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	01/23/2026

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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure the ice machine was cleaned and sanitized properly. This deficient practice had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 91 of 91 medically compromised residents who received food from the kitchen.Findings: During a concurrent observation and interview on 1/20/2026 at 11:15 a.m., with the Dietary Services Supervisor (DSS), observed a combination of dark black/grey dots along with a pink colored slime on a paper towel that was used to wipe underneath where the ice machine dispenses ice cubes. The DSS stated, I don't know what that is. It's the first time I'm seeing it. The DSS stated that she was not aware of the deep cleaning procedures as the Maintenance Department was responsible for deep cleaning. The DSS stated she had emergency ice to use for the remainder of the day. During a concurrent observation and interview on 1/20/2026 at 12:15 p.m. with the Maintenance Staff (MS), the MS was asked to demonstrate the deep cleaning procedure where he removed three screws from the ice maker housing. The MS leaned back the cover approximately 20 degrees. The MS stated, I take a clean rag and wipe it with sanitizer like I was told by my supervisor (Maintenance Supervisor). Observed on the cover were clusters of black dots with a web-like substance spanning 4.0 x 0.5 centimeters. Upon request, the MS removed the cover completely for a more thorough inspection where a steel plate fixed to the base of the ice maker located directly above the container where ice is dispensed and held, a substance was observed. The MS could not identify the substance. The MS stated, I don't know. Something dirty, like a stain. The MS wiped the area with a paper towel which resulted in a combination of dark black/grey dots along with a pink colored slime. During a concurrent interview and record review on 1/20/2026 at 11:15 a.m., with the DSS, of the Ice Machine Daily Cleaning log, the log indicated deep cleaning was signed off once per month, including 1/9/2026. The DSS stated cleaning and disinfection was performed on the ice container and signed off daily, whereas deep cleaning was performed monthly. During a review of the facility policy and procedure (P&P) titled Sanitation, undated, the P&P indicated, Ice which is used in connection with food or drink shall be from a sanitary source and shall be handled and dispensed in a sanity manner. During a review of the facility P&P titled Ice Machine, dated 4/2017, the P&P indicated, Maintenance staff will clean the ice making mechanism per manufacturer's guidelines. The P&P indicated Manufacturer guidelines to be followed for cleaning and sanitizing the ice making system. During a review of the manufacturer guidelines for the Ice Machine, undated, the manufacturer guidelines indicated to remove the evaporator cover, remove the water pipe retaining cover and water pipe, and use a brush to clean the inside of water pipe.

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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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose of garbage properly when the dumpster lid was overflowing with bags of waste on two consecutive days. This deficient practice had the potential to increase the likelihood of pest and vermin infestation contributing to unsanitary conditions on the facility premises.Findings: During a concurrent observation and interview on 1/20/2026 at 9:30 a.m., with the Administrator, observed the trash dumpster and several smaller bins labeled Soiled Linen located near the parking lot of the facility were filled beyond capacity and overflowing with bags of waste. The trash dumpster was located within a wooden shed which was disheveled with broken roofing. The Administrator stated that trash was not picked up the day prior due to a national holiday and the trash company would dispose of all waste tomorrow (1/21/2026). During a review of the trash pickup schedule, posted on the company's website, the schedule indicated, If your service falls on or after the holiday, your pickup will be delayed by one day. During a review of the monthly pest control reports, the reports indicated recommendations were made to keep the trash can lids closed on 2/25/2025, 3/21/2025, and 5/22/2025 in order to reduce pest attraction and source for pest breeding. During an observation on 1/21/2026 at 10:30 a.m., observed both nursing and kitchen staff taking out trash to the dumpster and bins outside. During a concurrent observation and interview on 1/21/2026 at 11:23 a.m., with the Administrator, the dumpster was observed filled with black trash bags beyond capacity. The lids were propped open. Next to the dumpster, a bin on wheels labeled Trash, contained bags protruding beyond the capacity of the bin and the lid rested on top, unclosed. The Administrator stated he confirmed that the daily trash production of the facility exceeded the current capacity available. The Administrator stated the trash could be a vector for pests. The Administrator stated they may require a second bin despite obstacles with physical space and access.

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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** Based on observation, interview, and record review, the facility failed to develop a care plan with interventions for three of eight sampled residents (Resident 18, Resident 36, and Resident 48), addressing the use and refusal of dentures and hand tremors (involuntary, rhythmic, and alternating muscle contractions causing shaking in the hands or fingers). These deficient practices ha the potential to negatively affect Resident 18 and 36's mental, physical, and psychosocial well-being and had the potential to delay the delivery of necessary care and services. These deficient practice also had the potential for Resident 48 to exhibit impaired oral intake, aspiration (choking) and poor hygiene. Findings: a. During a review of Resident 18's admission Record, the admission Record indicated Resident 18 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 18's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (HTN- high blood pressure). During a review of Resident 18's Minimum Data Set (MDS – a resident assessment tool), dated 10/21/2025, the MDS indicated Resident 18's cognition (the ability to think and process information) was intact. The MDS indicated Resident 18 required moderate (helper does less than half the effort) assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 18 was assessed as not having any oral and/or dental issues including denture. During a review of Resident 18's History and Physical (H&P), dated 11/13/2025, the H&P indicated Resident 18 had the capacity to understand and make decisions. During a concurrent observation and interview on 1/20/2026 at 9:02 a.m., in Resident 18's room, Resident 18 was observed eating breakfast. Resident 18's dentures were placed on the top of the resident's bedside table. Resident 18 stated it was difficult to chew because she did not have any teeth. Resident 18 stated she had dentures but was not using them because they were too big. During a concurrent observation and interview on 1/22/2026 at 8:30 a.m., with the Minimum Data Set Nurse (MDSN) and Resident 18, in Resident 18's room, Resident 18 was observed with no upper and bottom teeth. The MDSN stated Resident 59's dentures were placed on the top of resident's bedside table, indicating that the resident had dentures. Resident 18 stated she was not using her dentures because they were too big and felt loose. During a concurrent interview and record review on 1/22/2026 at 8:45 a.m., with the MDSN, Resident 18's care plans were reviewed. The care plans did not indicate there was a care plan addressing Resident 18's use of dentures. The MDSN stated there should have been a care plan initiated upon Resident 18's admission to the facility since the resident had ill-fitting dentures. The MDSN stated care planning serves as a communication tool among facility staff responsible for the resident's care. The MDSN stated if there was no care plan, the staff would not be able to provide quality and coordinated care to residents. During an interview on 1/22/2026 at 3:55 p.m., with the Director of Nursing (DON), the DON stated it was important to develop a comprehensive care plan for each resident for continuity of care and services, based on resident needs and interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 36's admission Record, the admission Record indicated Resident 36 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included lack of coordination (inability to produce smooth, accurate, and voluntary muscle movements, resulting in jerky, unsteady, and clumsy motions) and diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 36's H&P, dated 12/5/2025, the H&P indicated Resident 36 was oriented to person, place and time. During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 36 required set up or clean up assistance for eating. The MDS indicated Resident 36 required supervision for oral hygiene, toileting hygiene, upper body dressing and putting on and taking off shoes. The MDS indicated Resident 36 required moderate assistance (helper does less than half the effort) for lower body dressing and personal hygiene. During a review of Resident 36's Psychiatric evaluation, dated 12/5/2026, the psychiatric evaluation indicated Resident 36 was alert and oriented to [NAME] and place. The psychiatric evaluation indicated Resident 36 was noted to have extrapyramidal symptoms ([EPS] drug-induced movement disorders, that result in involuntary movements, muscle stiffness, tremors, and restlessness). During a review of Resident 36's electronic medical record, the electronic medical record did not indicated a care plan addressing Resident 36's hand tremors. During an observation on 1/20/2026 at 9:51 a.m., in Resident 36's room, Resident 36 was observed sitting on her bed. Resident 36's hands were shaking. During an observation on 1/21/2026 at 12:32 p.m., in the dining room, Resident 36 was observed seated at a table. Resident 36's hands were shaking. During an interview on 1/22/2026 at 10:57 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 36 suffered from hand tremors and she recently noticed the tremors have gotten worse. LVN 1 stated Resident 36 received medication for EPS. LVN 1 stated a care plan should be developed for Resident 36's EPS because it would serve as a guideline for Resident 36's care. During a concurrent interview and record review on 1/22/2026 at 11:12 a.m. with LVN 1, Resident 36's electronic medical record was reviewed. The records did not indicate a care plan was developed for Resident 36' hand tremors. LVN 1 stated Resident 36 needed a care plan for her hand tremors. LVN 1stated if there was no care plan, staff would not monitor Resident 36 symptoms and goals would not be set for her. LVN 1 stated Resident 36's care plan should have interventions to assist Resident 36 with mobility, monitor for progression of tremors, monitor during activities of daily living and assist Resident 36 with eating. During an interview on 1/23/2026 at 2:02 p.m. with the Director of Nursing (DON), the DON stated Resident 36's hand tremors should have been care planned. The DON stated a care plan serves as a plan for Residents care and set goals for the residents to get better. The DON stated if there was no care plans, nursing staff would not know what interventions to follow for Residents 36's hand tremors. The DON stated if there was no care plan there was a potential for Resident 36 to suffer an injury or not receive quality care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 48's diagnoses included dysphagia (difficulty swallowing), dementia (a progressive state of decline in mental abilities), and abnormalities of gait and mobility. During a review of Resident 48's MDS, dated [DATE], the MDS indicated Resident 48's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 48 required supervision for eating and required partial assistance (helper does less than half of the effort) for oral hygiene, toileting and putting on footwear. During a review of Resident 48's H&P, dated 12/7/2025, the H&P indicated Resident 48 had fluctuating capacity to understand and make decisions. During an interview on 1/20/2026 at 3:09 p.m. with the MDSN, the MDSN stated she knew Resident 48 refused to wear her dentures. During a concurrent observation and interview on 1/21/2026 at 12:18 p.m. with Resident 48's family member (FM) 1, Resident 48 was observed eating food without dentures. FM 1 stated Resident 48 had trouble eating because she did not have her dentures. During a concurrent record review and interview on 1/22/2026 at 1:41 p.m. with the MDSN, all of Resident 48's care plans were reviewed. There were no care plan in place for Resident 48's refusal to wear her dentures. The MDSN stated Resident 48 should have had a care plan in place to address her refusal to use dentures to ensure appropriate care was provided. The MDSN stated if Resident 48 did not have a care plan, Resident 48 was placed at risk for poor oral care, poor oral intake, and choking. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person Centered, revised 12/2016, the P&P indicated a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was to be developed and implemented for each resident. During a review of the facility's P&P titled Care Plans, Comprehensive Person- Centered, revised 2016, the P&P indicated the facility would develop and implement a comprehensive person-centered care plan for each resident that would include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. During a review of facility's P&P titled Care Plans, Comprehensive Person-Centered, dated 12/2026, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional need is developed and implemented for each resident. The P&P indicated care plan would describe services that would be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, and record review, the facility failed to ensure all Restorative Nursing Aides (RNA) received training and demonstrated competency in performing Range of Motion (ROM) exercises for one of three sampled residents (Resident 38). This failure had the potential to place Resident 38 at risk for inconsistent or improper restorative care leading to decline in ROM.Findings:During an interview on 1/22/2026 at 9:34 a.m. with RNA 4, RNA 4 stated she receives in-service with new orders and residents with special concerns.During an interview on 1/22/2026 at 2:19 p.m. with the Director of Rehabilitation (DOR), the DOR stated RNA in-service included review of the RNA referral form which includes RNA order, instructions, and training for activity to be completed by the RNA. The DOR stated the form was for new orders and began on 12/05/2025. The DOR stated, regular RNA competency in-service and checklist and keeping record were important because RNAs needed to understand the orders, how to carry out the orders, and how the order impacts the resident's ROM. The DOR stated, lack of in-service and competency checklist could hinder resident's maintenance and lead to ROM decline.During an interview on 1/23/2026 at 9:20 a.m., with the DON, the DON stated the importance of ROM training and competency was to monitor RNA's skills and their need for education that effects resident's care. The DON stated lack of competency effects care and can lead to decline in ROM and quality of care. The DON verbalized the importance of keeping record of trainings to monitor RNA education needs and to keep skills updated to support resident's needs and prevent decline in ROM.During an interview on 1/22/2026 at 2:43 p.m., with the DSD, the DSD stated ROM training was not included in list of trainings. The DSD stated it was important to include ROM exercises as part of the CNA/RNA mandatory training to support resident ROM and well-being. The DSD stated without the training, the RNA could provide the wrong treatment which could result in the resident's ROM declining.During a review of facilities' In-service Training Program for CNA/RNA training log, dated 12/2019, CNA in-service training program did not include ROM training and competency checklist.During a review of the facility's Restorative Range of Motion policy, dated 2/2017, the P&P indicated The Physical Therapist (PT) or Physical Therapist Assistant (PTA) will review the program with the RNA at least every other month and advise on technique and documentation.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to ensure safe medication administration and accurate accountability of all controlled medications (medications with a high potential for abuse) for three of three residents (Resident 89, Resident 12, and Resident 27) by failing to: 1. Notify Resident 89's doctor as ordered when the resident's blood sugar was 436 milligrams per deciliter (mg/dL, which measures the amount of sugar in a specific amount of blood) on 1/22/2026, which was over the parameter of 400 mg/dL requiring doctor notification.This failure increased the risk of Resident 89 experiencing harmful effects from high blood sugar, which could lead to nerve damage, kidney disease, heart disease, stroke (a sudden loss of brain function due to a blocked or burst blood vessel), and vision loss. 2. Remove a discontinued controlled medication, lorazepam (a medication used to treat anxiety), 0.5 mg, for Resident 27 from the medication cart and not document the administration of lorazepam 0.5 mg incorrectly as lorazepam 1 mg on 1/18/2026. 3. Document Resident 12's controlled medication, hydrocodone-acetaminophen 10 mg/325 mg (a pain-relief medicine that combines a strong painkiller called hydrocodone and a milder pain reliever called acetaminophen), on the resident's Medication Administration Record (MAR, a record of each medication given, dosage, time, and person administering) on 1/21/2026 during morning medication administration before going to the next resident. These deficient practices created the potential for unsafe care, treatment, and medication administration for Resident 89, Resident 12, and Resident 27. The deficient practice increased the risk of not being able to readily identify controlled medication loss, drug diversion (illegal distribution or use of prescription drugs), or medication errors, which resulted in Resident 27 being administered a wrong dose of lorazepam on 1/18/2026.Findings: 1. During a review of Resident 89's admission Record, the admission record indicated Resident 89 was admitted to the facility on [DATE], and readmitted on 1/17/ 2026 with diagnoses that included, Type 2 diabetes mellitus (Type 2 DM, a condition where the body cannot properly use sugar for energy), heart failure (the heart cannot pump enough blood and oxygen to the body's organs), and hypertension (high blood pressure). During a review of Resident 89's Minimum Data Set (MDS - a resident assessment tool), dated 11/17/2025, the MDS indicated Resident 89's cognition (ability to learn reason, remember, understand, and make decisions) was intact. During a review of Resident 89's Physician Order Summary, the Order Summary indicated an order dated 1/18/2026, with instructions to administer Insulin Lispro Injection Solution 100 UNIT/ML (a fast-acting insulin used to control blood sugar levels in diabetes) per the following sliding scale (a method for adjusting the dose of insulin based on blood sugar levels). The Order Summary indicated inject as per sliding scale: if blood glucose (BG) is 61 - 150 = 0 units (no insulin). The Order Summary indicated if BG was less than (<) 70 give glucose gel (a fast-acting sugar) 1 tube by mouth (PO) or Glucagon (a hormone that raises blood sugar levels) 1 milligram (mg, unit of measurement), then call to doctor (MD). The Order Summary indicated the following sliding scale:BG 151 - 200 = 3 units;BG 201 - 250 = 5 units;BG 251 - 300 = 8 units;BG 301 - 350 = 10 units;BG 351 - 400 = 12 units;if BG > (is greater than) 400, give 15 units, then call to MD,Inject subcutaneously (under the skin) four times a day for Type 2 DM before meals and at bedtime. During a review of Resident 89's undated care plans titled Resident has Hyperglycemia (high blood sugar) and Resident has Diabetes Mellitus,, the care plans indicated the resident has hyperglycemia and Type 2 Diabetes Mellitus. The interventions indicated to give medication as ordered, monitor compliance with diet and document any problems, monitor blood sugar as ordered, monitor for signs and symptoms of high or low blood sugar, and notify MD as needed. During a concurrent medication pass observation and interview on 1/21/2026 between 11:30 AM to 11:40 a.m., with Licensed Vocational Nurse (LVN) 1, at Medication Cart (MedCart) B, observed LVN 1 enter Resident 89's room. LVN 1 pricked the resident's finger on the right hand to check the resident's (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	BG. LVN 1 stated that Resident 89's BG read 436. LVN 1 was observed preparing and administering Insulin Lispro to Resident 89. LVN 1 stated 15 units of Insulin Lispro was administered to Resident 89 based on the sliding scale parameters for BG greater than 400 (mg/dL). During an interview on 1/21/2026 at 2:26 p.m. with LVN 1, LVN 1 stated that Resident 89's physician had not been notified of the resident's BG being over 400 during the BG check earlier on 1/21/2026 during the scheduled 11:30 AM medication pass. LVN 1 stated the physician should have been notified right away when the BG was over 400 as ordered. LVN 1 stated the facility's protocol was to inform the doctor and to recheck the BG after the insulin administration. LVN 1 stated that she will recheck Resident 89's BG now and then call the physician. During a concurrent interview and record review on 1/22/2026 with the Director of Nursing (DON), Resident 89's Order Summary, Nursing Progress Notes, and BG results were reviewed. The DON stated Resident 89'a nursing progress note dated 1/21/2026 at 11:34 a.m., documented a BG of 436 and licensed nurse documented, Will advise MD. The DON stated there was no documentation that indicated Resident 89's physician was notified of the resident's BG being over 400 as ordered on 1/21/2026. The DON stated there was a progress note dated 1/19/2026 for Resident 89's BG of 524 which indicated, MD notified. The DON stated there was no documentation of when the physician was notified or response or what instructions were given. The DON stated the licensed nurses have to document in the nursing progress notes the time the physician was notified, the instructions given by the physician, and follow any orders given by the physician for the resident. During a concurrent interview and record review on 1/22/2026 at 2:00 p.m., with Resident 89's Primary Care Physician (PCP) 1, Resident 89's BG results were reviewed. PCP 1 checked and stated, he did not see a message from the facility's nurse about Resident 89's BG of 436 on 1/21/2026. PCP 1 stated he was able to see a message on 1/18/2026 when Resident 89's BS read 448, and made an insulin dose adjustment, but was unable to see any other messages from the facility when Resident 89's BS was over 400. PCP 1 stated the expectation is to be informed by the facility about abnormal BG readings and abnormal laboratory results. During a review of Resident 89's BG readings between December 2025 to January 2026, the BG readings indicated the following:On 1/21/2026 at 9:05 p.m. (21:05) - 400.0 mg/dL On 1/21/2026 4:40 p.m. (16:40) - 400.0 mg/dL On 1/21/2026 at 11:34 a.m. - 436.0 mg/dL On 1/19/2026 at 11:12 a.m. - 524.0 mg/dL On 1/18/2026 at 5:08 p.m. (17:08) - 448.0 mg/dL On 1/17/2026 at 9:40 p.m. (21:40) - 498.0 mg/dL On 1/14/2026 at 8:56 p.m. (20:56) - 500.0 mg/dL On 1/13/2026 at 4:47 p.m. (16:47) - 412.0 mg/dL On 1/10/2026 at 4:08 p.m. (16:08) - 497.0 mg/dL On 1/8/2026 at 9:38 p.m. (21:38) - 411.0 mg/dL On 1/8/2026 at 9:36 p.m. (21:36) - 411.0 mg/dL On 1/8/2026 at 4:18 p.m. (16:18) - 441.0 mg/dL On 1/8/2026 at 11:19 a.m.- 452.0 mg/dL On 1/7/2026 at 11:30 a.m. - 458.0 mg/dL On 1/4/2026 at 5:09 p.m. (17:09) - 453.0 mg/dL On 1/4/2026 at 11:06 a.m. - 401.0 mg/dL On 1/3/2026 at 4:07 p.m. (16:07) - 500.0 mg/dL On 1/2/2026 at 11:19 a.m. - 424.0 mg/dL On 1/1/2026 at 11:04 a.m.- 491.0 mg/dL On 12/31/2025 at 8: 14 p.m. (20:14) - 500.0 mg/dL On 12/31/2025 at 11:32 a.m. - 434.0 mg/dL On 12/30/2025 at 11:19 a.m. - 449.0 mg/dL On 12/28/2025 at 5:32 p.m. (17:32) - 499.0 mg/dL On 12/26/2025 at 11:36 a.m. - 421.0 mg/dL On 12/25/2025 at 8:40 p.m. (20:40) - 496.0 mg/dL On 12/22/2025 at 11:23 a.m. - 454.0 mg/dL On 12/21/2025 at 6:06 p.m. (18:06) - 456.0 mg/dL On 12/21/2025 at 11:46 a.m. - 500.0 mg/dL On 12/19/2025 at 4:51 p.m. (16:51) - 411.0 mg/dL On 12/17/2025 at 9:20 p.m. (21:20) - 500.0 mg/dL On 12/14/2025 at 11:35 a.m. - 431.0 mg/dL On 12/13/2025 at 8:16 p.m. (20:16) - 447.0 mg/dL On 12/13/2025 at 11:21 a.m. - 439.0 mg/dL On 12/12/2025 at 8:47 p.m. (20:47) - 477.0 mg/dL On 12/12/2025 at 4:06 p.m. (16:06) - 429.0 mg/dL On 12/11/2025 at 4:32 p.m. (16:32) - 463.0 mg/dL On 12/10/2025 at 4:36 p.m. (16:36) - 434.0 mg/dL On 12/3/2025 at 3:30 p.m. (15:30) - 457.0 mg/dL On 12/2/2025 at 4:22 p.m. (16:22) - 405.0 mg/dL On 12/2/2025 at 11:13 a.m. - 401.0 mg/dL On 12/1/2025 at 10:50 a.m. - 441.0 mg/dL During an interview on 1/22/2026, at 2:15 p.m. with Primary Care Provider (PCP) 1, PCP 1 stated that acute (sudden and severe) complications from high blood glucose may include diabetic ketoacidosis (a dangerous condition where the body makes high levels of acids [ketones]) and confusion. PCP 1 stated chronic (persistent and long-lasting) complications (continued on next page)

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	01/23/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	may include kidney injury, neuropathy (nerve damage), increased risk of stroke, and heart disease are common with high blood glucose levels. During a review of the facility's policy and procedures (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated, Medications are administered in accordance with prescriber orders. During a review of the facility's P&P titled, Diabetic Management, dated 1/2021, the P&P indicated, Hyperglycemia - High blood sugar [typically above 200 mg/dL].The licensed nurse assesses the resident for any hyper/hypoglycemic episodes and intervenes as necessary by documenting, communicating findings to the physician and implementing appropriate interventions.Managing Diabetes, checking blood sugar.Request the registered dietitian to develop a diet plan that will help the resident get better blood sugar control if needed. Request the consulting pharmacist to assess possible causes of glucose changes.Document doctor's order in the physician orders and nurses' notes. During a review of the facility's undated P&P titled, Policy and Procedures on Licensed Nurse Progress Notes, the P&P indicated, Evaluation and assessment of a resident's status & condition shall include, at a minimum.Any recent change of conditions including interventions done to address problem and meet resident's needs.It is the responsibility of the licensed nurse to ensure accuracy in reporting resident's status & condition. 2. During a review of Resident 27's admission Record, the admission record indicated Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included anxiety disorder (a mental health condition characterized by excessive worry or fear). During a review of Resident 27's MDS dated [DATE], the MDS indicated Resident 27's cognition was severely impaired. During a review of Resident 27's physician orders dated 10/21/2025, the order indicated lorazepam 0.5 mg, to give one tablet by mouth every 6 (six) hours as needed for anxiety manifested by (m/b) sudden striking out for 90 days. The order was discontinued on 1/16/2026. During a review of Resident 27's physician orders dated 1/16/2026, the order indicated lorazepam 1 (one) mg, to give 1 mg by mouth every 4 hours as needed for anxiety m/b restless and agitation. The order was discontinued 1/18/2028. During a review of Resident 27's physician orders dated 1/19/2026, the order indicated lorazepam 1 mg, to give 1 (one) tablet by mouth every 4 hours as needed for anxiety m/b restless and agitation. The order indicated the lorazepam 1 mg order was placed on hold on 1/20/2026 for Resident 27's 911 transfer to hospital. During a concurrent observation and interview on 1/21/2026 at 2:49 p.m., with LVN 3, at MedCart A, observed inside of MedCart A was a medication card (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the medication) labeled to contain lorazepam 0.5 mg for Resident 27. LVN 3 stated Resident 27 do not have a current order for lorazepam 0.5 mg. During a concurrent interview and record review on 1/21/2026 at 2:50 p.m., LVN 3, Resident 27's Controlled Drug Record (CDR, a continuous log that tracks the inventory of controlled substances to prevent misuse)) and MAR for the month of January 2026 were reviewed. Resident 27's CDR for lorazepam 0.5 mg indicated by documentation and licensed nurse's initials that one dose was marked as removed on 1/18/2026 at 8 a.m Resident 27's January 2026 MAR indicated by documentation and licensed nurse's initials the resident was administered one dose of lorazepam 1 mg on 1/18/2026 at 7:12 AM. LVN 3 stated Resident 27's lorazepam 0.5 mg was discontinued on 1/16/2026 and the resident's CDR was marked to indicate a dose of lorazepam 0.5 mg was removed on 1/18/2026, and marked on the resident's MAR as if resident was administered lorazepam 1 mg. LVN 3 looked through MedCart A and stated there was no lorazepam 1 mg for Resident 27 in stock. LVN 3 reviewed Resident 27's lorazepam 1 mg order, that indicated, need to be ordered. LVN 3 stated when Resident 27's lorazepam 0.5 mg order changed to lorazepam 1 mg, the discontinued medication should have been removed from the medication cart and not available for use. During a telephone interview on 1/21/2026 at 3:43 p.m.with the facility's dispensing pharmacy technician (PharmTech) 1 in the presence of LVN 3, PharmTech 1 stated lorazepam 1 mg was not sent to the facility for Resident 27 as they were waiting for the physician to approve the controlled medication order. PharmTech 1 stated for Resident 27, lorazepam 0.5 mg was last sent to the facility on [DATE]. During an interview on 1/22/2026 at 12:44 p.m. with the DON, the DON stated there should be no (continued on next page)

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	056218	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discontinued controlled medications stored in the medication cart. DON stated the licensed nurse should bring the discontinued controlled medication to the DON right away. DON stated if the controlled medication is discontinued at night or during the weekend the discontinued controlled medication should be given to the DON the next day or on Monday if occurs over the weekend. During a concurrent interview and record review on 1/22/2026 at 1:36 PM with the DON, Resident 27's physician orders, transfer records, and January MAR were reviewed. The DON stated Resident 27 was transferred to the hospital on 1/12/2026 and returned to the facility on 1/16/2026 with a new order for lorazepam 1 mg which was not communicated to the charge nurses. DON stated on 1/18/2026 Resident 27's order was for lorazepam 1 mg and the charge nurse did not match the order and accidentally gave lorazepam 0.5 mg. DON stated administering lorazepam 0.5 mg to Resident 27 on 1/18/2026 was a medication error as the facility did not have lorazepam 1 mg in stock for the resident on 1/18/2026. During a review of the facility's P&P titled, Disposal of Medications, dated 7/2022, the P&P indicated, Discontinued medication and/or medications left in the nursing care center after a resident's discharge, which do not qualify for return to the pharmacy, are identified and removed from current medication supply in a timely manner for disposition.The Director of Nurses (DON) and/or its designee shall be responsible for implementation and enforcement of this policy.Controlled Substances listed in Schedules II, III, IV, and V remaining in the facility after the order has been discontinued are retained in the facility in a securely double locked area with restricted access until destroyed. During a review of the facility's P&P titled, Medication Administration-General Guidelines, dated 1/2022, the P&P indicated the following:a. Five Rights - Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away.b. The medication administration record (MAR) is always employed during medication administration. Prior to administration of any medication, the medication and dosage schedule on the resident's medication administration record (MAR) are compared with the medication label. If the label and MAR are different and the container has not already been flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule .c. Medications are administered in accordance with written orders of the prescriber. 3. During a review of Resident 12's admission Record, the admission record indicated Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Type 2 DM, disorder of muscle, gout (a common, treatable form of inflammatory arthritis caused by high levels of uric acid in the blood forming crystals in joints), and polyneuropathy (a condition where many nerves in the body are damaged). During a review of Resident 12's MDS dated [DATE], the MDS indicated Resident 12's cognition was intact. During a review of Resident 12's Physician Order Summary, the Order Summary included an order dated 11/6/2025, for hydrocodone-acetaminophen 10 mg/325 mg, with instructions to give one tablet by mouth every eight hours as needed (PRN) for severe pain of seven (7) to 10 (the severity of pain is assessed on a scale of zero [no pain] to ten [worst possible pain], with seven (7) to ten (10) indicating severe pain). During a concurrent interview and record review on 1/21/2026 at 3:06 p.m. with RN 1, at MedCart C, Resident 12's Controlled Drug Record (CDR, a continuous log that tracks the inventory of controlled substances to prevent misuse) for hydrocodone-acetaminophen and the MAR, printed on 1/21/2026 at 3:31 p.m. was reviewed. Resident 12's MAR indicated the last dose of hydrocodone-acetaminophen was given on 1/20/2026 at 11:06 p.m. Resident 12's CDR indicated a dose of hydrocodone-acetaminophen was removed from the medication card on 1/21/2026 at 9:48 a.m. RN 1 stated she forgot to document the administration of Resident 12's hydrocodone-acetaminophen on the MAR on 1/21/2026 at 9:48 a.m. During an interview on 1/21/2026 at 3:38 p.m. with RN 1, RN 1 stated that she should have documented on Resident's 12's MAR the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration of hydrocodone-acetaminophen 10 mg/ 325 mg immediately after administration on 1/21/2026 at 9:48 a.m. RN 1 stated not documenting the administration of a controlled medication had the risk for Resident 12 to receive duplication of medication, experience adverse reactions (harmful effects), or lack of pain control. During a review of Resident 12's progress notes, dated 1/21/2026 at 9:48 a.m., the progress note indicated hydrocodone/acetaminophen was given at 9:48 am but was not documented until 4:27 p.m. on 1/21/2026, almost seven hours after administration. During an interview on 1/22/2026 at 1:24 p.m., with the DON, the DON stated licensed nurses must follow the one by one administration and documentation. The DON stated the facility's licensed nurses must document the administration of all medications on the MAR on time especially for PRN controlled medications for pain and before going to the next resident. During a review of the facility's P&P titled, Medication Administration-General Guidelines, dated 1/2022, the P&P indicated, The individual who administers the medication dose records the administration on the resident's MAR/eMAR directly after the medication is given. During a review of the facility's P&P titled, Controlled Substances, dated 4/2019, the P&P indicated, Upon Administration: The nurse administering the medication is responsible for recording.signature of nurse administering medication

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	056218	A. Building B. Wing	01/23/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to dispose of non-controlled medications in the presence of a witness in accordance with the facility's policy titled, Disposal of Medications. This deficient practice increased the risk for lack of accountability for disposal of non-controlled medications throughout the facility.Findings: During a concurrent medication storage inspection and interview on 1/22/2026 at 12:32 p.m. with the Director of Nursing (DON), inside of the DON's office, the non-controlled medication disposal logs documentation between 11/26/2025 through 1/15/2026 was reviewed. The logs indicated one licensed nurse's initials were on the forms. The DON stated the non-controlled disposal log was used by both nursing stations (Station A and Station B). The DON stated non-controlled drug disposal was done by one person, either by the DON or the Registered Nurse (RN) Supervisor and did not require a witness. During an interview with the DON on 1/23/2026 at 11:25 a.m., the DON provided a copy of the facility's policy titled, Disposal of Medications. The DON stated that the facility's policy indicated, non-controlled medication disposal requires disposal in the presence of a pharmacist or nurse and one witness. During a review of the facility's policy and procedures (P&P) titled, Disposal of Medications, dated 7/2022, the P&P indicated, Medications not listed in Schedules II, III, IV and V (non-controlled medications) shall be destroyed by the facility in the presence of a pharmacist or nurse and one other witness. Medications may not be left in the original vials or container for disposal.

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	056218	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure the cook (Cook 1) followed the Korean menu recipes and failed to ensure the zucchini recipe ingredients were not altered. These deficient practices had the potential to alter nutrition, provide the appropriate therapeutic texture, and introduce allergens to resident meal trays.Findings: During a concurrent observation, interview, and record review on 1/20/2026 at 12:05 p.m., with the Dietary Services Supervisor (DSS), the Weekly Korean Menu and Recipe titled Korean Pot Stickers were reviewed. The menu indicated Korean Pot Stickers and Dipping Sauce. The recipe indicated procedures to wrap meat mixture into pot sticker or won ton wraps. Observed a pan of chunky meat with cabbage and peppers being served for lunch service. The DSS stated the chunky meat with cabbage and peppers were being served, from the Korean Menu, at lunch. The DSS stated that [NAME] 1 may have followed Monday's menu mistakenly. The DSS stated that the food being served on 1/20/2026 was also not aligned with Monday's menu and corresponding recipe. During a concurrent observation, interview, and record review, on 1/20/2026 at 12:10 p.m., with the DSS and [NAME] 1, the facility's Weekly Menu was reviewed. The weekly menu indicated Seasoned Zucchini. [NAME] 1 was observed serving a vegetable dish which contained a combination of zucchini, carrots, red peppers, and corn. During lunch service [NAME] 1 added boiled cauliflower to a pan on the steam table toward the end of lunch service. The DSS stated, I don't know why she (Cook 1) added that. [NAME] 1 stated the facility was out of zucchini and she chose to add cauliflower. During a concurrent observation, interview, and record review, on 1/21/2026 at 11:50 p.m., with the DSS and [NAME] 1, the Weekly Korean menu and recipe titled Fish Stew was reviewed. The menu indicated Fish Stew. The recipe indicated to make a soup using the fish. [NAME] 1 was observed serving whole filets of fish for the Korean menu. The DSS stated [NAME] 1 baked it instead of making a stew and [NAME] 1 did not check the menu. The DSS stated, It's different from what the menu says. It changes nutrient and changes everything. Changes resident expectation. The DSS was not able to present a substitution log denoting any menu changes that were documented or revised and approved by a Registered Dietitian. During an interview with the DSS on 1/21/2026 at 1:45 p.m., the DSS stated this practice is a risk for changing nutritive value, decreasing meal satisfaction by introducing disliked items, and potentially exposing residents to allergens.

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	056218	A. Building B. Wing	01/23/2026

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the correct food texture-modified diet (alters the consistency of food and liquids to make swallowing safer and easier for people with chewing or swallowing difficulties) for two of eight sampled residents (Resident 44 and 77). This deficient practice has the potential for Resident 44 and 77 to have problems chewing and swallowing and increased the risk for Residents to choke while eating.Findings:During an observation on 1/20/2026 at 12:30 p.m., in the dining room, Resident 44 was eating lunch. Resident 44's food plate had one toasted garlic bread and chopped chicken with vegetables. Resident 44's diet card indicated Resident 44 had a mechanical soft texture diet (foods that are physically altered-chopped, ground, mashed, or pureed-to be easy to chew and swallow, reducing choking risks).During a review of Resident 44's admission Record, the admission Record indicated Resident 44 was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 44's diagnoses included dysphagia (difficulty swallowing) and dementia (a progressive state of decline in mental abilities).During a review of Resident 44's History and Physical (H&P), dated 6/29/2025, the H&P indicated Resident 44 did not have the capacity to understand and make decisions.During a review of Resident 44's Minimum Data Set ([MDS] a resident assessment tool), dated 12/18/2025, the MDS indicated Resident 44's cognitive skills for daily decision making was severely impaired (ability to think and reason). The MDS indicated Resident 44 required maximum assistance (helper does more than half the effort) for eating.During a review of Resident 44's Dietary Profile dated 12/19/2025, the dietary profile indicated Resident 44's food texture diet was L5 minced and moist (a texture-modified diet designed for individuals with chewing or swallowing difficulties, food that is soft, moist, and cut into small pieces). The dietary profile indicated Resident 44 had a history of dysphagia.During a review of Resident 44's Order Summary Report, dated 12/29/2025, the Order Summary Report indicated Resident 44 had an order for an L5 minced and moist texture diet.During an interview on 1/20/2026 at 12:36 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 44's food had to be cut into smaller pieces because chunks of chicken are too big for her to chew and swallow. CNA 4 stated it was not the first time Resident 77 received food that size and she usually cut the food to a smaller size before feeding it to Resident 44.During an interview on 1/23/2026 at 10:10 a.m. with CNA 4, CNA 4 stated a mechanical soft diet was food texture that was cut into small pieces. CNA 4 stated on 1/20/2026 for lunch Resident 44 did not receive the correct food texture because she had to cut the food into smaller pieces. CNA 4 stated the edges of the bread were hard to cut down with a fork. During an observation on 1/20/2026 at 12:47 p.m., in the dining room, Resident 77 was eating lunch. Resident 77's food plate had one toasted garlic bread, chicken with vegetables and a full quesadilla. Resident 77's diet card indicated Resident 77 had a mechanical soft texture dietDuring a review of Resident 77's admission Record, the admission Record indicated Resident 77 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting left non dominant side of body.During a review of Resident 77's H&P, dated 12/10/2025, the H&P indicated Resident 77 had the capacity to understand and make decisions.During a review of Resident 77's MDS, dated [DATE], the MDS indicated Resident 77's cognitive skill for daily decision making was moderately impaired. The MDS indicated Resident 77 required supervision for eating.During a review of Resident 77's Order Summary Report, dated 12/9/2025, the Order Summary Report indicated Resident 77 had an order for an L6 soft and bite sized texture diet. During a review of Resident 77's Dietary Profile dated 12/25/2025, the dietary profile indicated Resident 77's food texture diet was L6 soft and bite sized texture diet (therapeutic diet consisting of moist, tender (continued on next page)

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	01/23/2026

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	food, cut into pieces).During an interview on 1/20/2026 at 12:49 p.m. with the Dietary Supervisor (DS), the DS stated the food that Resident 77 had on her plate was for a regular food texture diet and not for a mechanical soft diet. The DS stated Resident 77's quesadilla should not be served in full and that it should be served in smaller pieces.During an interview on 1/23/2026 at 1:17 p.m. with the DS, the DS stated residents that have swallowing or chewing problems get an order for mechanical soft texture diet order. The DS stated if a resident did not receive the correct food texture they were at risk for choking. The DS stated a mechanical soft diet was a chopped or soft and bite size food. The DS stated Resident 77 did not receive the correct food texture because the bread should have been soaked to make it soft and the chicken should have been cut into smaller pieces.During an interview on 1/23/2026 at 2:40 p.m. with Director of Nursing (DON) the DON stated residents with chewing and swallowing problems had food texture diets as a precaution and safety measure to prevent choking. The DON stated it was not acceptable for a resident to receive food texture that was not ordered for them. The DON stated it was the dietary department's responsibility to check food before it left the kitchen and it was the licensed nurses' responsibility to check food before it is given to the residents. During a review of facility's menu for 1/20/2026 lunch meal, the menu indicated for L6 and L5 food texture, the chicken had to be minced. The menu indicated the garlic bread for L6 texture had to be chopped, soaked and drained. The menu indicated the garlic bread for L5 texture had to be minced and moist.During a review of facility's Policy and Procedure (P&P) titled Mechanical or Dental Soft dated 2018, the P&P indicated a mechanically altered diet provided food that was easily chewed. The P&P indicated the diet was for individuals who have chewing problems, and swallowing problems. The P&P indicated food was modified in texture by chopping, dicing, and grinding. The P&P indicated food must be served moist to facilitate chewing and swallowing.

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	01/23/2026

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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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident's personal belongings were inventoried and tracked upon discharge and readmission for one out of one sampled residents (Resident 48). This deficient practice resulted in the facility's inability to account for Resident 48's hearing aids and dentures.Findings: During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 48's diagnoses included dysphagia (difficulty swallowing), dementia (a progressive state of decline in mental abilities), and abnormalities of gait (manner of walking) and mobility. During a review of Resident 48's Minimum Data Set ([MDS], a resident assessment tool), dated 11/27/2025, the MDS indicated Resident 48's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 48 required supervision for eating and required partial assistance (helper does less than half of the effort) for oral hygiene, toileting and putting on footwear. During a review of Resident 48's History and Physical (H&P), dated 12/7/2025, the H&P indicated Resident 48 had fluctuating capacity to understand and make decisions. During a review of Resident 48's Theft and Loss Form dated 10/1/2025, the Form indicated Resident 48 reported her dentures were missing and was unable to recall where they were. During a review of Resident 48's Inventory Lists, dated from 2021 through 2026, there was only one inventory list dated 5/30/2021. The Inventory list indicated Resident 48 had a right and left hearing aid. During a concurrent observation and interview on 1/21/2026 at 12:18 p.m. with Resident 48's Family Member (FM) 1, Resident 48 was observed eating her food without her dentures. FM 1 stated he had known Resident 48 to have dentures and believed the dentures were missing. During an interview on 1/22/2025 at 8:58 a.m. with the Director of Staff Development (DSD), the DSD stated the certified nursing assistants (CNAs) were responsible for completing the resident inventory lists. During an interview on 1/22/2026 at 9:00 a.m. with Restorative Nurse Aide (RNA) 1, RNA 1 stated CNAs were to complete the resident's inventory lists upon discharge and readmission to the facility. RNA 1 stated she was responsible for completing Resident 48's inventory list upon the resident's readmission on [DATE]. RNA 1 stated she did not complete the inventory list because she knew Resident 48 had a locked closet and also kept belongings at her bedside. RNA 1 stated she did not try to locate or obtain the key so she could complete Resident 48's inventory list. RNA 1 stated all residents had the right to keep their belongings safe while residing in the facility. RNA 1 stated not having an inventory list resulted in the facility's inability to account for Resident 48's belongings. During a concurrent interview and record review on 1/23/2026 at 9:46 a.m. with the Director of Nursing (DON), Resident 48's Census (admission and readmission Dates), and all of Resident 48's Inventory Lists, dated in 2025, were reviewed. The Census indicated Resident 48 was discharged and readmitted to the facility five times between 10/2025 through 1/2026. The DON stated there should have been at least one to two inventory lists completed within that timeframe to account for Resident 48's valuable belongings, like her hearing aids and dentures. During a review of the facility's Policy and Procedure (P&P) titled, Resident's Personal Property, dated 12/2016, the P&P indicated residents were permitted to retain personal possession and any personal clothing or possessions retained by the facility for the resident during his or her stay would be identified and inventoried upon admission and the copy of inventory provided to the resident. The P&P indicated documentation of inventoried personal effects was to be completed.

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	056218	A. Building B. Wing	01/23/2026

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a PRN (as needed) order for Lorazepam (psychotropic medication- drug that affects mental processes, moods, and behaviors) indicated a stop date for one of six sampled residents (Resident 16). This deficient practice placed Resident 16 at risk for continued use of unnecessary psychotropic medication without timely physician reassessment and had the potential for Resident 16 to be chemically restrained by the administration of unnecessary psychotropic medication, and/or suffer extrapyramidal symptoms (a group of movement disorders that can occur because of certain medications, particularly antipsychotics) due to prolonged use. Findings: During a review of Resident 16's admission Record, the admission Record indicated Resident 16 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 16's diagnosis included depression (a mental disorder that affects how person thinks, feels, and acts), anxiety (a feeling of fear, and dread), and epilepsy (a brain disorder), During a review of Resident 16's Minimum Data Set (MDS- a resident assessment tool), dated 12/11/2025, the MDS indicated Resident 16's cognition (the ability to think and process information) was intact. The MDS indicated Resident 16 was dependent (helper does all the effort) on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 16's order summary report, dated 1/5/2026, the order summary report indicated Resident 16 was to receive Lorazepam (a psychotropic medication) 0.5 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), one (1) tablet by mouth every eight (8) hours as needed for anxiety. The order did not indicate a stop date for the administration of Lorazepam. During a concurrent interview and record review on 1/23/2026 at 1:25 p.m., with the Director of Nursing (DON), Resident 16's physician order for Lorazepam 0.5 mg, dated 1/5/2025, and the facility's policy and procedure (P&P) titled Psychoactive Medication Physician's Order, dated 7/2017, were reviewed. The DON stated the physician order did not indicate a stop date for the administration of Lorazepam. The DON stated the P&P indicated the resident's psychotropic medication order was to be written by a physician for specific time period. The DON stated the P&P indicated PRN orders for psychotropic medications were limited to 14 days. The DON stated Resident 16's Lorazepam order was not in alignment with the facility's P&P. The DON stated the purpose of the 14-day limit was to ensure the continued need for the psychotropic medication was clinically justified to prevent unnecessary use of such medications.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete an accurate Minimum Data Set (MDS, a resident assessment tool) assessment for one of six sampled residents' (Resident 18) oral and/or dental status. This deficient practice resulted in incorrect data transmitted to the Centers for Medicare and Medicaid Services (CMS) regarding Resident 18's missing natural teeth and had the potential to negatively affect the resident care plan and delivery of necessary care and services. Findings: During a review of Resident 18's admission Record, the admission Record indicated Resident 18 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 18's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (HTN- high blood pressure). During a review of Resident 18's MDS, dated [DATE], the MDS indicated Resident 18's cognition (the ability to think and process information) was intact. The MDS indicated Resident 18 required moderate (helper does less than half the effort) assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 18 was assessed as not having any oral and/or dental issues. During a review of Resident 18's History and Physical (H&P), dated 11/13/2025, the H&P indicated Resident 18 had the capacity to understand and make decisions. During a concurrent observation and interview on 1/20/2026 at 9:02 a.m., in Resident 18's room, Resident 18 was observed eating breakfast. Resident 18 stated it was difficult to chew the food because she did not have any teeth. Resident 18 stated I have dentures, but they don't fit, they're too big. During a concurrent interview and record review on 1/22/2026 at 8:45 a.m., with the Minimum Data Set Nurse (MDSN), Resident 18's MDS, dated [DATE], section oral/dental status were reviewed. The MDS indicated Resident 18 was assessed as not having any oral and/or dental issues. The MDSN stated Resident 18's MDS oral/dental status assessment was coded incorrectly, as it did not reflect the resident's actual oral and/or dental status. The MDSN stated that because Resident 18 did not have her natural teeth, the MDS should have been coded to reflect that the resident was edentulous (toothless). The MDSN stated accuracy of the MDS assessment was important not only for outcome measures and quality indicators, but also for developing and individualizing the care plan based on the resident's actual needs. The MDSN stated inaccuracy of the MDS assessment had the potential to negatively impact the care provided, leading to inappropriate care planning and not meeting the residents' needs and services. During a review of the facility's policy and procedures (P&P) titled Minimum Data Set (MDS) Accuracy, dated 10/2023, the P&P indicated the facility would ensure MDS accuracy for each resident's status, needs, and strengths. The P&P indicated MDS data element set was reviewed for accuracy of coding.

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	056218	A. Building B. Wing	01/23/2026

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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** Based on observation, interview, and record review, the facility failed to ensure services met professional standards when a medication for one of five sampled residents (Resident 63) was not handled according to instructions. This deficient practice had the potential to result in adverse side effects, absorption of medication, and birth defects for the nurse. Findings: During a review of Resident 63's admission Record, the admission record indicated Resident 63 was admitted to the facility on [DATE] with diagnoses that included but not limited to, benign prostatic hyperplasia (BPH- a noncancerous enlargement of the prostate gland), retention of urine, and chronic kidney disease (a long-term condition where the kidneys gradually lose their ability to filter waste and excess fluids from the blood effectively). During a review of Resident 63's Minimum Data Set (MDS- a comprehensive assessment and screening tool) dated 12/19/2025, the MDS indicated Resident 63 cognitive skills (ability to think and reason) for daily decision making was moderately impaired. The MDS indicated Resident 63 required setup or clean-up assistance for eating, oral and personal hygiene, and upper body dressing. The MDS indicated Resident 63 required moderate staff assistance for shower/bathing and lower body dressing. During an observation on 1/21/2026 at 9:12 a.m., at Resident 63's room, with Licensed Vocational Nurse (LVN) 1, LVN 1 was observed not wearing gloves while handling and preparing finasteride (a prescription medication used for BPH) for administration to the resident. During a concurrent interview and record review on 1/21/2026 at 9:16 a.m. with LVN 1, Resident 63's physician's order dated 12/12/2025 was reviewed. The physician's order indicated finasteride oral tablet 5 milligrams (mg, unit of measurement by weight), to give 5 mg by mouth in the morning for BPH, wear gloves when handling/administering medication. LVN 1 stated she did not wear gloves when administering medications but should have read the order and followed the instructions when administering finasteride to prevent the risk of absorption of the medication through the skin. During a review of Resident 63's Consultant Pharmacist's Medication Regimen Review (MRR), dated 12/20/2025, the MRR indicated gloves should be worn when handling or administering finasteride. During an interview on 1/22/2026 at 1:00 p.m. with the Director of Nursing (DON), the DON stated, gloves must be worn when giving finasteride to avoid absorption of the medication through the skin and the nurse being exposed to the medication. The nurses should be following pharmacy recommendations and doctor's orders for each medication ordered, including finasteride. During a review of the facility's policy and procedure (P&P) titled, Medication Administration-General Guidelines, dated 1/2022, the P&P indicated, examination gloves are worn during medication administration when ordered by the prescriber.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 36), who had hand tremors, was assisted during mealtimes. This deficient practice had the potential to cause a negative impact on Resident 36's overall health status. Findings: During an observation on 1/21/2026 at 12:30 p.m., in the dining room, Resident 36 was observed seated at a table. A cup of coffee and food tray was placed on top of the table. Resident 36 was observed not eating. Resident 36's hands were shaking. Resident 36 grabbed the cup of coffee and brought it toward her face. Resident 36 began to spill coffee over herself and she returned the cup coffee back to the table. During a review of Resident 36's admission Record, the admission Record indicated Resident 36 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included lack of coordination (inability to produce smooth, accurate, and voluntary muscle movements, resulting in jerky, unsteady, and clumsy motions) and diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 36's History and Physical (H&P), dated 12/5/2025, the H&P indicated Resident 36 was oriented to person, place and time. During a review of Resident 36's Psychiatric evaluation, dated 12/5/2026, the psychiatric evaluation indicated Resident 36 was alert and oriented to person and place. The psychiatric evaluation indicated Resident 36 was noted to have extrapyramidal symptoms ([EPS] drug-induced movement disorders, that result in involuntary movements, muscle stiffness, tremors, and restlessness). During a review of Resident 36's Minimum Data Set ([MDS] a resident assessment tool), dated 12/4/2025, the MDS indicated Resident 36's cognitive skills for daily decision making was moderately impaired (ability to think and reason). The MDS indicated Resident 36 required set up or clean up assistance for eating. The MDS indicated Resident 36 required supervision for oral hygiene, toileting hygiene, upper body dressing and putting on and taking off shoes. The MDS indicated Resident 36 required moderate assistance (helper does less than half the effort) for lower body dressing and personal hygiene. During an interview on 1/21/2026 at 12:35 p.m. with Certified Nursing Assistant (CNA) 5, CNA 5 stated Resident 36 had hand tremors but did not require assistance to eat and could eat on her own. During a concurrent observation and interview on 1/21/2026 at 12:42 p.m., in the dining room, with CNA 5, observed CNA 5 ask Resident 36 if she needed help with eating. Resident 36 replied yes. CNA 5 set up Resident 36's food and fed the resident. CNA 5 stated she assisted Resident 36 with eating because she observed her hands were aggressively shaking and knew she would not be able to feed herself. During an interview on 1/22/2026 at 10:57 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 36 had hand tremors but has always been able to feed herself. LVN 1 stated Resident 36 would benefit from feeding assistance when her tremors were more aggressive. LVN 1 stated Resident 36 needed assistance to eat to ensure adequate nourishment and to avoid food and drink spillage. LVN 1 stated Resident 36 should receive assistance. During an interview on 1/23/2026 at 2:02 p.m. with the Director of Nursing (DON), the DON stated Resident 36 was independent and did not require assistance for eating. The DON stated a resident with hand tremors would not be able to feed themselves and would require staff's assistance to eat. During a review of the facility's P&P titled Quality of Life dated 11/2019, the P&P indicated it was the facility's policy to ensure that residents received treatment and care in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs.

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	056218	A. Building B. Wing	01/23/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain good grooming and personal hygiene for two of 12 sampled residents (Resident 33 and Resident 3) by failing to keep their nails clean and neat. This deficient practice had the potential to result in a negative impact on Residents 33 and 3's quality of life and self-esteem and had the potential for development of infection. Findings: a. During a review of Resident 33's admission Record, the admission Record indicated Resident 33 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 33's diagnoses included enterocolitis (an infection causing inflammation of the small intestine and colon), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (HTN- high blood pressure). During a review of Resident 33's Minimum Data Set (MDS- a resident assessment tool), dated 11/19/2025, the MDS indicated Resident 33's cognition (ability to think and process information) was intact. The MDS indicated Resident 33 required moderate (helper does less than half the effort) assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview on 1/20/2026 at 9:30 a.m., with Resident 33, in Resident 33's room, observed Resident 33's fingernails long with black substance underneath her nails. Resident 33 stated her fingernails looked long and that she would like to have her fingernails cut and cleaned. During an observation on 1/21/2026 at 1:13 p.m., in Resident 33's room, Resident 33 was observed to have long fingernails with a black substance underneath all ten fingernails. During an interview on 1/21/2026 at 2:13 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated nail care was a part of the CNA's duties, which include clipping, trimming, and cleaning the resident's nails. CNA 1 stated residents' nails should be monitored daily to ensure they remain clean and neat. CNA 1 stated that residents may scratch themselves, and if their fingernails were dirty, this could lead to open wounds and increased risk for infection. CNA 1 stated dirty fingernails were unsanitary, especially when residents use their hands to eat, as bacteria under the nails could be transferred to food or utensils and then injected. CNA 1 stated having dirty fingernails also placed other residents at risk, as bacteria from one resident's hands could be transferred to share surfaces or objects, potentially spreading germs and increasing the risk of illness among residents. During an interview on 1/23/2026 at 2:15 p.m., with the Director of Nursing (DON), the DON stated it was the facility's expectation for nursing staff, including CNAs, to monitor and assist residents with nail hygiene as a part of their routine care. The DON stated dirty overgrown fingernails could pose health and infection control concerns. The DON stated staff were expected to trim or report unclean fingernails promptly and to document any refusal or limitations. b. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included diabetes mellitus and dementia (a progressive state of decline in mental abilities). During a review of Resident 3's History and Physical (H&P), dated 10/7/2024, the H&P indicated (continued on next page)

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	056218	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 3 was dependent on staff for all ADL's. During a review of Resident 3's Order Summary Report, dated 1/10/2026, the Order Summary Report indicated podiatry (treatment of the feet and their ailments) consult as needed. During a review of Resident 3's care plan titled ADLs, dated 7/23/2025, the care plan indicated interventions were during baths/showers staff would check nail length, trim, and clean nails on bath days and as necessary. During a concurrent observation and interview on 1/23/2026 at 9:40 a.m. with CNA 2, in Resident 3's room, observed Resident 3's toenails were long, yellow, thick and digging into adjoining toes. CNA 2 stated he reported the nails to the charge nurse and to social services director (SSD). CNA 2 stated he informed the SSD that Resident 3 needed to get her nails cut and the SSD stated Resident 3 had issues with insurance and could not receive that service at that moment. CNA 2 stated he spoke to the facility's podiatrist (a person who treats the feet and their ailments) when he came to cut Resident 3's roommate's toenails and asked if he was going to cut Resident 3's nails. CNA 2 stated the podiatrist replied no because Resident 3 was not on his list of residents to be seen. During an interview on 1/23/2026 at 1:40 p.m. with the SSD, the SSD stated all residents were seen by the podiatrist on admission and every two months after. The SSD stated if residents' nails got too long it could be uncomfortable and non-hygienic. The SSD stated residents were not seen by the podiatrist when they refused or when they have billing issues. The SSD stated Resident 3 was last seen by the podiatrist on 7/19/2025. The SSD stated Resident 3 was not seen since the last visit because Resident 3 had insurance issues. The SSD stated Resident 3 should have been seen by podiatry even though she was having insurance issues because the facility offered that service without charge. The SSD stated she did not put Resident 3 on the list to be seen by the podiatrist since 7/19/2025. The SSD stated she should have followed up to prevent any injuries or complications due to Resident 3's long nails. During an interview on 1/23/2026 at 2:36 p.m. with the DON, the DON stated all residents must be seen by podiatry once a month. The DON stated residents must see a podiatrist for infection control and for hygiene purposes. The DON stated if residents do not see a podiatrist routinely, they have a risk of infection and could potentially miss skin injuries around toenails. During a review of the facility's policy and procedure (P&P) titled Fingernails/Toenails, Care of, revised 2/2018, the P&P indicated the facility would provide daily nail care including cleaning and regular trimming, to prevent the resident from accidentally scratching, injuring his or her skin, and to prevent infections. During a review of the facility's Job Description for Social Services Designee, dated 5/2017, the job description indicated the Social Services Designee would work cooperatively with resident/family, administration, and facility staff to assure that the physiological and concrete needs are maintained for their well-being of the resident (i.e. optical, dental, audiological, clothing, etc.).

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	056218	A. Building B. Wing	01/23/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physician's orders, ensure medication parameters were followed, and orthostatic hypotension (sudden, sustained drop in blood pressure that occurs when standing up from a sitting or lying position) monitoring was performed for three of 12 sampled residents (Resident 84, Resident 2, and Resident 6). These deficient practices placed Residents 84 and 2 at risk for serious medication related complications, including potential overdose, underdose, or adverse effects due to unmonitored response to treatment, and placed Resident 6 at risk for undetected episodes of hypotension, falls, and injury for not being monitored. Findings: a. During a review of Resident 84's admission Record, the admission Record indicated Resident 84 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 84's diagnoses included hypertension (HTN- high blood pressure), dementia (a progressive state of decline in mental abilities) and epilepsy (a chronic brain disorder). During a review of Resident 84's Minimum Data Set (MDS – a resident assessment tool), dated 10/13/2025, the MDS indicated Resident 84's cognition (ability to think and process information) was moderately impaired. The MDS indicated Resident 84 required moderate (helper does less than half the effort) assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 84's History and Physical (H&P), dated 11/7/2025, the H&P indicated Resident 84 did not have the capacity to make medical decisions. During a review of Resident 84's physician's order, dated 11/4/2025, the order indicated to monitor Resident 84's weight weekly for four weeks. During a review of Resident 84's Order Summary Report, dated 12/9/2025, the order summary report indicated on 11/5/2025, Resident 84's attending physician prescribed Lisinopril (medication used to treat hypertension) 10 milligrams ([mg]- metric unit of measurement, used for medication dosage and/or amount) by mouth daily in the morning for hypertension. The order included a clinical hold parameter, which directed nursing staff to withhold Lisinopril dose if the resident's systolic blood pressure (SBP) was below 110 millimeters of mercury ([mm/Hg] measure blood pressure), or the heart rate (HR) below 60 beats per minute (bpm) at the time of administration. During a concurrent interview and record reviewed on 1/22/2026 at 3:50 p.m., with the Director of Nursing (DON), Resident 84's physician's order, dated 11/5/2025, and Medication Administration Record (MAR), dated 11/2025 through 1/2026, and weights and vitals summary, dated 1/23/2026, were reviewed. The physician order indicated Resident 84 was to receive Lisinopril 10 mg by mouth daily in the morning, with parameters to hold medication if SBP below 110 mm/Hg or HR below 60 bpm. The DON stated the MAR indicated The DON stated the MAR indicated Resident 84 received Lisinopril 10 mg daily from 11/9/2025 through 1/22/2026. The DON stated Resident 84's BP was recorded as ordered; however, the HR was not recorded prior to medication administration. The DON stated there were no HR readings documented from 11/5//2025 to 1//22/2026. The DON stated there was no documented evidence explaining missed Lisinopril doses from 11/5/2025 to 11/7/2025. Upon further review of Resident 84's weights and vitals summary, dated 1/23/2026, the DON stated the last weight recorded for Resident 84 was on 1/28/2025, even though a physician order dated 11/4/2025 indicated staff to monitor weight weekly for four weeks. The DON stated the facility did (continued on next page)

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	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not implement the weight monitoring order as written. The DON stated the HR and weight monitoring had not been completed as ordered. The DON stated the facility's expectation was for all physician orders to be reviewed and implemented as written. The DON stated failure to follow the physician order for HR monitoring placed Resident 84 at risk for medication side effects and worsening heart function, such as hypotension (low blood pressure), and bradycardia (abnormal heart rate below 60 bpm). The DON stated that without accurate and timely HR monitoring could result in delayed recognition of Resident 84's changes in condition, inappropriate continuation of antihypertension medication, and health decline. The DON stated failure to implement physician order for weight monitoring timely placed Resident 84 at risk for potential unavoidable weight loss or gain. b. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included hypertension (high blood pressure) and heart failure (progressive heart disease that affects pumping action of the heart muscles, causes fatigue and shortness of breath). During a review of Resident 2's H&P, dated 10/26/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 2 required supervision for eating and oral hygiene. The MDS indicated Resident 2 required moderate assistance (helper does less than half the effort) for upper body dressing and personal hygiene. The MDS indicated Resident 2 required maximal assistance (helper does more than half the effort) for toileting hygiene, lower body dressing, and putting on and taking off shoes. During a review of Resident 2's Order Summary Report, dated 10/27/2025, the Order Summary Report indicated Resident 2 had an order for diltiazem (used to treat high blood pressure) oral tablet 60 mg, one tablet by mouth three times a day for atrial fibrillation ([Afib], irregular heart rhythm) hold if SBP was less than 110. During a review of Resident 2's MAR, dated 1/1/2026 – 1/31/2026, the MAR indicated on 1/3/3036, 1/9/2026 and 1/10/2026 at 9:00 p.m., on 1/18/2026 at 9:00 a.m., and on 1/22/2026 at 5:00 p.m., Resident 2 was administered diltiazem. The MAR indicated Resident 2's SBP was less than 110. During an interview on 1/23/2026 at 11:02 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated blood pressure parameters were used to prevent blood pressures to drop. LVN 3 stated a resident with a systolic blood pressure less than 110 should not receive diltiazem medication because it could potentially lower blood pressure to an unsafe level. LVN 3 stated licensed nurse should hold medication and inform the doctor the resident did not receive mediation. During a concurrent interview and record review on 1/23/2026 at 11:25 a.m. with LVN 3, Resident 2's MAR, dated 1/1/1016 – 1/31/2026 was reviewed. The MAR indicated Resident 2 received diltiazem medication on days where the SBP was less than 110. LVN 3 stated it was an unsafe practice to administer this medication when the resident's SBP was already low. LVN 3 stated the medication would lower Resident 2's blood pressure more. During an interview on 1/23/2026 at 2:40 p.m. with the DON, the DON stated nursing staff must follow all medication parameters. The DON stated it would be harmful to administer medication if Resident 2's SBP was lower than 110. The DON stated she expected nursing staff to retake the blood pressure. (continued on next page)

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	056218	A. Building B. Wing	01/23/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated if the blood pressure was still low to hold the medication and document why the medication was not administered. c. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included hypertension and end stage of renal disease ([ESRD], irreversible kidney failure). During a review of Resident 6's H&P, dated 11/11/2025, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 6 required set up and clean up assistance for eating. The MDS indicated Resident 6 required supervision for eating and upper body dressing. The MDS indicated Resident 6 required moderate assistance for toileting hygiene, lower body dressing and personal hygiene. During a review of Resident Order Summary Report, dated 12/24/2025, the Order Summary Report indicated to check Resident 6's orthostatic hypotension every Sunday. During a review of Resident 6's MAR, dated 1/1/2026 – 1/31/2026, the MAR did indicate Resident 6's orthostatic blood pressure was documented for sitting, lying and standing positions on Sundays. During an interview on 1/23/2026 at 11:38 a.m. with LVN 3, LVN 3 stated orthostatic blood pressure was monitored to find out if there was a sudden drop of blood pressure when changing positions from lying, sitting and standing. During a concurrent interview and record review on 1/24/2026 at 11:47 a.m. with LVN 3, Resident 6's MAR, dated 1/1/2026 - 1/31/2022 was reviewed. The MAR indicated Resident 6's orthostatic blood pressure for lying, sitting and standing was not monitored. LVN 3 stated she monitored Resident 6's blood pressure in the lying and sitting position but it did not show in the MAR. LVN 3 stated she did not monitor Resident 6's orthostatic blood pressure when standing. LVN 3 stated she was supposed to monitor the orthostatic blood pressure when standing but did not. LVN 3 stated the blood pressure monitoring was inaccurate and there was no way of knowing if there was a difference in Resident 6's blood pressures when in different positions. During an interview on 1/23/2026 at 2:28 p.m. with the DON, the DON stated orthostatic blood pressures were monitored for any changes in blood pressure when the residents change positions. The DON stated if the orthostatic blood pressures were not monitored there would be a risk of injury for residents. The DON stated if orthostatic blood pressures were not monitored, the doctor's orders were not followed and the residents' doctor had to be notified. During a review of the facility's Policy and Procedure (P&P) titled Medication Administration, dated 12/2019, the P&P indicated medications would be administered in accordance with written orders of the prescriber. During a review of the facility's P&P titled Medication Administration- General Guidelines, revised 12/2019, the P&P indicated the facility should follow specific procedures for medication administration, including, but not limited to, documentation of medication refusal, holding of doses, (continued on next page)

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	056218	A. Building B. Wing	01/23/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and monitoring vital signs. During a review of the facility's P&P titled Physician's Order Clarification, dated 11/2021, the P&P indicated all physician orders must be clear, complete, and accurately transcribed into the resident's medical record. The P&P indicated the order would be communicated to all relevant staff, would be promptly implemented and caried out. During a review of facility's LVN Job Description, dated 5/2017, the Job Description indicated LVN's would follow through resident care services needed to meet the individualized needs of each resident. The job description indicated LVN's would administer medications in a proficient manner. The job description indicated LVN's would correctly differentiate between normal and abnormal clinical findings and intervene in accordance with clinical standards of practice and per physician orders.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review the facility failed to ensure one of three sampled residents (Resident 38) was provided active-assist range of motion [(AAROM), a physical therapy term for exercises where the patient moves a body part independently but a therapist or device assists further] as indicated in the physician's (MD, medical doctor) order.This failure had the potential for Resident 38 to exhibit range of motion (ROM, full movement potential of a joint) decline. Findings: During a review of Resident 38's admission Record, the admission Record indicated the facility admitted Resident 38 on 6/26/2025 with diagnoses including cerebral ischemia (reduced or blocked blood flow to the brain), hypertension (HTN-high blood pressure), dysphagia (difficulty swallowing), and lack of coordination. During a review of Resident 38's Minimum Data Set (MDS, a resident assessment tool) dated 1/02/2026, the MDS indicated Resident 38 had moderate cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 38 was dependent on staff for Activities of Daily Living (ADLs) such as bathing, dressing and toileting.During a review of Resident 38's history and physical (H&P), dated 6/29/2025, the H&P indicated Resident 38 did not have capacity to understand and make medical decisions.During a review of Resident 38's physician (MD, medical doctor) order, dated 12/1/2025, the order indicated Resident 38 was to receive restorative nursing aide [(RNA), a certified nursing assistant (CNA) with specialized training in therapeutic rehabilitation, focused on helping patients maintain or improve functional mobility and independence] services for AAROM to bilateral (both) upper extremities (BUE)/bilateral lower extremities (BLE) as tolerated daily 5 times a week. During a review of resident 38's care plan dated 1/15/2026, the care plan indicated Resident 38 needed assistance with Activity of Daily Living (ADL). Resident 38 had an ADL self-care performance deficit and needed assistance from staff with interventions that included encouraging the resident independence, restorative nursing program as ordered, notifying the charge nurse or rehabilitation MD of any decline, and providing RNA for AAROM to BUE/BLE as tolerated daily 5 times a week as ordered. During an observation on 1/21/2026 at 1:56 p.m., at Resident 38's bedside, Resident 38 was observed receiving Passive Range of Motion [(PROM), moving of joints through their full range without muscle effort from the patient] exercises by Restorative Nursing Aide (RNA) 2. During an observation on 1/21/2026 at 3:17 p.m., at Resident 38's bedside, Resident 38 was observed receiving PROM and AAROM exercises to BUE and BLE by Physical Therapist (PT). During interviews on 1/21/2026 at 1:56 p.m. and 1/22/2026 at 9:25 a.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 38 cannot do AAROM on the right side of the body. CNA 2 stated she was performing PROM exercises on Resident 38. CNA 2 stated Resident 38's order indicated Resident 38 should receive AAROM to BUE and BLE. CNA 2 stated it was important to follow the MD order to identify changes that may need to be reported. During an interview on 1/21/2026 at 3:17 p.m., with the PT, the PT stated Resident 38's order indicated Resident 38 should receive AAROM to BUE and BLE. During an interview on 1/22/2026 at 8:35 a.m., with RNA 3, RNA 3 stated Resident 38's order indicated Resident 38 should receive AAROM to BUE and BLE. RNA 3 stated if the resident cannot participate independently, the RNA does PROM. RNA 3 stated it was important to follow orders so the residents' ROM can improve. During an interview on 1/22/2026 at 9:50 a.m., with the Director of Staff Development (DSD), the DSD stated Resident 38 receives AAROM because the resident can initiate movement of BUE and BLE and staff will assist with AAROM. DSD 1, stated it was important to follow the physician's order so the resident will benefit and not decline in ROM. During an interview on 1/23/2026 at 9:20 a.m., with the Director of Nursing (DON), the DON stated not following the order could result in decreased mobility. DON stated the importance of following RNA orders to prevent contractures and improve quality of care. During an interview on 1/23/2026 at 10:35 a.m., with the Director of Rehabilitation (DOR), the DOR stated, AAROM exercises will allow resident to activate (continued on next page)

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	056218	A. Building B. Wing	01/23/2026

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	muscles themselves. The DOR stated not following the order could lead to increased tension in the muscle resulting in decreased ROM.During a review of the facility's Restorative Range of Motion policy, dated 2/2017, the P&P indicated Restorative ROM should be conducted as directed by the physician's order.

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	056218	A. Building B. Wing	01/23/2026

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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** Based on observation, interview, and record review, the facility failed to ensure care and services related to urinary Foley catheter (a flexible tube inserted through the urethra [a hollow tube that lets urine leave the body] into the bladder to drain urine into a collection bag) management were provided for one of two sampled residents (Resident 11) by failing to:a. Irrigate (wash out) Resident 11's Foley catheter as needed as indicated by the physician orders.b. To Notify the Resident 11's physician of urine sediment (matter that settles to the bottom of a liquid), cloudiness and urinary pain.These deficient practices resulted in urinary catheter obstruction, and had the potential for increased infection, discomfort and decline in Resident 11's health status.Findings:During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was admitted to the facility on [DATE]. Resident 11's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), neuromuscular dysfunction of bladder (a dysfunction of the bladder caused by nerve damage, resulting in loss of bladder control, urinary incontinence, or retention), chronic kidney disease (long-term, irreversible loss of kidney function), hearth failure (a condition where the heart muscle doesn't pump blood as well as it should), and epilepsy (a chronic brain disorder causing recurring seizures due to abnormal electrical activity among brain cells).During a review of Resident 11's History and Physical (H&P), dated 1/22/2026, the H&P indicated Resident 11 did not have the capacity to understand and make decisions.During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool), dated 12/9/2025, the MDS indicated Resident 11 had severe cognitive skills for daily decision making (ability to think and reason). The MDS indicated Resident 11 required substantial/maximal assistance (helper does more than half the effort). Substantial/maximal assistance for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a concurrent observation and interview on 1/20/2026 at 9:40 a.m., with Resident 11, Resident 11's Foley catheter was observed to be cloudy and clogged with sediment. Resident 11 stated, I don't think the Foley catheter has ever been flushed. Resident 11 stated he had on and off urinary pain and burning when urinating. Resident 11 stated the nurses were aware, but nothing had been done.During a concurrent interview and record review on 1/21/2026 at 2:03 p.m., with Registered Nurse (RN) 2, Resident 11's nursing progress notes for the months of 11/2025, 12/2025 and 1/2026 were reviewed. RN 2 stated the last time Resident 11's Foley catheter was flushed was 11/15/2025. RN 2 stated that he was not aware as to why the Foley catheter had not been irrigated, changed or reinserted recently as per the physician orders. RN 2 stated he was unable to locate any progress notes or change in condition notes regarding physician notification of the urine sediment, cloudiness and reports of urinary pain and burning for Resident 11.During a concurrent interview and record review on 1/21/2026 at 2:15 p.m., with the Infection Preventionist (IP), Resident 11's physician orders dated 12/04/2025 were reviewed. The physician orders indicated:1. May irrigate with 100 cc (cubic centimeters - measurement of volume) normal saline as needed for tube clogging or maintain patency.2. Change catheter bag as needed when bag is soiled or catheter dislodged as needed.3. May reinsert Foley catheter as needed for malfunction or dislodgment.During a concurrent observation and interview on 1/21/2026 at 2:33 p.m., with the IP, and Resident 11, Resident 11's indwelling Foley catheter was observed with visible sediment and cloudy urine. The IP asked Resident 11 if he had pain. Resident 11 replied, I have on and off urinary pain and burning. The IP stated that urine from a Foley catheter should be clear and free of sediment. The IP stated that the presence of sediment and cloudiness indicated an abnormal finding. The IP stated that the physician's orders related to Foley catheter care had not been followed. The IP indicated that this represented a significant failure to provide appropriate care for Resident 11. The IP stated that failure to follow physician orders places the resident at increased risk for urinary tract infection, sepsis (a (continued on next page)

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	056218	A. Building B. Wing	01/23/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	life-threatening blood infection) , and worsening of the resident's medical condition.During a review of the facility's policy and procedure (P&P) titled, Indwelling Catheter Care dated 2/2017, the P&P indicated To ensure the care of the urinary catheter is carried out in a manner that minimizes trauma and infection risk. Maintenance: change catheter and drainage bag as needed for any signs of infection and obstruction.During a review of the facility's P&P titled, Change of Condition dated 8/2017, the P&P indicated It is the facility's policy that it shall promptly notify resident's attending physician of changes in the resident's medical condition and/or status.During a review of the facility's P&P titled, Physician's Order Clarification dated 11/2021, the P&P indicated physician orders to ensure resident safety, regulatory compliance, and effective communication among healthcare providers in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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** Based on interview and record review, the facility failed to ensure a pain scale (an assessment tool used to rate pain level) was used when administering Tramadol (a narcotic medication used to treat moderate to severe pain) for one of one sample resident (Resident 33). This deficient practice had the potential to result in the resident having inadequate treatment, miscommunication between nurses and physicians, and poorly controlled pain. Findings: During a review of Resident 33's admission Record, the admission record indicated Resident 33 was admitted to the facility on [DATE] and was readmitted [DATE] with diagnoses that included but not limited to Type II diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (high blood pressure), and low back pain. During a review of Resident 33's Minimum Data Set (MDS- a resident assessment tool) dated 11/19/2025, the MDS indicated Resident 33's cognitive skills (ability to think and reason) for daily decision making was intact. The MDS indicated Resident 33 required set up or clean up assistance for eating. The MDS indicated Resident 33 required moderate assistance (helper does less than half the effort) for oral and personal hygiene, and upper body dressing. The MDS indicated that Resident 33 required maximal assistance (helper does more than half the effort) from staff for toileting, lower body dressing and dependent upon staff for shower/bathing. During a concurrent interview and record review on 1/21/2026 at 3:06 p.m. with Registered Nurse (RN) 1, Resident 33's Tramadol Administration details from the medication administration record (MAR) printed on 1/21/2026 at 3:31pm was reviewed. The tramadol administration detail did not indicate a pain rating for Resident 33. RN 1 stated that Tramadol was given for pain, but she did not document a pain rating. During an interview on 1/21/2026 at 3:06 p.m. with RN 1, RN 1 stated a pain rating was needed to determine the correct medication to give Resident 33. RN 1 stated, that not giving the correct medication could result in Resident 33's pain not being controlled. During a review of Resident 33's physician's order for Tramadol dated 1/12/2026 at 9:22 p.m., the physician's order indicated tramadol should be given as needed for moderate pain of four through six (4-6) (on a scale from 0 to 10, where 0 represents no pain and 10 represents the worst possible pain). During an interview on 1/22/2026 at 1:00 p.m. with the Director of Nursing (DON), the DON stated that pain rating must be documented when administering a pain medication. During a review of the facility's policy and procedure (P&P) titled, Pain, dated 2005, the P&P indicated staff should assess for pain using a tool such as a pain scale (an assessment tool residents can use to rate the intensity of pain). During a review of the facility's P&P titled, Ordering and Implementing PRN Medications and Treatments, dated 2005, the P&P indicated as needed (PRN) orders will clearly identify appropriate circumstances for a medication's use.

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	056218	A. Building B. Wing	01/23/2026

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow physician orders for dialysis treatment (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) on Sundays, Tuesdays, and Fridays, and failed to ensure staff assessed the dialysisaccess site (surgically created access allowing blood removal and return during dialysis) each shift for two of two sampled residents (Residents 90 and 102). These deficient practices placed Resident 102 at risk for undetected dialysis access site complications, including swelling, pain, bleeding, bruising, and access malfunction, and placed Resident 90 at an increased risk of missed or delayed dialysis treatments, potentially resulting in serious adverse health outcomes.Findings: 1. During a review of Resident 102's admission Record, the admission Record indicated Resident 102 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) and diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 102's History and Physical (H&P), dated 1/22/2026, the H&P indicated Resident 102 had the capacity to understand and make decisions. During a review of Resident 102's Minimum Data Set ([MDS] a resident assessment tool), dated 12/2/2025, the MDS indicated Resident 102's cognitive skills for daily decision making was intact (ability to think and reason). The MDS indicated Resident 102 required set up or clean up assistance for eating. The MDS indicated Resident 102 required supervision for oral hygiene, toileting hygiene, upper body dressing, putting on and taking off shoes, and personal hygiene. The MDS indicated Resident 102 required maximal assistance (helper does more than half the effort) for shower/bathing. During a review of Resident 102's Order Summary Report, dated 1/12/2026, the Order Summary Report indicated to monitor Resident 102's dialysis access site, right upper chest for signs and symptoms of infection, bleeding, redness, swelling, and discharge every shift. During a review of Resident 2's Medication Administration Record (MAR), dated 1/1/2026 – 1/31/2026, the MAR indicated Resident 102's perma catheter (catheter placed inside a blood vessel in the neck or under collarbone and then threaded into the right side of heart, used for dialysis) would be monitored for signs and symptoms of infection such as redness, swelling, soreness, pain warmth and bleeding on every shift. The MAR indicated monitoring was discontinued on 1/12/2026. During an interview on 1/23/2026 at 10:40 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated dialysis access sites must be monitored every day and on every shift. LVN 1 stated dialysis access sites must be monitored for signs and symptoms of infection. LVN 1 stated if dialysis sites were not get monitored for signs and symptoms of infection or for bleeding there would be a risk of delayed care. During a concurrent interview and record review on 1/23/2026 at 10:50 a.m. with LVN 1, Resident 102's MAR, dated 1/1/1016 – 1/31/2026 was reviewed. The MAR indicated Resident 102 perma catheter would be monitored for signs and symptoms of infection such as redness, swelling, soreness, pain warmth and bleeding on every shift. The MAR indicated perma catheter monitoring was (continued on next page)

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	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discontinued on 1/12/2026. LVN 1 stated she was not aware Resident 102's perma catheter monitoring order was not renewed after he returned to the facility. LVN 1 stated the MAR indicated Resident 102's perma catheter site was not monitored since he returned from the General Acute Care Hospital (GACH) on 1/12/2026. LVN 1 stated if Resident 102's perma catheter site was not monitored there would be no way of knowing if the site was bleeding or had signs of infection. During an interview on 1/23/2026 at 2:20 p.m. with the Director of Nursing (DON), the DON stated dialysis access sites have to be monitored to make sure they were in working condition. The DON stated if dialysis access sites were not monitored, there was a risk of not providing the care that residents needed. 2. During a review of Resident 90's admission Record, the admission Record indicated the facility admitted Resident 90 on 6/28/2024 with diagnoses including diabetes mellitus, hyperlipidemia (high cholesterol), and end stage renal disease (ESRD, the final, permanent stage of kidney failure) and dependent on renal dialysis. During a review of Resident 90's History and Physical (H&P), dated 9/26/2024, the H&P indicated Resident 90 had the capacity to understand and make decisions. During a review of Resident 90's MDS, dated [DATE], the MDS indicated Resident 90's was dependent (helper does all of the effort.). The MDS indicated Resident 90 was dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs). During an interview on 1/20/2026 at 9 a.m., with Resident 90, Resident 90 stated that she attends dialysis on Monday, Wednesday, and Friday. During a concurrent interview and record review on 12/22/2026 at 2:51 p.m., with Licensed Vocational Nurse (LVN) 2, Resident 90's physician orders for dialysis dated 12/22/2025 were reviewed. The physician order indicated: Hemodialysis every Sunday, Tuesday, Friday. LVN 2 stated Resident 90 was sent for dialysis every Monday, Wednesday and Friday which was not consistent with the physician's orders. LVN 2 stated the dialysis order was not being followed. LVN 2 stated that this failure could have placed Resident 90 at risk for fluid overload, electrolyte imbalance and demonstrate noncompliance with physician orders. During an interview on 1/23/2026 at 10:50 a.m., with the Director of Nursing (DON), the DON stated that all physician orders must be followed to provide proper care for all residents. The DON stated that not all residents have the same dialysis schedule and therefore their dialysis schedule must be followed to avoid potential schedule conflict with the dialysis center and/or transportation company. The DON stated that not following the physician orders for dialysis placed Resident 90 at risk for fluid overload, inadequate toxin removal and potential hospitalization. During a review of the facility's Policy and Procedure (P&P) titled Dialysis Care, undated, the P&P indicated it was the facility's policy to provide standards of care to residents receiving dialysis care. The P&P indicated shunt sites ([vascular access] a high flow, easily accessible pathway to the bloodstream for dialysis) would be checked every shift for condition and patency. During a review of the facility's P&P titled, Hemodialysis, Care of Residents dated 8/2017, the P&P indicated Review and ensure orders upon admission are received for follow-up dialysis center appointments, shunt care, diet and fluid restriction. The P&P indicated the facility would provide (continued on next page)

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	01/23/2026

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents with safe, accurate, and appropriate care, assessments and interventions to improve resident outcomes. The P&P indicated facility would review and ensure orders upon admission are received for follow-up shunt care. The P&P indicated the facility would provide routine shunt care and monitoring per physician order.

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	056218	A. Building B. Wing	01/23/2026

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician face-to-face visits were conducted at least once every 30 days for the first 90 days following admission for two of six sampled residents (Residents 16 and 33).This deficient practice had the potential to result in undetected changes in Residents 16 and 33's medical, physical, mental, and psychosocial conditions, and potentially delay the provision of medically necessary care, treatment, and services.Findings:a. During a review of Resident 16's admission Record, the admission Record indicated Resident 16 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 16's diagnoses included epilepsy (a brain disorder), depression (a mental disorder that affects how person thinks, feels, and acts), anxiety (a feeling of fear, and dread), and hypertension (HTN-high blood pressure).During a review of Resident 16's History and Physical (H&P), dated 6/8/2025, the H&P indicated Resident 16 had the capacity to understand and make decisions. The H&P was signed by Nurse Practitioner (NP-a registered nurse who has advanced training to diagnose and treat patients).During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool), dated 12/11/2025, the MDS indicated Resident 16's cognition (the ability to think and process information) was intact. The MDS indicated Resident 16 was dependent (helper does all the effort) on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a review of Resident 16's progress note, dated 7/4/2025, the progress note indicated Resident 16 was seen by NP for a monthly visit.During a review of Resident 16's progress note, dated 8/2/2025, the progress note indicated Resident 16 was seen by NP for a monthly visit.During a concurrent interview and record review on 1/21/2026 at 4:01 p.m., with the Medical Record Director (MRD), Resident 16's H&P, dated 6/8/2025, and progress notes dated 7/4/2025 and 8/2/2025, were reviewed. The MRD stated the H&P was where physicians documented their initial face-to-face visit and comprehensive assessment of newly admitted residents. The MDR stated Resident 16's H&P, dated 6/8/2025, indicated Resident 16 was seen by NP. The MRD stated the H&P dated 6/8/2025, and progress notes dated 7/4/2025 and 8/2/2025, indicated Resident 16's physician did not conduct any in-person visit following admission on [DATE] and/or readmission on [DATE].b. During a review of Resident 33's admission Record, the admission Record indicated Resident 33 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 33's diagnosis included enterocolitis (an infection causing inflammation of the small intestine and colon), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension.During a review of Resident 33's MDS, dated [DATE], the MDS indicated Resident 33's cognition was intact. The MDS indicated Resident 33 required moderate (helper does less than half the effort) assistance from staff for ADLs.During a concurrent interview and record review on 1/21/2026 at 4:10 p.m., with the MRD, Resident 33's electronic medical records (EMRs), dated 11/13/2025 to 1/21/2026, were reviewed. The MRD stated there was no documented evidence that Resident 33 was seen by a physician following her admission on [DATE].During an interview on 1/22/2025 at 3:30 p.m., with the Director of Nursing (DON), the DON stated the expectation was for the physician to conduct an in-person visit for newly admitted residents within the first 30 days and then every 30 days thereafter for the first 90 days, in accordance with the facility's policy and federal requirements. The DON stated the facility failed to follow the facility's policy and did not meet federal requirements to ensure residents were seen timely by a physician. The DON stated this failure had the potential to place Resident 16 and 33 at risk for undetected changes in condition, delayed diagnosis, and delayed medical care and necessary treatment.During a review of the facility's policy and procedure (P&P) titled Physician Services, dated 6/2022, the P&P indicated:The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.A physician visit is considered timely if it occurs no later than 10 days after the date the visit was required.

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	01/23/2026

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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** Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards for three of sampled residents (Resident 12, 33, and 36) by not ensuring licensed staff documented:1. Resident 12's medication administration and pain reassessment in a timely manner.2. Resident 33's pain reassessment in a timely manner.3. Resident 36's hand tremors.These deficient practices resulted in incomplete resident medical care information and placed residents at risk for confusion in the provision of care and services.Findings 1. During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 12's diagnoses included Type II diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), disorder of muscle, and gout (a common, treatable form of inflammatory arthritis caused by high levels of uric acid in the blood forming crystals in joints). During a review of Resident 12's Minimum Data Set ([MDS] a resident assessment tool), dated 1/2/2026, the MDS indicated Resident 12's cognitive skills (ability to think and reason) for daily decision making was intact. The MDS indicated Resident 12 required set up or clean up assistance for eating. The MDS indicated Resident 12 required moderate assistance (helper does less than half the effort) for oral and personal hygiene, and upper body dressing. The MDS indicated that Resident 12 required maximal assistance (helper does more than half the effort) from staff for toileting, lower body dressing and dependent upon staff for shower/bathing. During a concurrent interview and record review on 1/21/2026 at 3:06 pm with Registered Nurse (RN) 1, Resident 12's eMAR, printed on 1/21/2026 at 3:31 pm was reviewed. Resident 12's eMAR indicated the last time hydrocodone-acetaminophen was given was on 1/20/2026 at 11:06 pm. RN 1 stated she forgot to document administering the hydrocodone-acetaminophen on 1/21/2026 at 9:48 am on Resident 12's eMAR. During an interview on 1/21/2026 at 3:38 pm with RN 1, RN 1 stated she should have documented the hydrocodone-acetaminophen immediately after giving it to Resident 12 because she put Resident 12 at risk for medication duplication and inaccurate documentation. During a review of Resident 12's progress notes, dated 1/21/2026 at 9:48 am, the progress note indicated hydrocodone/acetaminophen was given at 9:48 am but was not documented until 4:27 pm. 2. During a review of Resident 33's admission Record, the admission Record indicated Resident 33 was admitted to the facility on [DATE] and was readmitted [DATE]. The admission Record indicated Resident 33's diagnoses included DM, hypertension (high blood pressure), and low back pain. During a review of Resident 33's MDS dated [DATE], the MDS indicated Resident 33's cognitive skills for daily decision making were intact. The MDS indicated that Resident 33 required setup or clean-up assistance for eating. The MDS indicated that Resident 33 required supervision or touch assistance for oral hygiene and upper body dressing, moderate assistance for personal hygiene and was dependent upon staff assistance for shower/bathing. (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 33's progress notes – pain reassessment dated [DATE] at 8:00 am, the pain reassessment was done at 8:00 am but not recorded on the medical record until 4:01 pm. During a review of Resident 12's progress notes – pain reassessment dated [DATE] at 10:27 am, the pain reassessment was done at 10:27 am but not recorded on the medical record until 4:28 pm. During an interview on 1/21/2026 at 3:06 pm with RN 1, RN 1 stated she has not documented the reassessment for pain level for Resident 12 or 33. RN 1 stated the reassessment for pain level should be documented after 30 minutes of giving a pain medication. During an interview on 1/22/2026 at 1:00 pm with the Director of Nursing (DON), the DON stated pain reassessments should be documented in the medical record within an hour of receiving the pain medication. The DON stated this is to ensure that the pain medication was effective. 3. During a review of Resident 36's admission Record, the admission Record indicated Resident 36 was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. The admission Record indicated Resident 36's diagnoses included lack of coordination (inability to produce smooth, accurate, and voluntary muscle movements, resulting in jerky, unsteady, and clumsy motions) and DM. During a review of Resident 36's History and Physical (H&P), dated 12/5/2025, the H&P indicated Resident 36 was oriented to person, place and time. During a review of Resident 36's Psychiatric evaluation, dated 12/5/2026, the psychiatric evaluation indicated Resident 36 was alert and oriented to [NAME], place. The psychiatric evaluation indicated Resident 36 was noted to have extrapyramidal symptoms ([EPS] drug-induced movement disorders, that result in involuntary movements, muscle stiffness, tremors, and restlessness). During a review of Resident 36's Minimum Data Set ([MDS] a resident assessment tool), dated 12/4/2025, the MDS indicated Resident 36's cognitive skills for daily decision making was moderately impaired (ability to think and reason). The MDS indicated Resident 36 required set up or clean up assistance for eating. The MDS indicated Resident 36 required supervision for oral hygiene, toileting hygiene, upper body dressing and putting on and taking off shoes. The MDS indicated Resident 36 required moderate assistance (helper does less than half the effort) for lower body dressing and personal hygiene. During a review of Resident 36's Daily Skilled Charting, dated 1/13/2026 – 1/23/2026, under neurological/sensory/communication section, tremors was not addressed. During a concurrent interview and record review on 1/24/2026 at 10:55 a.m. with Licensed Vocational (LVN) 1, Resident 36's Daily Skilled Charting, dated 1/22/2026 and 1/23/2026 were reviewed. The Daily Skilled Charting indicated on 1/22/2026 and 1/23/2026 under neurological/sensory/communication section, the presence of tremors was not addressed. LVN 1 stated Resident 36 had tremors on 1/22/2026 and 1/23/2026 and she should have documented that Resident 36 displayed tremors. LVN 1 stated she was not aware there was a section to acknowledge tremors and that was the reason why she didn't document it. LVN 1 stated it was important to document Resident 36 had tremors to inform staff she was assessed and potentially to change treatment. (continued on next page)

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	056218	A. Building B. Wing	01/23/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/24/2026 at 2:20 p.m. with the Director of Nursing (DON), the DON stated nursing staff must document their observations of tremors. The DON stated if tremors were not documented, the tremors could go untreated, and the resident would potentially not receive the care they need. During a review of facility's Policy and Procedure (P&P) titled Documentation Guidelines, dated 11/2021, the P&P indicated documentation must be completed for residents' condition and changes in the resident's condition. The P&P indicated to document resident observations, psychosocial and physical manifestations, incidents, unusual occurrences, and abnormal behavior. The P&P indicated that documentation should be done promptly as the events occur. During a review of the facility's P&P titled, Medication Administration – General Guidelines, dated December 2019, the P&P indicated the individual who administers the medication dose records the administration on the resident's eMAR directly after the medication is given. During a review of facility's undated P&P titled, Licensed Nurse Progress Notes, the P&P indicated the licensed nurse should document pain assessments at the time the assessment was completed.

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	056218	A. Building B. Wing	01/23/2026

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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** Based on interview, observation, and record review, the facility failed to implement and maintain an effective infection prevention and control program by failing to ensure the dialysis binder (used as a dialysis communication record and transported with the resident to and from dialysis appointments) used for one of one residents (Resident 90) was clean and free from visible contamination. This deficient practice increased the potential for the transmission of infectious agents and placed Resident 90, other residents, and staff, at risk for infections. Findings:During a review of Resident 90's admission Record, the admission Record indicated Resident 90 was admitted to the facility on [DATE]. Resident 90's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hyperlipidemia (high cholesterol), end stage renal disease (ESRD, the final, permanent stage of kidney failure) with dependence on renal (kidneys) dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 90's History and Physical (H&P), dated 9/26/2024, the H&P indicated Resident 90 had the capacity to understand and make decisions. During a review of Resident 90's Minimum Data Set (MDS - a resident assessment tool), dated 1/7/2026, the MDS indicated Resident 90's was dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs). During a review of Resident 90's physician orders dated 12/22/2025, the physician orders indicated Hemodialysis every Sunday, Tuesday, Friday. During a concurrent observation, interview, and record review on 1/22/2025 at 2:45 p.m., with the Infection Preventionist (IP), Resident 90's dialysis binder was reviewed. The binder was observed to have brown-colored staining on the back exterior surface. The IP indicated the dialysis binder is assigned solely to Resident 90 and routinely accompanies the resident to dialysis treatment. The IP stated the binder was sometimes placed between the resident and the transportation gurney (bed) during transport. The IP stated the staining might be fecal matter. The IP stated the dialysis binder should have been cleaned and disinfected after each return from dialysis, in accordance with infection prevention practices but this did not occur. The IP stated the failure to clean and disinfect the binder represented a breach in the facility's infection prevention and control practices, increasing the risk for cross-contamination and the transmission of infectious organisms to the residents, staff, and others. During a review of the facility's policy and procedure (P&P) titled, Scope of Infection Control Program dated 7/2022, the P&P indicated The scope of the program includes prevention, detection, management and control of spread of infection. Prevention of infection includes all policies and procedures that enhances the practice and prevention on the spread of infection. Staff will follow standards and transmission based precautions to prevent spread of infection. Cleaning removal of visible soil from objects and surfaces with detergents or enzymatic products. Staff will refer to infection control program policies for guidance on how to manage infection prevention, control and management of both residents and employees.

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	01/23/2026

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP) completed ten hours of continuing education in Infection Prevention and Control on an annual basis. This deficient practice had the potential for the IP to be unaware and be unable to educate the facility's staff of updated information regarding Infection Prevention and Control practices.Findings:During an interview on 1/23/2026 at 11:30 a.m., with the IP, the IP stated she was not able to provide documentation indicating the completion of ten hours of continuing education in infection prevention and control for 2025. The IP stated she completed continuing education hours when she renewed her nursing license, however, those hours were not obtained in 2025. The IP stated it was her responsibility to complete ten hours of infection prevention and control education each year, as required, in order to stay informed on new guidance, evidence-based practices and emerging infectious disease threats. The IP stated that these ten hours were essential for her to remain up to date with current infection prevention and control practices. During an interview on 1/23/2026 at 2:20 p.m., with the Director of Nursing (DON), the DON stated the IP was responsible for educating staff on current infection prevention and control practices. The DON stated for the IP to effectively educate staff, she must remain current on infection prevention and control updates. The DON stated that failure to complete the required annual ten hours of training could result in the IP missing critical changes in infection control practices, which could lead to inconsistent implementation of current infection prevention measures. During a review of the California Department of Public Health All Facilities Letter (AFL, an official communication issued by the California Department of Public Health (CDPH) to licensed or certified health facilities), dated 11/4/2020, the AFL indicated, The IP should complete 10 hours of continuing education in the field of [Infection Prevention and Control] on an annual basis. Facilities should provide encouragement and support for IP staff to stay abreast of current news and training sources through a nationally recognized infection prevention and control association.