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	12/29/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three residents (Resident 3), was weighed on admission and weekly for four (4) weeks, as indicated in its policy and procedure (P&P) titled, Weight Assessment and Interventions. This failure resulted in the facility not having resident's baseline weight on admission and placed Resident 3 at risk for unidentified weight loss and possible complications, like skin breakdown, other illnesses and possible hospitalization.Findings:During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 3's diagnoses included cellulitis (a skin infection that causes swelling and redness) of the right lower limb and acquired absence of other right toe(s) (a body part or organ that is missing because it was removed or lost after birth, typically due to surgery). During a review of Resident 3's History and Physical (H&P) dated 12/2/2025, the H&P indicated Resident 3 had the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set ([MDS] a resident assessment tool) dated 11/19/2025, the MDS indicated Resident 3 was cognitively intact (no issues with the ability to think, remember, and reason). The MDS indicated Resident 3 was dependent (helper does all of the effort) with staff to perform Activities of Daily Living (ADLs) such as showering/bathing self and was assessed as unsafe to perform movements such as changing positions from sitting to standing and walking ten (10) feet.During a review of Resident 3's Census List (a list that includes dates of admission, discharge, and room assignments of the resident while at or away from the facility), dated 12/29/2025, the Census List indicated Resident 3 was discharged from the facility on 11/26/2025 and was readmitted back on 11/27/2025.During a review of Resident 3's weights, Resident 3's weights did not include weight taken on 11/27/2025.During a review of Resident 3's care plan titled, Resident has alteration in nutritional status related to (r/t) Cellulitis of right lower limbs, dated 11/14/2025, the intervention included to monitor weight per policy.During an interview on 12/29/2025 at 12:35 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated residents should be weighed on admission and once a week for four weeks. LVN 1 stated residents who were at risk for weight loss should include intervention to monitor the weight every week for four weeks. During a concurrent interview and record review on 12/29/2025 at 2:58 p.m. with Registered Nurse (RN) 1, Resident 3's weights and census list and the facility P&P titled, Weight Assessment and Interventions, dated 11/2017, were reviewed. RN 1 stated Resident 3's weight was not taken when admitted on [DATE]. RN 1 stated policy indicated that resident's weights should be taken on admission, or the next day, and weekly for four (4) weeks thereafter. RN 1 stated the facility did not follow its P&P because Resident 3 was not weighed when admitted on [DATE].During a concurrent interview and record review on 12/29/2025 at 3:45 p.m. with the Director of Nursing (DON), Resident 3's record of weights, progress notes, dated 11/27/2025, 11/28/2025, and 12/13/2025 and the facility's P&P titled, Weight Assessment and interventions, dated 11/2017, were reviewed. The DON stated Resident 3's weight records did not indicate the resident was weighed on 11/27/2025. The DON stated Resident 3's progress notes did not indicate reasons why Resident 3 was not weighed on 11/27/2025, 11/28/2025, and 12/13/2025. The DON stated it was important for residents to be weighed on admission because weight can indicate a resident's health status. The DON stated the facility did not follow its P&P when Resident 3 was not weighed on 11/27/2025 as part of Resident 3's admission, then weekly on 12/13/2025. During a review of facility's P&P titled, Weight Assessment and Interventions, dated 11/2017, the P&P indicated, it was the facility's policy to monitor patient's weight. The P&P indicated the nursing staff should measure resident's weights on admission, the next day and weekly for 4 weeks thereafter. The P&P indicated, weights should be recorded in each unit's Weight Record chart or notebook and in the individual's medical record.