity). A review of Resident 11's MDS, dated [DATE], indicated Resident 11 had a GT for administration of artificial nutrition. i. A review of Resident 12's Admission Record indicated Resident 12 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 12's admitting diagnoses included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and presence of GT. A review of Resident 12's MDS, dated [DATE], indicated Resident 12 had a GT for administration of artificial nutrition. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	j. A review of Resident 13's Admission Record indicated Resident 13 was admitted to the facility on [DATE]. Resident 13's admitting diagnoses included end stage renal disease (ESRD; the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own), and dependence on renal dialysis ([hemodialysis] a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to). A review of Resident 13's MDS, dated [DATE], indicated Resident 13 was receiving hemodialysis while a resident of the facility. k. A review of Resident 14's Admission Record indicated Resident 14 was admitted to the facility on [DATE]. Resident 14's admitting diagnoses included ESRD and dependence on renal dialysis. A review of Resident 14's MDS, dated [DATE], indicated Resident 14 was receiving hemodialysis while a resident of the facility. l. A review of Resident 15's Admission Record indicated Resident 15 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 15's admitting diagnoses included BPH and urinary retention (when your bladder doesn't empty completely or at all). A review of Resident 15's MDS, dated [DATE], indicated Resident 15 had an indwelling urinary catheter. m. A review of Resident 16's Admission Record indicated Resident 16 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 16's admitting diagnoses included BPH and urinary retention. A review of Resident 16's MDS, dated [DATE], indicated Resident 16 had an indwelling urinary catheter. n. A review of Resident 17's Admission Record indicated Resident 17 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 17's admitting diagnoses included CKD, urinary retention, and Extended-spectrum beta-lactamase resistance (a multidrug resistant organism [MDRO]). A review of Resident 17's MDS, dated [DATE], indicated Resident 17 had an indwelling urinary catheter and open foot wounds/lesions. o. A review of Resident 18's Admission Record indicated Resident 18 was originally admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 18's admitting diagnoses included a urinary tract infection (an illness in any part of the urinary tract, the system of organs that makes urine) and resistance to vancomycin (an antibiotic used to treat bacterial infections). A review of Resident 18's MDS, dated [DATE], indicated Resident 18 had an indwelling urinary catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/10/2024 at 5:05 PM with Licensed Vocational Nurse (LVN 3), LVN 3 stated standard precautions (the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient) were used while providing direct care for residents with indwelling medical devices (including indwelling urinary catheters, GTs, and dialysis catheters [a flexible tube used for dialysis treatment]) and open wounds. LVN 3 stated staff did not use EBP for any facility residents. During an interview on 7/10/2024 at 5:17 PM, with the Director of Nursing (DON), the DON stated he was currently serving as the facility's Infection Preventionist (IP) Nurse and stated the facility did not have any residents on EBP. The DON stated EBP was required for residents with any indwelling medical devices and/or open/unhealed wounds. The DON stated EBP required staff to wear gown and gloves as personal protective equipment (PPE; protective clothing, goggles, or other garments designed to protect the wearer from infection) when providing direct care. The DON stated he discussed the implementation of EBP with the facility Administrator (ADM) two months prior, and stated the ADM told him EBP was not required. The DON stated the ADM was not a clinician (a health care professional). During an interview on 7/11/2024 at 9:07 AM, with Certified Nursing Assistant (CNA) 1, CNA 1 stated staff were trained to identify which residents required PPE by checking any applicable signage posted outside of the resident's room. CNA 1 stated there should also be a cart containing PPE outside of the resident's room. CNA 1 stated standard precautions were used for residents with indwelling medical devices and open wounds. CNA 1 stated that when providing care to residents with indwelling medical devices and/or open wounds she did not implement EBP. CNA 1 stated she had not been instructed to use EBP, or trained on how to implement EBP, for any residents in the facility. During an interview on 7/11/2024 at 9:46 AM, with the Medical Records Manager (MRM), the MRM stated the facility did not have a policy and procedure for EBP or the implementation of EBP in the facility. During a concurrent interview and record review, on 7/11/2024 at 11:01 AM, with the DON, a memorandum titled QSO(Quality, Safety, and Oversight) 24-08[BF1] , dated 3/20/2024, was reviewed. The DON stated the memorandum indicated implementation of EBP was mandatory. The DON stated he did not provide the memorandum to the ADM and stated he had followed up with the ADM after the first discussion of EBP and was still waiting for the ADM's decision. The DON stated the facility housed residents who qualified for the implementation of EBP, and stated it was not being implemented. The DON stated the purpose of EBP was to prevent the spread of infection, and stated a failure to implement EBP in the facility created the risk for spread of infection. During an interview on 7/11/2024 at 11:36 AM with the ADM, the ADM stated he was aware of what EBP was, and stated he thought implementation of EBPs was a recommendation, and not required. The ADM stated he was planning on initiating EBP in the facility but wanted to do his own research first. The ADM stated he was not a clinician. 2. During a concurrent interview and record review, on 7/10/2024 at 10:20 AM, with the DON, the facility's untitled and undated line list (a table containing key information about an outbreak) was reviewed. The DON stated there were two Covid-19 positive staff cases on 6/21/2024 (LS 1 and LVN 1) and one positive resident case (Resident 5 in Room A) on 6/24/2024. The DON stated all positive cases had been reported to the local health department. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056218	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Bell Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 4900 E. Florence Ave Bell, CA 90201	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/10/2024 at 10:37 AM with the facility's assigned Public Health Nurse (PHN) 1, PHN 1 stated the facility had an active Covid-19 outbreak from 6/11/2024 to 6/24/2024. PHN 1 stated the facility did not report the positive staff cases on 6/21/2024, or the positive resident case on 6/24/2024. PHN 1 stated the outbreak would have been extended beyond 6/24/2024 if the facility had notified her of the three new positive cases. PHN 1 stated the facility was supposed to report all positive cases during an outbreak in the facility. PHN 1 stated failure to report positive cases created the risk for transmission to vulnerable residents, visitors, and staff. PHN 1 stated Covid-19 was a high-risk infection and should be reported immediately. During an interview on 7/10/2024 at 3:08 PM with PHN 1, PHN 1 stated the outbreak clearance letter (a letter indicating the conclusion of the outbreak) was sent to the facility on [DATE] at 4:19 PM. PHN 1 stated the facility was instructed to notify her of all new admissions and readmissions to the facility during the outbreak. PHN 1 stated the DON did not notify her of Resident 6's admission to room A on 6/21/2024. PHN 1 stated all new admissions were supposed to be tested upon admission to the facility. PHN 1 stated the facility should have tested Resident 6 on 6/24/2024, 6/29/2024, and 7/4/2024 after identifying Resident 5 (Resident 6's roommate) was positive for Covid-19. During an interview on 7/11/2024 at 9:17 AM, with Resident 5's Family Member (FM) 1, FM 1 stated Resident 5 felt fatigued one to two days prior to testing positive for Covid-19 on 6/24/2024. FM 1 stated they notified facility staff of Resident 5's new onset fatigue, and stated facility staff told them it was likely because Resident 5 had been in bed for a long time. FM 1 stated on 6/24/2024, Resident 5 felt more fatigued, and began to have difficulty breathing. FM 1 stated they were at Resident 5's bedside on 6/24/2024 and did not see facility staff perform a Covid-19 test on Resident 5 when her symptoms worsened. FM 1 stated Resident 5's roommate (Resident 6) arrived a few days before Resident 5 was transferred to the hospital and tested positive for Covid-19. FM 1 stated Resident 6 was coughing a lot when she was admitted to Room A. FM 1 stated the curtain between Resident 5 and Resident 6's bed was drawn, but they did not feel comfortable. FM 1 stated staff wore a surgical mask (a mask effective in blocking splashes and large-particle droplets, that does not filter or block very small particles in the air that may be transmitted by coughs, sneezes, or certain medical procedures) when entering the room and providing care to Resident 5. FM 1 stated they wore a surgical mask. During an interview on 7/11/2024 at 10:24 AM, with LVN 1, LVN 1 stated their last day of work prior to testing positive for Covid-19 was 6/19/2024. LVN 1 stated she was assigned to Room A on 6/19/2024, and stated she began to experience a sore throat and did not feel well by the end of their shift. LVN 1 stated she tested positive on 6/20/2024, and stated the DON was notified via text message on 6/20/2024 of the positive Covid-19 test result. LVN 1 stated she wore a surgical mask 6/19/2024, and not an N95 respirator (a protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles), while providing care to the residents in Room A. A review of the facility census and staffing for 6/19/2024 indicated LVN 1 was assigned to Room A on 6/19/24 and indicated Resident 5 was in Room A on 6/19/2024. During an interview on 7/12/2024 at 9:26 AM, with LVN 1, LVN 1 stated the DON instructed staff to wear a surgical mask while at work. LVN 1 stated the DON informed facility staff that an N95 respirator was only required if the staff member was symptomatic. During an interview on 7/12/2024 at 10:08 with PHN 1, PHN 1 stated all facility staff were supposed to wear an N95 respirator while at work. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

During a concurrent interview and record review, on 7/11/2024 at 11:01 AM, with the DON, Resident 5's Change of Condition Evaluation (COC), dated 6/24/2024, was reviewed. The DON stated the COC indicated Resident 5's difficulty breathing was reported to the Charge Nurse at 12:26 PM on 6/24/2024. The DON stated difficulty breathing was considered a symptom of Covid-19 and should have been reported to PHN 1. The DON also stated residents with symptoms were supposed to be tested for Covid-19. The DON stated there was no documentation in Resident 5's medical record to indicate the resident was tested on ce her difficulty breathing was identified at 12:26 PM. The DON stated Resident 5 was transferred to general acute care hospital [BF2] (GACH) 1 on 6/24/2024 and stated FM 2 notified him at 4:05 PM that Resident 5 tested positive for Covid-19 upon arrival to GACH 1. The DON stated he was aware Resident 5's positive Covid-19 result and did not report it to PHN 1 prior to PHN 1's closure of the Covid-19 outbreak. The DON stated he should have reported the positive result and stated failing to report the positive result put other facility residents and staff at risk.

During a concurrent interview and record review, on 7/11/2024 at 1:37 PM, with the ADM, the facility's P&Ps titled Coronavirus Disease (Covid-19) Updated Policy on Surveillance, Testing, Reporting and Staffing Guidance , dated 10/7/2022, and Coronavirus Disease (Covid-19) Infection Prevention and Control Measures, dated 7/2020, were reviewed. The ADM stated these P&Ps were the current P&Ps followed in the facility for Covid-19. The ADM stated the P&Ps were not currently under review or in the process of being revised.

During a concurrent interview and record review, on 7/11/2024 at 2:35 PM, with the DON, the Health Officer Orders (HOO) sent to the facility by PHN 1, dated 6/11/2024, the facility census and staffing for 6/19/2024, and the facility's P&P titled Coronavirus Disease (Covid-19) Updated Policy on Surveillance, Testing, Reporting and Staffing Guidance , dated 10/7/2022 were reviewed. The DON stated the two positive staff cases on 6/21/2024 and positive resident case on 6/24/2024 were not reported, and stated the HOO indicated all positive cases were supposed to be reported. The DON stated LVN 1 was assigned to provide care to Resident 5, in Room A, and stated LVN 1 had been in close contact with Resident 5 during their shift. The DON stated Resident 6 was admitted to Room A on 6/21/2024. The DON stated the P&P indicated all new admissions were supposed to be tested for Covid-19 on admission, then again 3 days after and 5 days after admission. The DON reviewed Resident 6's medical record and stated there was no documentation to indicate Resident 6 was tested upon admission, three days after admission, 5 days after admission, or after it was identified that her roommate (Resident 5) was identified as positive for Covid-19 on 6/24/2024. The DON stated the P&P indicated facility-wide Covid-19 testing was supposed to be conducted in response to a positive case of Covid-19 in the facility, and stated this was not done after the two positive staff cases on 6/21/2024 and the positive resident case on 6/24/2024. The DON stated failure to report the positive cases and failure to perform the required testing created the risk for a worsening of the Covid-19 outbreak, and for more residents and staff to be infected by Covid-19.

During an interview on 7/11/2024 at 4:00 PM, with the ADM and DON, the ADM stated LVN 1's positive Covid-19 result was not reported because they did not believe the positive result was real. The DON stated LS 1's positive Covid-19 result was not reported because LS 1 was on vacation before testing positive. The DON stated the HOO provided at the beginning of the outbreak did not indicate it was at the facility's discretion to decide which positive results to report.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/12/2024 at 9:34 AM with LVN 2, LVN 2 stated LS 1 first reported having symptoms of Covid-19 while at work on 6/16/2024. LVN 2 stated the DON informed LVN 2 that LS 1 tested positive for Covid-19 on 6/16/2024 while at the facility. LVN 2 stated LS 1 took another Covid-19 test on 6/17/2024 which also resulted positive for Covid-19. LVN 2 stated LS 1 was sent home on 6/17/2024 and [BF3] LVN 2 stated she did not know when LS 1 returned to work. A review of LS 1's Timecard, dated 6/14/2024 to 6/30/2024, indicated LS 1 worked on 6/15/2024 from 4:53 AM to 12:28 PM, and on 6/16/2024 from 4:57 AM to 12:30 PM. The timecard indicated LS 1 was on vacation on 6/18/2024 and 6/21/2024. During an interview on 7/11/2024 at 1:00 PM, with LS 1, LS 1 stated they worked on 6/18/2024 and 6/20/20224. LS 1 stated she experienced a sore throat, body aches, a runny nose, and phlegm on 6/21/2024. LS 1 stated she went to work on 6/21/24 and took a Covid-19 test at the facility. LS 1 stated she left the facility after the test resulted positive and did not recall which staff she encountered on 6/21/2024 prior to returning home. LS 1 stated she returned to work on 7/2/2024. A review of the facility document titled Laundry Filter Cleaning Schedule , dated 6/2024, indicated LS 1 signed the log at 7:00 AM, 9:00 AM, and 11:00 AM on 6/27/2024 and 6/28/2024. A review of Resident 5's Admission Record indicated Resident 5 was admitted to the facility on [DATE], and most recently readmitted on [DATE]. Resident 5's admitting diagnoses included heart failure (when the heart muscle doesn't pump blood as well as it should), systemic lupus erythematosus (a disease where the immune system of the body mistakenly attacks healthy tissue), and asthma (a chronic lung disease affecting people of all ages), and respiratory failure (condition in which your blood doesn't have enough oxygen or has too much carbon dioxide). A review of Resident 5's MDS, dated [DATE], indicated Resident 5 had impaired short-term memory (ability to recall events from the last 5 minutes) and mild cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 5 did not display any rejection of care, and indicated she required substantial to maximal assistance from staff for eating, brushing her teeth, and getting dressed. The MDS indicated Resident 5 also needed substantial to maximal assistance from staff to reposition herself from left to right while in bed, and to move from a lying to a sitting position. The MDS further indicated that in the 14 days prior to the MDS assessment, and while residing in the facility, Resident 5 did not require oxygen therapy. A review of Resident 5's COC, dated 6/24/2024, indicated Resident 5 experienced difficulty breathing on 6/24/2024 at 12:26 PM and had an oxygen saturation (amount of oxygen in the blood) of 90% (normal range is between 95% and 100%) while on two (2) L/min of oxygen through a nasal cannula. The COC indicated the Charge Nurse placed Resident 5 into an upright position and increased the oxygen delivery rate to 3 L/min. The COC indicated that at 1:35 PM, Resident 5 reported feeling increasingly short of breath, and her heart rate and blood pressure were elevated and outside of normal range. The COC indicated the Charge Nurse called 911 (emergency services) to transfer patient to a GACH. A review of Resident 5's progress note, dated 6/24/2024, indicated Resident 5 was picked up by paramedics and transferred to GACH 1. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 5's records from GACH 1, dated 6/25/2024, indicated Resident 5 was admitted to GACH 1 on 6/24/2024 and the emergency department determined she was positive for Covid-19, and suffering from acute respiratory distress (a condition where the body needs more oxygen), pneumonia (an infection in your lungs caused by bacteria, viruses or fungi), and sepsis (a life-threatening complication in which the body responds improperly to an infection) due to Covid-19. The GACH 1 records also indicated Resident 5 received remdesivir (a medication used to treat Covid-19) during her GACH 1 admission. A review of the facility P&P titled Coronavirus Disease (Covid-19) Updated Policy on Surveillance, Testing, Reporting and Staffing Guidance , dated 10/7/2022, indicated the health department is notified of any resident with suspected or confirmed Covid-19, severe respiratory infection, or a cluster (3 or more residents or staff with new onset respiratory symptoms over 72 hours). The P&P indicated for routine diagnostic testing, in response to a positive test, testing will continue to be performed to resident and staff with higher-risk exposures or close contact to Covid19 (i.e., as part of response testing) , and indicated the Infection Preventionist will contact the local and/or state health departments to coordinate care as indicated . The P&P indicated for response driven testing, staff and residents should be tested promptly and the facility will contact Public Health Office for further guidance. The P&P indicated newly admitted .regardless of vaccination status, should have a series of three viral tests for SARS-COV-2 infection: immediately upon admission and if negative, again at 3 days and 5 days after their admission or return to facility .