STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555055	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baldwin Gardens Nursing Center	10786 Live Oak Avenue Temple City, CA 91780

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for four of four sampled residents (Residents 7, 9,12 and 23). These deficient practices had the potential for Residents 7, 9,12 and 23 not to receive necessary care or receive delayed services, placing the residents at risk for falls or injury. Findings: a. During a review of Resident 12's Admission Record (AR), the AR indicated Resident 12 was initially admitted to the facility on [DATE] and re admitted on [DATE] with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (type of ischemic [deficient supply of blood] stroke [sudden death of brain cells in a localized area due to inadequate blood flow] resulting from a blockage in the blood vessels supplying blood to the brain) affecting left non-dominant side and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 12's Fall Risk Assessment (FRA - method of assessing a patient's likelihood of falling) dated 11/2/2022, the FRA indicated Resident 12 was assessed as high risk for fall due to intermittent confusion, unable to assess gait/balance and presence of predisposing disease condition. During a review of Resident 12's untitled Care Plan (CP) dated 4/11/2023, the Care Plan indicated Resident 12 was at risk for fall secondary to history of falls, impaired balance and recent cerebrovascular accident (CVA, blood flow to a part of the brain is stopped either by a blockage or the rupture of a blood vessel).The CP interventions indicated for nursing staff to keep the resident's call light within easy reach and encourage the resident to call for assistance. During a review of Resident 12's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/16/2024, the MDS indicated Resident 12 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 12 was dependent (helper did all the effort and lifted or held trunk or limbs) to staff for oral/toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/19/2024 at 10:15 am, in Resident 12's room, Resident 12 was awake, lying in bed. Resident 12's call light was hanging on the left side rail of the bed. During a concurrent observation and interview on 11/19/2024 at 10:16 am, with the facility's Infection Prevention Nurse (IPN), the IPN stated, Resident 12 was unable to reach the call light because it was hanging on the left side rail. The IPN stated Resident 12's call light needed to be within reach for Resident 12 to use to call the staff if Resident 12 needed help in case of emergency or if the resident needed assistance from the facility staff. b. During a review of Resident 23's AR, the AR indicated Resident 23 was admitted to the facility on [DATE] with diagnoses that included paraplegia (impairment in motor or sensory function of the lower extremities) and lack of coordination. During a review of Resident 23's untitled CP dated 11/1/2024, the CP indicated Resident 23 was at risk for fall secondary to paraplegia. The CP interventions indicated for nursing staff to keep the resident's call light and bed controls within easy reach, answer the call light in a timely manner and encourage the resident to call for assistance. During a review of Resident 23's MDS dated [DATE], the MDS indicated Resident 23 had moderately impaired cognition for daily decision making. The MDS indicated Resident 23 was dependent to staff for oral/toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During an observation on 11/19/2024 at 10:01 am, in Resident 23's room, Resident 23 was awake and lying in bed. Resident 23's call light was hanging at the left side rail of the bed. Resident 23 stated, I cannot reach my call light. During a concurrent observation and interview on 11/19/2024 at 10:02 am, with the facility's IPN, the IPN stated Resident 23's call light needed to be within reach for Resident 23 to use to ask for help and assistance. During an interview on 11/19/2024 at 10:40 am with the facility's Director of Nursing (DON), the DON stated, the call light needed to be within reach for the residents to use so that staff could assist in a timely manner. 40438 c. During a review of Resident 7's AR, the AR indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included intervertebral disc disorder with myelopathy (a condition where the spinal cord is compressed), spondylosis (age-related wear and tear of the spinal disks), and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures). During a review of Resident 7's untitled CP dated 8/11/2022, the CP indicated Resident 7 required to use bilateral (both sides) 1/4 partial padded bedside rail for seizure precautions. The CP interventions indicated to place the call light and frequently used items within reach and to answer call light promptly. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7 had severely impaired cognition and dependent with oral and toileting hygiene, shower, upper and lower body dressing, and personal hygiene. During a concurrent observation and interview on 11/19/2024 at 10:48 am with Licensed Vocational Nurse 1 (LVN 1) inside Resident 7's room, Resident 7's call light was on the floor. LVN 1 stated Resident 7's call light should be placed close and next to the resident to use when assistance was needed. d. During a review of Resident 9's AR, the AR indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the blood that affects the brain), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness on one side of the body). During a review of Resident 9's untitled CP dated 10/9/2023, the CP indicated Resident 9 was at risk for falls secondary to cerebrovascular accident (CVA, or stroke, caused by interrupted blood flow to the brain) with hemiplegia and hemiparesis. The CP interventions included to keep the resident's call light and bed controls within easy reach. During a review of Resident 9's MDS dated [DATE], the MDS indicated Resident 9 had severely impaired cognition and dependent with oral and toileting hygiene, shower, upper and lower body dressing, and personal hygiene. During a concurrent observation and interview on 11/19/2024 at 10:25 am with LVN 2 inside Resident 9's room, Resident 9's call light was under the bed and the cord was tangled in between the bed and the siderails. LVN 2 stated Resident 9's call light should be placed within reach of the resident to be able to call staff when help was needed. During an interview on 11/21/2024 at 11:22 am with the Director of Nursing (DON), the DON stated, the resident's call light or pad sensor should be placed next to the resident's strong arm and hand so that the resident could call for assistance and staff could assist the resident timely. During a review of the facility's Policy and Procedure (P&P) titled, Answering the Call Light, dated 10/2010, the P&P indicated when the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident. The P&P indicated to answer the resident's call light as soon as possible.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on interview and record review, the facility failed to provide information regarding Advance Directive (AD, a written preferences regarding treatment options, a process of communication between individuals and their healthcare agents when individuals are not able to make their own healthcare decisions) for two of two sampled residents (Residents 11 and 25) in accordance with the facility's Policy and Procedure (P&P) titled Advance Directives. This failure had the potential for the facility staff to provide services and treatment against the residents' choices. Findings: a. During a review of Resident 11's Admission Record (AR), the AR indicated the facility admitted Resident 11 on 10/9/2021 and readmitted on [DATE] with diagnoses that included dependence on supplemental oxygen and gastrostomy (creation of an artificial external opening into the stomach for nutritional support) status. During a review of Resident 11's Minimum Data Set Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/9/2024, the MDS indicated Resident 11 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 11 required total dependence (helper does all of the effort) with oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent interview and record review of Resident 11's medical records (chart) on 11/19/2024 at 2:27 pm with Social Services Director (SSD), the SSD stated there was no Advance Directive Acknowledgement Form in Resident 11's chart. The SSD stated AD Acknowledgement form needed to be initiated and formulated upon Resident 11's admission. b. During a review of Resident 25's AR, the AR indicated the facility admitted Resident 25 on 2/6/2020 with diagnoses that included essential hypertension (elevated blood pressure without a known cause) and gastrostomy status. During a review of Resident 25's MDS dated [DATE], the MDS indicated Resident 25 had severely impaired cognition for daily decision making. The MDS indicated, Resident 25 required total dependence with oral hygiene, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent interview and record review of Resident 25's chart on 11/19/2024 at 2:31 pm with SSD, the SSD stated there was no Advance Directive Acknowledgement Form in Resident 25's chart. The SSD stated AD Acknowledgement form needed to be initiated and formulated upon Resident 25's admission. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/19/2024 at 2:51 pm with the facility's Director of Nursing (DON), the DON stated the AD Acknowledgement form needed to be in the resident's chart for accessibility and to identify Resident 25's wants and wishes. During a review of the facility's P&P titled, Advance Directives, dated 11/2023, the P&P indicated upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate advance directive if he she chooses to do so. The P&P indicated prior to or upon admission of a resident, the social services director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The P&P indicated information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents' (Residents 16 and 55) Minimum Data Set (MDS - a federally mandated resident assessment tool) reflected an accurate assessment, by failing to: a. Ensure Resident 16's discharge destination was coded correctly. Resident 16 was discharged to a Skilled Nursing Facility (SNF - care provided by trained registered nurses in a medical setting under a doctor's supervision) and was coded in the MDS assessment as being discharged to home or community. b. Ensure Resident 55's diagnosis was coded accurately. These deficient practices resulted in an inaccurate reporting to the Centers for Medicare and Medicaid (CMS, a federal agency that administers the Medicare program and works with state governments to administer the Medicaid and health insurance portability standards) Services agency and had the potential for Residents 16 and 55 not to receive interventions to address their specific care concerns. Findings: a. During a review of Resident 16's Admission Record (AR), the AR indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Post-Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event) and muscle weakness. During a review of Resident 16's History and Physical (H&P), dated 2/23/2023, the H&P indicated Resident 16 did not have a diagnosis of PTSD. During a review of Resident 16's MDS dated [DATE], the MDS indicated Resident 16 had active diagnosis of PTSD. During a review of Resident 16's MDS dated [DATE], the MDS indicated, Resident 16 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 16 was dependent (helper did all the effort and lifted or held trunk or limbs) to staff for oral/toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 16 had active diagnosis of PTSD. During a concurrent observation and interview on 11/19/2024 at 12:13 pm, Resident 16 was sitting on his wheelchair outside Resident 16's room. Resident 16 stated I do not have any trauma in the past. During an interview on 11/20/2024 at 2:04 pm, with the facility's Minimum Data Set Nurse (MDSN), the MDSN stated Resident 16 did not have any previous or active diagnosis of PTSD. The MDSN stated, she did not know why it was coded in the system and an error of the previous MDSN. The MDSN stated Resident 16's MDS assessment should have been coded accurately to give correct information to the Centers for Medicare and Medicaid services. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 55's AR, the AR indicated Resident 55 was admitted to the facility on [DATE] with diagnoses that included essential hypertension (elevated blood pressure without a known cause) and anemia (decrease in the total amount of red blood cells in the blood). During a review of Resident 55's Physician's Order (PO) dated 9/10/2024, timed 11:25 am, the PO indicated to discharge Resident 55 to SNF with medications and personal belongings. During a review of Resident 55's Progress Notes (PN) dated 9/10/2024, timed 2:27 pm, the PN indicated Resident 55 was discharged to SNF with all personal belongings and medication. During a review of Resident 55's MDS dated [DATE], the MDS indicated Resident 55 was discharged to home/community. During an interview on 11/20/2024 at 11:47 pm, with the facility's Social Services Director (SSD), the SSD stated Resident 55 was discharge to SNF on 9/10/2024 and not to home or community. During a concurrent interview and record review of Resident 55's MDS dated [DATE] on 11/20/2024 at 12:52 pm, with the facility's MDSN, the MDSN stated Resident 55 was coded in the MDS as discharged to home/community. The MDSN stated, Resident 55 was discharged to SNF and not to home/community on 9/10/2024. The MDSN stated, Resident 55's MDS assessment needed to be coded discharged to SNF and not to home/community. The MDSN stated Resident 55's MDS assessment needed to be coded accurately to give accurate information to CMS. During a review of the facility's Policy and Procedure (P&P) titled, Resident Assessments, dated 11/2019, P&P indicated the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducted timely and appropriate resident assessments and reviews according to the following requirements: OBRA required assessments conducted for all residents in the facility, such as initial assessment - conducted within fourteen days of th resident's admission to the facility and discharge assessment - conducted when an resident was discharged from the facility.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview, and record review, the facility failed to ensure the Low Air Loss (LAL) mattress (Alternating Pressure Mattress which provides alternating pressure and is designed to be used in the prevention, treatment and management of pressure injury [PI- a localized damage to the skin and underlying soft tissue usually over a bony prominence]) was set up accurately based on the resident's weight for one of two sampled residents (Resident 10). This failure had the potential risk for Resident 10 to develop PI. Findings: During a review of Resident 10's Admission Record (AR), the AR indicated Resident 10 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) and Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control). During a review of Resident 10's Order Summary Report (OSR) dated 11/1/2024, the OSR indicated Resident 10 had an order for LAL mattress for wound management. During a review of Resident 10's Weight Summary (WS), the WS indicated on 11/12/2024, Resident 10 weighed 162 lbs. During a review of Resident 10's quarterly Minimum Data Set (MDS, a resident assessment tool) dated 11/15/2024, the MDS indicated Resident 10 had clear speech, sometimes understood others, and sometimes made self-understood. The MDS indicated Resident 10 was dependent (helper does all of the effort) for toileting hygiene and chair/bed-chair transfer. During an observation and interview on 11/19/2024 at 10:33 am, in Resident 10's room, Resident 10 was lying in bed on a LAL mattress and the LAL mattress controller (model-Proactive 4000 series) had a weight indicator at 280 pounds (lbs.) During an observation and interview on 11/19/2024 at 2:41 pm, in Resident 10's room, Resident 10 was lying in bed sleeping. Resident 10's LAL mattress controller indicated 280 lbs. During a concurrent interview, Licensed Vocational Nurse 3 (LVN 3) stated, Resident 10's LAL was set at 280 lbs. and Resident 10's actual weight was 162 lbs. LVN 3 stated, Resident 10 was bed bound and had history of PI. LVN 3 stated, the LAL set up for Resident 10 should be based on Resident 10's weight for wound management to prevent recurrence of PI. During an interview on 11/20/2024 at 9:43 am with the facility's Treatment Nurse (TN), the TN stated, staff should set Resident 10's LAL mattress by weight per manufacturer's recommendation so that the mattress would alternate and provide proper relief of body's pressure points to prevent possible PI to Resident 10. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Proactive Operation Manual for Resident 10's LAL mattress, the manual indicated Users can adjust air mattress to a desired firmness according to patient's weight or the suggestion from health care professional. During a review of the facility's Policy and Procedure (P&P) titled Support Surface Guidelines, revised 9/2013, the P&P indicated Any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as foam, gel, static air, alternating air, or air-loss or gel when lying in bed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to ensure the residents had an environment free from accident hazards(risks) for two of five sampled residents (Residents 7 and 53) by failing to: a. Ensure Resident 7's bilateral 1/4 siderails were padded as ordered by the physician. b. Ensure Resident 53's floor mat (used to reduce fall related trauma if a patient gets up from bed, loses balance, and falls to the floor) was close to the bed and the resident's bed lowered at the lowest position. These failures had the potential to result in accidents and hazards for Residents 7 and 53. Findings: a. During a review of Resident 7's Admission Records (AR), the AR indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included intervertebral disc disorder with myelopathy (a condition where the spinal cord is compressed), spondylosis (age-related wear and tear of the spinal disks), and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizure [sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking and loss of consciousness]). During a review of Resident 7's untitled Care Plan (CP) dated 2/20/2021, the CP indicated, Resident 7 had a seizure disorder. The CP interventions included for staff to apply bilateral padded side rails for seizure precautions. During a review of Resident 7's untitled CP dated 5/24/2021, the CP indicated Resident 7 had a potential for actual impairment to skin integrity. The CP interventions included for staff to pad the bed rails, wheelchair arms or any other source of potential injury. During a review of Resident 7's Order Summary Report (OSR) dated 1/25/2023, the OSR indicated Resident 7 had an order for padded side rails for seizure precautions. During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 10/19/2024, the MDS indicated Resident 7 had severely impaired cognition (ability to understand) and dependent (helper did all of the effort, resident did none of the effort to complete the activity) with oral and toileting hygiene, shower, upper and lower body dressing, and personal hygiene. During a concurrent observation on 11/19/2024 at 10:48 am inside Resident 7's room, Resident 7 was in bed, lying on her back with 1/4 siderails up on both sides of the bed. The siderails were not padded. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a interview on 11/20/2024 at 11:28 am with Licensed Vocational Nurse 1 (LVN 1) inside Resident 7's room, LVN 1 stated, Resident 7's siderails needed to be padded on both sides of the bed for resident's safety during seizure activity. During an interview on 11/21/2024 at 11:27 am with the facility's Director of Nursing (DON), the DON stated siderails were ordered for residents with seizure to prevent harm and injury during seizure activity. During a review of the facility's Policy and Procedure (P&P) titled, Bed Safety, revised December 2007, the P&P indicated, To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, siderails, headboard, footboard, and bed accessories), the facility shall identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g., altered mental status, restlessness, etc.) 40037 b. During a review of Resident 53's Admission Record, the admission record indicated Resident 53 was admitted to the facility on [DATE], with diagnoses that included muscle weakness and lack of coordination. During a review of Resident 53's Admission/Readmission Initial Assessment, dated 10/25/2024, the Admission Assessment indicated, Resident 53's fall risk assessment score was 14. A total score of 10 or above represents a high risk for falls. During a review of Resident 53's Minimum Data Set (MDS, a resident assessment tool), dated 10/28/2024, the MDS indicated, Resident 53 had clear speech, rarely/never understood others, and rarely/never made self-understood. The MDS further indicated Resident 53 required substantial/maximal assistance (helper does more than half the effort) for toilet hygiene and chair/bed-to-chair transfer. During a review of Resident 53's Order Summary Report dated 11/1/2024, the Order Summary indicated, Low bed with gym mats as least restrictive measure due to fall risk. During an observation on 11/19/2024 at 9:46 am, while in Resident 53's room, Resident 53 was lying in bed awake. Resident 53's bed was in a high position and the floor mats were at each side of Resident 53's bed. The floor mat on the right side of Resident 53's bed was two feet away from the edge of the bed. During a continued observation and concurrent interview on 11/19/2024 at 10:12 am, in Resident 53's room, there was no change in Resident 53's bed position lever and floor mats. Licensed Vocational Nurse 3 (LVN 3) stated, Resident 53's bed was not at its lowest position and the right floor mat was too far away from Resident 53's bedside. LVN 3 stated, if Resident 53 fell on the right side, Resident 53 would not land on the floor mat. LVN 3 stated, Resident 53 was newly admitted to this facility and had a history of falls. LVN 3 stated, Resident 53's bed should be placed at the lowest position, and the floor mats should be placed close to Resident 53's bedside so Resident 53 could land on the floor mat to cause less of an impact on the body if there is a fall. LVN 3 stated, these measures were to prevent the resident from sustaining injuries after a fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled Fall Risk Assessment, revised 11/2023, the P&P indicated The staff will seek to identify environmental factors that may contribute to falling, such as lighting and room layout. The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable.

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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** 40438 Based on observation, interview, and record review, the facility failed to provide necessary care and services for a resident with Foley catheter (a medical device that helps drain urine from the bladder) in accordance with the facility's Policy and Procedure (P&P) on catheter care for one of one sampled resident (Resident 9). This failure had the potential to result in catheter-related complications for Resident 9. Findings: During a review of Resident 9's Admission Records (AR), the AR indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included urinary tract infection (UTI- an infection of the bladder/urinary tract) and chronic kidney disease (characterized by progressive damage and loss of function in the kidneys). During a review of Resident 9's untitled Care Plan (CP) dated 11/20/2023, the CP indicated, Resident 9 had an indwelling catheter. The CP interventions included to check the tubing for kinks each shift. During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool), dated 10/6/2024, the MDS indicated Resident 9 had severely impaired cognition (ability to understand) and dependent (helper did all of the effort, resident did none of the effort to complete the activity) with oral and toileting hygiene, shower, upper and lower body dressing and personal hygiene. The MDS indicated Resident 9 had an indwelling catheter (foley catheter). During a concurrent observation and interview on 11/20/2024 at 2:14 pm with the Treatment Nurse (TN) inside Resident 9's room, Resident 9 was in bed, lying on his left side with a Foley catheter. The Foley catheter tubing was kinked where the tubing and the catheter was connected. The TN stated, Resident 9's Foley catheter tubing should be straight and free from kinks to prevent backflow of urine and cause UTI to the resident. During an interview on 11/21/2024 at 12:15 pm with the facility's Director of Nursing (DON), the DON stated Foley catheter tubing should be clear and straight and not kinked to allow urine to flow downward freely from the bladder and prevent back up of urine and cause UTI to the resident. During a review of the facility's P&P titled, Catheter Care, Urinary, revised September 2014, the P&P indicated, Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to provide necessary care and services for gastrostomy tube (GT, a tube inserted through the abdomen that delivers nutrition directly to the stomach) site as ordered by the physician and as indicated in the plan of care for three of four sampled residents (Residents 1, 26 and 36). These failures had the potential for complications related to tube feedings for Residents 1, 26 and 36. Findings: a. During a review of Resident 1's Admission Records (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included gastrostomy (a surgical opening fitted with a device to allow feedings/medication to be administered directly to the stomach), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness on one side of the body). During a review of Resident 1's untitled Care Plan (CP), dated 8/1/2022, the CP indicated Resident 1 had the potential for skin breakdown related to new G-tube stoma (the opening in the skin where the gastrostomy tube or G-tube is inserted into the stomach). The CP interventions included to provide G-tube stoma treatment as ordered, to cleanse the site with normal saline (NS), pat dry and apply a t-drain sponge (a pre-cut sponge that fits snugly around catheters, tubes and designed to keep moisture away from the site). During a review of Resident 1's Order Summary Report (OSR) dated 7/5/2023, the OSR indicated Resident 1 had an order for licensed staff to clean the gastrostomy site with NS, pat dry, and cover with T-drain dressing daily. During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 10/22/2024, the MDS indicated Resident 1 had severely impaired cognition (ability to understand) and dependent (helper did all of the effort, resident did none of the effort to complete the activity) with eating, oral and toileting hygiene, shower, upper and lower body dressing and personal hygiene. The MDS indicated Resident 1 was on feeding tube for nutrition. During a concurrent observation and interview on 11/19/2024 at 10:02 am with Licensed Vocational Nurse 2 (LVN 2) inside Resident 1's room, Resident 1 was sitting in a reclining chair. Resident 1's skin around the G-tube stoma was red and the site was not covered. LVN 2 stated the G-tube stoma should be covered with a T-drain sponge dressing as ordered by the physician to minimize skin breakdown and prevent infection around the G-tube site. During an interview on 11/20/2024 at 10:39 am with the Treatment Nurse (TN), TN stated Resident 1's GT site and stoma would be cleansed with NS, pat dry, covered with T-drain sponge dressing and secured with a tape to prevent pulling and tugging. The TN stated GT site should be covered to absorb leaks or drainage around the GT site to prevent infection. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/21/2024 at 11:35 am with the Director of Nursing (DON), the DON stated, Resident 1's GT site/stoma needed to be covered with a T-drain sponge dressing to absorb drainage and prevent infection around the site. During a review of the facility's Policy and Procedure (P&P) titled, Gastrostomy/jejunostomy Site Care, revised 10/2022, the P&P indicated, Verify that there is a physician's order for this procedure. Review the resident's care plan to assess for any special needs of the resident. Assemble the equipment and supplies as needed. b. During a review of Resident 36's AR, the AR indicated Resident 36 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing), gastrostomy, and dementia (a progressive state of decline in mental abilities). During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36 had severely impaired cognition and dependent with eating, oral and toileting hygiene, shower, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 1 was on feeding tube for nutrition, During a concurrent observation and interview on 11/19/2024 at 10:12 am with LVN 2 inside Resident 36's room, Resident 36 was not in the room. Resident 36's GT tubing was hanging on the pole with the tubing end exposed and not covered. LVN 2 stated the GT tubing end should have a cap when not in use and not left exposed to prevent tubing contamination and cause infection to the resident. During an interview on 11/21/2024 at 11:35 am with the Director of Nursing (DON), the DON stated, all tubing/catheter ends needed to be capped when not in use or disconnected from the resident to prevent entry of bacteria on the port and cause infection to the resident. During a review of the facility's P&P titled, Enteral Feedings-Safety Precautions, revised 11/2024, the P&P indicated, Cap the feeding tubing when disconnected from the G-tube. 40037 c. During a review of Resident 26's AR, the AR indicated Resident 26 was admitted to the facility on [DATE], with diagnoses that included gastrostomy and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 26's MDS dated [DATE], the MDS indicated Resident 26 had unclear speech, sometimes understood others, and sometimes made self-understood. Resident 26 was dependent (helper does all the effort) in toileting hygiene and chair/bed-chair transfer. During a review of Resident 26's OSR dated 11/1/2024, the OSR indicated, Every shift continuous water via GT Administer 40ml/hr. (milliliter/hour) for 20 hours using enteral pump for a total of 800ml in 24 hours. On at 12 pm, off at 8 am or until total volume is complete. During an observation on 11/19/2024 at 12:48 pm, in Resident 26's room, Resident 26 was sitting up in bed having lunch. The enteral pump was at the bedside with 100 ml's of water left inside the water bag. There was no infusion of water at this time. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/19/2024 at 2:41 pm, in Resident 26's room, Resident 26 was in bed sleeping. The enteral pump was not started with the water infusion. During a concurrent interview, Licensed Vocational Nurse 3 (LVN 3) stated, LVN 3 turned the GT feeding pump off at 8 am and did not start the infusion of water afterwards. LVN 3 stated, LVN 3 did was not aware that Resident 26 had a physician's order for a water infusion at 40ml/hr. for 20 hours which should start at 12 pm. LVN 3 stated, per the physician's order, LVN 3 should start the water infusion at 40ml/hr. at 12 pm. LVN 3 stated, LVN 3 did not follow the physician's order for Resident 26. LVN 3 stated, it was important to provide water to Resident 26 to keep the resident hydrated to avoid electrolytes imbalance. LVN 3 stated, the nurse should review the physician's order and carry it out. During an interview with the Director of Nursing (DON) on 11/19/2024 at 2:52 pm, the DON stated, nurses should follow the physician's order to provide water at 40ml/hr. via the enteral pump for 20 hours for 24 hours. The DON stated, this was to prevent Resident 26 from dehydration (body loses more fluid than intake) and for resident safety and quality of care. A review of the facility's Policy and Procedure (P&P) titled Enteral Nutrition revised 11/2018, the P&P indicated Adequate nutritional support through enteral nutrition is provided to residents as ordered. The decision to continue or discontinue the use of the feeding tube is made through collaboration between the interdisciplinary team, the provider, and the resident. The nurse conforms that orders for enteral nutrition are complete including: instructions for flushing [solution, volume, frequency, timing and 24-hour volume.])

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to label and date the intravenous (IV, administered into a vein) site consistent with professional standards of practice for one of one sampled resident (Resident 157). This deficient practice had the potential to result in infection to Resident 157. Findings: During a review of Resident 157's Admission Record (AR), the AR indicated Resident 157 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis (inflammation of bone and bone marrow due to infection) and left foot amputation (a surgical procedure that removes a limb or other body part). During a review of Resident 157's Order Summary Report (OSR), dated 11/13/2024, Resident 157 had an order of Ceftriaxone (Antibiotic-medication to treat infection) 2 grams (gm, a unit of measurement) IV, once a day for osteomyelitis to left foot amputation. During a review of Resident 157's Minimum Data Set (MDS, a resident assessment tool) dated 11/17/2024, the MDS indicated Resident 157 had intact cognition (ability to understand) and dependent (helper did all of the effort, resident did none of the effort to complete the activity) with toileting hygiene, shower, upper and body dressing. During an observation on 11/19/2024 at 10:29 am inside Resident 157's room, Resident 157 had an IV site on the resident's right forearm. The IV site was not labeled and dated when it was started. The IV tubing port was not capped nor covered. During an interview on 11/20/2024 at 11:50 am with Registered Nurse Supervisor (RNS), RNS stated, the IV access should be labeled and dated when it was started and initialed with the nurse who started the IV to determine when the IV was started and when to change. RNS stated IV tubing port should be capped and covered to prevent infection. During an interview on 11/21/2024 at 11:24 pm with the Director of Nursing (DON), the DON stated IV access could be used for seven days. The DON stated IV access should be dated with date of insertion and initialed with the nurse who started it to identify when the IV access should be changed or needed to rotate the insertion site. The DON further stated, the IV tubing port should be covered with a cap for infection control purposes. During a review of the facility's Policy and Procedure (P&P) titled, Peripheral IV Catheter Insertion, revised April 2016, the P&P indicated, label on dressing should include date and time of dressing placement, initials, gauge, size, and length of catheter. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Administration Set/Tubing Changes, revised 11/2023, the P&P indicated, Devices that were added to tubing such as extension sets, filters, stopcocks, end caps, or any other devices should be changed when tubing is changed. All equipment should be of needless design. Primary tubing should have a sterile end cap applied to end of tubing when it is disconnected from the catheter. The sterile end cap is discarded when tubing is to be reconnected to the catheter.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview and record review, the facility staff failed to label the nasal cannula (NC-tube which on one end splits into two prongs which are placed in the nostrils to deliver oxygen) tubing for one of two sampled residents (Resident 41). This failure had the potential to result in infection to Resident 41. Findings: During a review of Resident 41's Admission Record (AR), the AR indicated Resident 41 was readmitted to the facility on [DATE] with diagnoses that included dependence on supplemental oxygen and dysphagia (difficulty swallowing). During a review of Resident 41's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/31/2024, the MDS indicated Resident 41 had no speech, rarely/never understood others, and rarely/never made self-understood. Resident 41 was dependent (helper does all of the effort) for personal hygiene and chair/bed-chair transfer. During a review of Resident 41's Order Summary Report (OSR) dated 11/1/2024, the OSR indicated Resident 41 was ordered oxygen at two liters per minute via NC continuously for shortness of breath, every shift. During an observation on 11/19/2024 at 9:43 am, Resident 41 was lying in a recliner chair in the Activity Room with eyes opened. Resident 41 had ongoing oxygen via NC running at two liters per minute. During a concurrent interview with the facility's Infection Prevention Nurse (IPN), the IPN stated Resident 41's NC should be labeled with a date when the NC was applied to the resident. The IPN stated the NC should be changed weekly for infection control purposes. The IPN stated, without labeling the NC, staff would not know when the NC was applied and when it was due to be changed.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to attempt the use of appropriate alternatives to siderails before its installation for two of two sampled residents (Residents 9 and 39). These failures placed Residents 9 and 39 at risk for entrapment and injury from the use of siderails. Findings: a. During a review of Resident 39's Admission Records (AR), the AR indicated Resident 39 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included depression (loss of pleasure or interest in activities for long periods of time) and compression fracture (occurs when one or more bones in the spine weaken and crumple) of first lumbar vertebrae. During a review of Resident 39's Minimum Data Set (MDS, a resident assessment tool) dated 9/30/2024, the MDS indicated Resident 39 had intact cognition (ability to understand) and required partial/moderate assistance (helper did less than half the effort) with oral hygiene, upper body dressing and personal hygiene. Resident 39 required maximum assistance (helper did more than half the effort) with toileting, shower, and lower body dressing. During a review of Resident 39's Order Summary Report (OSR) dated 9/14/2024, the OSR indicated Resident 39 had an order for bilateral 1/4 side rails for bed mobility. During a concurrent observation and interview on 11/19/2024 at 10:18 am with Licensed Vocational Nurse 2 (LVN 2) inside Resident 39's room, Resident 39 was in bed, lying on his back with 1/4 siderails up on both sides of the bed. LVN 2 stated Resident 39 was alert and oriented. During a concurrent interview and record review on 11/20/2024 at 12:32 pm with Registered Nurse Supervisor (RNS), Resident 39's medical records (chart) and PointClickCare (PCC, a cloud-based software) were reviewed. The RNS stated there were no documented evidence that appropriate alternatives were attempted and did not meet the needs of Resident 39 before the siderails were installed. RNS stated other options appropriate for mobility for Resident 39 included the use of trapeze. RNS stated the facility should have tried other least restrictive appropriate options before the installation of siderails to prevent the risk of entrapment and injury to Resident 39. b. During a review of Resident 9's AR, the AR indicated Resident 9 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance in the blood), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness on one side of the body). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 9's MDS dated [DATE], the MDS indicated Resident 9 had severely impaired cognition and dependent (helper did all of the effort, resident did none of the effort to complete the activity) with oral and toileting hygiene, shower, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 9 had an indwelling catheter (thin, sterile tube inserted into the bladder to drain urine into a bag outside the body). During a review of Resident 9's OSR dated 6/12/2024, the OSR indicated Resident 9 had an order for bilateral 1/4 siderails for bed mobility. During a concurrent observation and interview on 11/19/2024 at 10:25 am with LVN 2 inside Resident 9's room, Resident 9 was in bed, lying on his back with 1/4 siderails up on both sides of the bed. LVN 2 stated Resident 9 was confused. During a concurrent interview and record review on 11/20/2024 at 12:32 pm with RNS, Resident 9's medical records and PCC were reviewed. RNS stated, there were no documented evidence that appropriate alternatives were attempted and did not meet the needs of Resident 9 before the siderails were installed. RNS stated Resident 9 had contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of upper extremities and not able to use the siderails for turning and repositioning. RNS stated the facility should have tried other least restrictive appropriate options before the installation of siderails to prevent risk of entrapment and injury to Resident 9. During an interview on 11/21/2024 at 11:28 am with the facility's Director of Nursing (DON), the DON stated least restrictive alternatives should have been attempted and did not meet the resident's needs prior to installation and use of side rails for the safety of Residents 9 and 39. During a review of the facility's Policy and Procedure (P&P) titled, Bed Safety and Bed Rails, revised August 2022, the P&P indicated, The use of bed rails or side rails (including temporary raising the side rails for episodic use during care) is prohibited unless the criteria for use have been meet, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 40438 Based on interview and record review, the facility failed to include the census information on the daily shift staffing posting for three of three recertifications days inspected (11/19/2024, 11/20/2024, and 11/21/2024). This deficient practice of posting incomplete daily shift staffing information could mislead the residents and visitors and potentially affect the quality of nursing care provided to the residents. Findings: During a review of the facility's daily shift staffing posting dated 11/19/2024, 11/20/2024, and 11/21/2024, the daily shift staffing posting information included the name of the facility, the date for which the information was posted, type and category of nursing staff working during the shift, the projected and actual hours worked during the shift for each category and the nursing staff. During an interview on 11/21/2024 at 11:02 am with the Lobby Receptionist (LR), LR stated she was responsible for completing and posting the daily shift staffing. LR stated the daily shift staffing posting should include the census information at the beginning of the shift to ensure the facility had enough staff to care for the number of residents, every shift. LR stated the daily shift staffing information was posted for the staff and residents to be aware of the number of employees working every shift. During an interview on 11/21/2024 at 12:17 pm with the facility's Director of Nursing (DON), the DON stated, the daily shift staffing posting should include the census information to determine if there was enough staff working to care for the residents, on every shift. During a review of the facility's Policy and Procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers, revised July 2016, the P&P indicated, Shift staffing information shall be recorded on the Nursing Staff Directly Responsible for Residents Care form for each shift. The information recorded on the form shall include the name of the facility, the date for which the information is posted, the resident census at the beginning of the shift for which the information is posted, twenty-four (24) hour shift schedule operated by the facility, the shift for which the information is posted, type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift, the actual time worked during that shift for each category and type of nursing staff and total number of licensed and non-licensed nursing staff working for the posted shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555055	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baldwin Gardens Nursing Center	10786 Live Oak Avenue Temple City, CA 91780

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to follow up on the pharmacist's medication regimen review (MRR, a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication.) recommendations of the physician evaluating the use of Cyclobenzaprine (muscle relaxant medicine) in the elderly for one of five sampled residents (Resident 10). This deficient practice had the potential to result in the resident receiving unnecessary medications and not maintaining the resident's highest practicable level of physical, mental, and psychosocial well-being and not preventing or minimizing adverse consequences related to medication therapy to the extent possible. Findings: During a review of Resident 10's Admission Record, the Admission Record indicated Resident 10 was admitted on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 10's quarterly Minimum Data Set (MDS, a resident assessment tool) dated 11/15/2024, indicated Resident 10 had clear speech, sometimes understood others, and sometimes made self-understood. Resident 10 was dependent (helper does all of the effort) in toileting hygiene and chair/bed-chair transfer. During a review of the facility's MRR for recommendations between 9/1/2024 and 9/24/2024, for Resident 10, the MRR indicated, This patient currently has order for Cyclobenzaprine/Flexeril PRN (as needed) as a muscle relaxant. Unfortunately, Flexeril has been characterized by OBRA (Omnibus Budget Reconciliation Act, AKA Nursing Home reform act of 1987) as an 'Inappropriate drug therapy' in the elderly due to this anticholinergic/sedative side effects and being poorly tolerated by the geriatric population. Although the medication maybe beneficial and no side effects warranted, your evaluation is necessary in order to keep the facility in compliance. During an interview on 11/20/2024 at 1:28 pm, the Director of Nursing (DON) stated, the DON was in charge of reviewing and acting upon the facility's monthly MRR report from the pharmacist. The DON stated, the MRR for Resident 10 's Cyclobenzaprine use should be followed up by sending the recommendation to the prescribing physician for evaluation as indicated by the MRR. The DON stated, there was no documentation in Resident 10's medical record that indicated this MRR recommendation had been addressed. The DON stated it was missed. The DON stated, the pharmacist's monthly MRR should be acted upon within 3 to 5 days after receiving the report and sent to the physician as needed. The DON stated, if nursing staff do not receive a response from the physician within 24 hours, the nursing staff should do a follow up call. The DON stated these measures were to prevent unnecessary medication to be given to residents for their health, safety, and quality of life. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555055	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baldwin Gardens Nursing Center	10786 Live Oak Avenue Temple City, CA 91780

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy and Procedure (P&P) titled Medication Regimen Reviews, revised 5/2019, the P&P indicated The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medications. The medication regimen and associated treatment goals involve collaboration with the resident or representative, family members, and the interdisciplinary team (IDT). As such, the MRR includes a review of the resident's stated preferences, the comprehensive care plans and information provided about the risks and benefits of the medication regimen. If the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, he/she contacts the medical director or the administrator. The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555055	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baldwin Gardens Nursing Center	10786 Live Oak Avenue Temple City, CA 91780

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, the facility failed to offer pneumococcal vaccine that protects against serious and potentially fatal pneumococcal disease that is caused by bacteria called Streptococcus pneumoniae (pneumococcus)] based on the Centers of Disease Control and Prevention (CDC)'s recommended schedule guidelines for one of five sampled residents (Resident 10). This failure had the potential to result in leaving residents at risk of acquiring, transmitting, or experiencing complications from pneumococcal disease. Findings: During a review of Resident 10's Admission Record, the Admission Record indicated Resident 10 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 10's quarterly Minimum Data Set (MDS, a resident assessment tool) dated 11/15/2024, the MDS indicated Resident 10 had clear speech, sometimes understood others, and sometimes made self-understood. Resident 10 was dependent (helper does all of the effort) for toileting hygiene and chair/bed-chair transfer. During a review of the facility's line list for required vaccines for residents, the line list indicated, Resident 10 received PPSV23 pneumococcal vaccine on 5/9/2014 and Prevnar13 pneumococcal vaccine on 2/16/2019. During a review of the current CDC's Pneumococcal Vaccine Timing for Adults (PVTA, pneumococcal vaccine schedule guideline/recommendation), the PVTA indicated, adults might choose to receive PCV20 pneumococcal vaccine if they received their PCV13 at any age and PPSV23 after [AGE] years old, for more than five years. During an interview on 11/20/2024 at 10:53 am, the Infection Prevention Nurse (IPN) stated, the IPN stated Resident 10 was due for a PCV 20 pneumococcal vaccine in 2/2024, which was more than five years after the last Prevnar13 pneumococcal vaccine in 2/2019 per CDC recommended guideline for pneumococcal vaccine. The IPN stated, the IPN had missed to inform Resident 10 or Resident 10's responsible party that Resident 10's pneumococcal vaccine was not up to date, and Resident 10 might have the option to receive another dose. The IPN stated, it was important to provide residents up to date pneumococcal vaccine to prevent them from pneumonia (lung infection) which could lead to hospitalization . During a review of the facility's Policy and Procedure (P&P) titled Pneumococcal Vaccine, revised 3/2023, the P&P indicated All residents will be offered pneumococcal vaccine to aid in preventing pneumonia/pneumococcal infections. Pneumococcal vaccine will be administered to residents (unless medically contraindicated, history unknown, or refused) per our facility's physician-approved pneumococcal vaccination protocol. Administration of the pneumococcal vaccines or revaccinations will be made in accordance with current CDC recommendations at the time of the vaccination.