

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555081	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/10/2024
NAME OF PROVIDER OR SUPPLIER Del Mar Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 North Del Mar Avenue Rosemead, CA 91770	
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 - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview, and record review, the facility failed to accommodate the needs two of three sampled residents (Resident 21 and Resident 23) by ensuring the residents ' call lights (a device used to alert staff to the resident ' s room) were placed within the resident ' s reach, in accordance with the facility ' s policy and procedure [P&P] titled Call Lights: Accessibility and Timely Response. This deficient practice had the potential for the residents not to receive care and services that could result in accidents and falls. Findings: 1. During a review of Resident 21 ' s Admission Record, the Admission Record indicated the resident was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (total or partial paralysis of one side of the body), hemiparesis (weakness or an inability to move on one side of the body), and paralytic syndrome (a condition that causes weakness, muscle wasting, and loss of reflexes in the body) During a review of Resident 21 ' s History and Physical (H&P), dated 3/15/2024, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 21 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/16/2024, the MDS indicated the resident has severely impaired cognition (ability to reason and thought process). The MDS indicated the resident was dependent (helper does all of the effort) for activities such as toileting and lower body dressing. The MDS also indicated the resident required substantial assistance (helper does more than half the effort; helper lifts or holds trunk or limbs and provides more than half the effort.) for bed mobility such as rolling left and right, sitting, and transferring from bed to chair. During a review of Resident 21 ' s care plan for falls, initiated on 3/14/2024, the care plan indicated Resident 21 was at risk for falls. The care plan included interventions for staff to ensure the resident ' s call light is within reach and encourage the resident to use if for assistance as needed. The resident needs prompt response to all requests for assistance. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555081	Facility ID: 555081 If continuation sheet Page 1 of 16

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 21 ' s care plan for Impaired communication Function, initiated on 3/14/2024, the care plan indicated Resident 21 has impaired communication due to having impaired cognition. The care plan interventions included to provide a safe environment such as ensuring the call light [is] in reach. During a concurrent observation and interview on 11/08/2024 at 5:58 PM with Certified Nursing Assistant (CNA) 1, Resident 21 ' s call light was observed hanging on the left side of the resident ' s bed and not within Resident 21 ' s reach. CNA 1 stated Resident 21 ' s call light is not within the resident ' s reach because it was hanging on the left side of the bed. CNA 1 stated the call light must be within reach of the resident. During an interview on 11/10/2024 at 12:07 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated call lights are used by residents to call for help. LVN 1 stated residents would not be able to call for help if they cannot reach the call light. During an interview on 11/10/2024 at 2:07 PM with the Director of Nursing (DON), the DON stated staff must ensure call lights are within resident ' s reach. The DON stated the facility ' s fall prevention interventions include making sure residents are taught to use their call lights and that the residents ' call lights are within their reach. The DON stated residents could fall if they get up without asking for help using their call light. A review of the facility ' s policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response, revised 12/19/2022, indicated staff will ensure the call light is within reach of resident and secured, as needed. The P&P also indicated the call system will be accessible to residents while in their bed. 2. During a review of Resident 23 ' s Admission Record indicated the resident was admitted on [DATE] with diagnoses that included traumatic subdural hemorrhage (a type of bleeding near the brain that can happen after head injury) without loss of consciousness, dysphagia (difficulty swallowing), and hemiplegia (total or partial paralysis of one side of the body), hemiparesis (weakness or an inability to move on one side of the body) During a review of Resident 23 ' s History and Physical (H&P), dated 8/13/2024, indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 23 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/5/2024, indicated the resident had moderately impaired cognitive skills for decision making. During a review of Resident 23 ' s care plan for falls, initiated on 7/31/2024, indicated Resident 23 was at risk for falls. The care plan included interventions for staff to place the resident ' s call light within reach and encourage the resident to use it for assistance as needed. The care plan indicated the resident needed prompt response to all requests for assistance. During an observation in Resident 23 ' s room on 11/9/2024 at 10:50 AM, Resident 23 was observed sitting in his wheelchair next to the window. Resident 23 ' s call light was observed on resident ' s bed, more than 3 feet away from Resident 23. Resident 23 was unable to reach the call light. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview in Resident 23 ' s room on 11/9/2024 at 11 AM, Certified Nursing Assistant (CNA) 2 stated she placed Resident 23 by the window. CNA 2 stated Resident 23 ' s could not reach the call light. CNA 2 stated it was important for Resident 23 ' s call light to be within reach so residents could call for help if they needed anything. CNA 2 placing the call light within reach was for resident safety. During an interview with the Director of Nursing (DON) on 11/10/2024 at 4:25 PM, the DON stated the importance of placing call lights within resident ' s reach was for residents to call for assistance when residents required help. The DON stated in cases such as resident discomfort or change in condition, the call light should be easily accessible for residents to call for assistance. 48854		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42854 Based on interview and record review, the facility failed to ensure: 1. Resident 37 ' s Physician Orders for Life Sustaining Treatment (POLST) and Advance Directive Acknowledgment Form reflected Resident 37 ' s Advance Directive. 2. Resident 30 ' s POLST reflected Resident 30 ' s Advance Directive wishes and failed to provide Resident 30 with an Advance Directive Acknowledgment form. This deficient practice had the potential to result in misinformation of medical care and treatment and not honoring resident ' s wishes in cases where the resident and/or responsible party was unable to participate in making healthcare decisions. Findings: 1. During a review of Resident 37 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated a readmission to the facility on [DATE] with diagnoses that included of spinal stenosis (spaces inside the bones of the spine get too small), encounter of orthopedic (branch of surgery concerned with conditions involving the musculoskeletal system) and surgical aftercare, and Parkinson ' s Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and a slow, imprecise movements). During a review of Resident 37 ' s History and Physical [H&P] dated 9/9/2024, the H&P indicated the resident was not able to make his own decisions. During a review of Resident 37 ' s POLST dated 5/28/2024, the POLST indicated the resident had an Advance Directive dated 12/29/2023. During a review of Resident 37 ' s Advance Directive Acknowledgement form dated 9/10/2024, the form indicated Resident 37 did not have an Advance Directive. During a review of Resident 37 ' s medical chart on 11/9/2024 at 12:31 PM, an Advance Directive dated 12/29/2023 was found. During a concurrent interview and record review of Resident 37 ' s medical chart with the Social Services Assistant (SSA) on 11/9/2024 at 12:44 PM, the SSA stated he assists with resident admissions with the Admission Coordinator and licensed nurses. The SSA stated he translates and explains the forms in the presence of the Admission Coordinator and licensed nurses. The SSA confirmed Resident 37 ' s POLST and Advance Directive Acknowledgment form did not match. The SSA stated it was important to make sure all the dates and documents reflected Resident 37 ' s wishes in the case of an emergency the staff would know what to do. The SSA stated because the acknowledgment form dated 9/10/2024 indicated there was no Advance Directive and Resident 37 had an Advance Directive on file, the facility should clarify with the family what they want and update the chart. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 37 ' s medical chart with the Director of Nursing (DON) on 11/10/2024 at 8:20 PM, the DON confirmed Resident 37 ' s POLST dated 5/28/2024 and Advance Directive Acknowledgment form dated 9/10/2024 did not reflect resident ' s Advance Directive. The DON stated medical information should match and a medical records audit will be done. The DON stated if there was any discrepancy, the facility would call the family to clarify the use of resident ' s Advance Directive. 2. During a review of Resident 30 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included traumatic subdural hemorrhage without loss of consciousness, hemiplegia and hemiparesis (a severe or complete loss of strength or paralysis on one side of the body) following a cerebral infraction (a condition that occurs when blood flow to the brain is blocked, causing brain tissue to die) affecting right dominant side, end stage renal disease (a chronic kidney disease that reached a point where the kidneys can no longer function on their own). During a review of Resident 30 ' s History and Physical Assessment [HPA] dated 10/31/2024, the HPA indicated Resident 30 has the capacity to understand and make medical decisions. During a review of Resident 30 ' s Minimum Data Set (a federally mandated resident assessment tool) dated 9/16/2024 indicated Resident 30 ' s cognition was moderately impaired During a review of Resident 30 ' s Physician Orders for life sustaining treatment (POLST), the POLST did not indicate if Resident 30 had an Advance directive. During an interview and concurrent record review on 11/09/2024 with the Social Services Assistant (SSA), the SSA stated there was no advance directives or evidence that indicated an Advance Directive acknowledgment form was offered to Resident 30 or the responsible party [RP]. The SSA stated advance directives is completed on admission as part of the resident ' s admission paperwork and it should be in the paper chart to indicate Resident 30 ' s wishes. The SSA stated it was important to get this information, so the facility know what the resident ' s or the RP ' s wishes are in case of an emergency. During a review of the facility ' s policy and procedure titled Resident Rights Regarding Treatment and Advanced Directives with a revision date of 12/19/2022, indicated It is the policy of this facility to support and facilitate a resident ' s right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. 1. On Admission the facility will determine if the resident has executed an advanced directive, and if not, determine whether the resident, if cognitively able to, would like to formulate an advanced directive. 42878		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview and record review for two of three sampled residents (Resident 24 and 54) the facility failed to ensure: 1. Ensure Resident 24 ' s family representative received a written notification of proposed transfer and/or discharge notification upon resident ' s transfer to the General Acute Care Hospital (GACH) in accordance with the facility ' s policy and procedure and have documented evidence Resident 30 ' s notice was sent to the Ombudsman 2. For Resident 54, the facility did not have documented evidence that notice of transfer was sent to the Ombudsman. This failure violated the resident ' s and resident representative ' s rights to make informed decisions and receive transfer/discharge information of their rights to appeal the transfer/discharge. Findings: 1.A review of Resident 24 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated the resident was originally admitted to the facility on [DATE] and then readmitted on [DATE], with diagnoses that included Chronic respiratory failure with hypoxia (a condition where you don ' t have enough oxygen in the tissue in your body), Alzheimer ' s disease unspecified (a brain disorder that slowly destroys the memory and thinking and other skills). During a review of Resident 24 ' s History and Physical [H&P] dated 8/28/2024, indicated Resident 24 does not have the capacity to understand and make medical decisions. During a review of Resident 24 ' s Notice of Proposed Transfer/discharge date d 8/12/2024, the Notice indicated Resident 24 ' s Responsible Party (RP1) was notified of Resident 24 ' s transfer to the acute hospital on 8/12/2024.The Notice of Proposed Transfer/Discharge indicated the transfer/discharge was necessary for the welfare and the needs cannot be met in the facility. The Notice indicated the resident ' s and the resident representative ' s rights to appeal the transfer/discharge if they believed transfer/discharge was inappropriate/involuntary. The Notice indicated the addresses and contact numbers of the Departments to file the appeal, including the timeframes and deadlines in filing the appeal. During the review of the Notice of Proposed Transfer/Discharge, the Notice had two signature lines: one line was for resident/representative that was observed blank, the other line was for the facility representative had a signature observed dated 8/12/2024. During a review of Resident 24 ' s telephone order dated 8/12/2024 timed at 6:20 P.M., the order indicated may transfer resident via paramedics to the acute hospital. For further evaluation related to respiratory distress, oxygen desaturation. (continued on next page)		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 24 ' s transfer form dated 8/12/2024 at 6:30 P.M., the form indicated At 6:05 PM, Resident 24 was heard wheezing with congestion, suction with received dark brown fluid, VS temperature 97. 2, Blood pressure 126/58, Heart Rate 93, Respirations 26, Oxygen saturation 80% on 2 Liters per min via nasal canula (a device that provides supplemental oxygen to a patient through their nose), titrated oxygen to 15 Liters per minute via mask still wheezing and congested. Spoke to Resident Representative regarding condition and Physician said Resident request no resuscitation but wants emergency treatment if necessary to save life. Doctor aware with orders carried out. Paramedics arrived at 6:20 PM and transferred Resident 24 to acute hospital. Physician and Responsible party made aware. During a concurrent interview and record review of Resident 24 ' s Notice of Proposed Transfer/Discharge form with the Director of Nursing (DON) on 11/10/2024 at 7:15 PM, the DON stated she could not find any documented evidence that Resident 24 ' s Notice of Proposed Transfer/Discharge form was sent to the Ombudsman or to the Resident Representative. The DON stated the Notice should be signed by the Resident ' s Representative or indicate on the Notice that the resident representative was notified. The DON stated it is important for the facility staff to notify and provide in writing the 24 ' s Notice of Proposed Transfer/Discharge form to the residents and their representatives so that they may be informed of their rights when a resident gets transferred. 2. During a review of Resident 54 ' s Face Sheet (FS- front page of the chart that contains a summary of basic information about the resident), the FS indicated a readmission to the facility on [DATE] with diagnoses that included of intrahepatic bile duct (tiny canals that connect some of the organs in the digestive system) carcinoma (cancer that forms in the bile ducts), obstruction of bile duct, and other retroperitoneal (space behind the peritoneum [membrane that lines the inside of the abdomen and pelvis] abscess (pocket of pus). During a review of Resident 54 ' s History and Physical [H&P] dated 10/2/2024, the H&P indicated the resident had the capacity to understand and make her own decisions. During a review of Resident 54 ' s Minimum Data Set (MDS, a federally mandated resident assessment) dated 11/3/2024, the MDS indicated resident had moderately impaired cognition. During a concurrent interview and record review of Resident 54 ' s Notice of Proposed Transfer/Discharge form with the Director of Nursing (DON) on 11/10/2024 at 7 PM, the DON stated this was the form that was sent to the Ombudsman and should be signed by the Resident ' s representative. The DON stated Resident 54 ' s family member was notified of the resident ' s transfer and would sign the form when resident returns to the facility. During an interview with the DON on 11/10/2024 at 7:14 PM, the DON stated there was no fax confirmation for receipt of Resident 54 ' s Notice of Proposed Transfer/Discharge form. The DON stated she was not sure if the notice was sent to the Ombudsman. The DON stated Resident 54 was transferred out of the facility on 11/6/2024 and there was still time to send notice to the Ombudsman. (continued on next page)		

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled Transfer and Discharge, dated 12/19/2022, indicated generally, the notice must be provided at least 30 days prior to a facility-initiated transfer or discharge of the resident. The P&P indicated exceptions to the 30-day requirement apply when the transfer or discharge is effected because: (a) the health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident; (b) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (c) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (d) a resident has not resided in the facility for 30 days. The P&P indicated in these exceptional cases, the notice must be provided to the resident, resident ' s representative if appropriate, and long term care (LTC) ombudsman as soon as practicable before the transfer or discharge. The P&P also indicated the facility will maintain evidence that the notice was sent to the Ombudsman. 42878		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42878 Based on observation, interview and record review, the facility failed to ensure residents assessed at risk for falls received care and services, in accordance with their individualized level of risk to minimize the likelihood of falls, as indicated with the facility ' s policy and procedure [P&P] titled Fall prevention program for two of three sampled residents (Resident 6 and 30) by failing to: 1. Ensure the facility staff place the motion alarm on the bed when transferring Resident 6 from the wheelchair to the bed as indicated in Resident 6 ' s care plan for Falls. 2. Ensure to monitor the function and placement of Resident 30 ' s motion alarm when in bed and wheelchair. On 11/08/2024, Resident 30 ' s motion alarm was observed disconnected while in bed. These failures had the potential to result in multiple falls with injuries for both Resident 6 and 30 who were assessed as high risk for falls. Findings: 1. During a review of Resident 6 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the resident was admitted to the facility on [DATE], with diagnoses that included Type 2 Diabetes Mellitus (Type 2 diabetes is a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), Alzheimer ' s disease unspecified (a brain disorder that slowly destroys the memory and thinking and other skills). During a review of Resident 6 ' s History and Physical Assessment [HPA] dated 2/24/2024, the HPA indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Resident 6 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/20/2024, the MDS indicated Resident 6 ' s cognition was severely impaired. The MDS further indicated Resident 6 requires supervision (helper provides verbal cues) with eating, oral hygiene. The MDS indicated Resident 6 required partial (helper does less than half the effort) with toileting, shower and lower body dressing. During a review of Resident 6 ' s Order Summary Report indicated an order to monitor motion alarm function and placement every shift with a start date of 7/11/2024. During a review of Resident 6 ' s Order Summary Report, the Report indicated an order to have Motion alarm when in bed or wheelchair to alert resident not to get out of bed or wheelchair unassisted and to remind resident to wait for assistance with a start date of 7/11/2024. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 6 ' s care plan for falls, initiated on 2/24/2024, the care plan indicated Resident 6 risk for falls related to impaired physical/cognitive functions. The care plan goals indicated Resident 6 would be free from falls through the review date. The care plan interventions included: Monitor motion alarm function and placement every shift, motion alarm when in bed or wheelchair to alert resident not to get out of bed or wheel unassisted and to remind the resident to wait for assistance with initiation date of 7/11/2024. During an observation on 11/08/2024 at 5:31 PM in Resident 6 ' s bedroom, Resident 6 was observed being wheeled into his room by the facility receptionist with a portable motion alarm attached to the Resident 6 ' s wheelchair. The facility receptionist was observed assisting Resident 6 back to his bed, then placed the wheelchair across Resident 6 ' s bed before leaving the room. During the observation, the portable motion alarm was still attached to the wheelchair while Resident 6 was in bed. During a concurrent observation and interview on 11/08/2024 at 5:35 PM with LVN 2, LVN 2 stated Resident 6 was assessed at high fall risk due to the resident ' s lack of safety awareness. LVN 2 stated Resident 6 had a habit of getting up unassisted that was the reason he needed to have a motion alarm when in bed to remind the resident to call for help and alert facility staff. LVN 2 stated facility staff should always transfer Resident 6 ' s portable motion alarm from his wheelchair to his bed when Resident 6 returns to bed. LVN 2 stated the facility receptionist should not have left Resident 6 ' s motion alarm on the wheelchair, after assisting the resident back to bed. LVN 2 stated that the facility receptionist should have notified a nurse before leaving the Resident 6 ' s bedside. 2. During a review of Resident 30 ' s Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE], and recently readmitted on [DATE], with diagnoses that included traumatic subdural hemorrhage without loss of consciousness, hemiplegia and hemiparesis (a severe or complete loss of strength or paralysis on one side of the body) following a cerebral infraction (a condition that occurs when blood flow to the brain is blocked, causing brain tissue to die) affecting right dominant side, end stage renal disease (a chronic kidney disease that reached a point where the kidneys can no longer function on their own). During a review of Resident 30 ' s HPA dated 10/31/2024, the HPA indicated Resident 30 had the capacity to understand and make decisions. During a review of Resident 30 ' s MDS dated [DATE], the MDS indicated Resident 30 ' s cognition was moderately impaired. The MDS indicated Resident 30 required partial/moderate assistance (helper does less than half the effort) with eating, oral hygiene. The MDS indicated Resident 30 was dependent (helper does all of the effort) with toileting, shower and lower body dressing. During a review of Resident 30 ' s Order Summary Report, the Report indicated an order to monitor motion alarm function and placement every shift with a start date of 10/30/2024. During a review of Resident 30 ' s Order Summary Report, the Report indicated an order to have Motion alarm when in bed or wheelchair to alert resident not to get out of bed or wheelchair unassisted and to remind resident to wait for assistance with a start date of 10/30/2024. During a review of Resident 30 ' s initial Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated Resident 30 ' s fall risk score was 10 which indicated Resident 30 was at Risk for falls. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555081	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/10/2024
NAME OF PROVIDER OR SUPPLIER Del Mar Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 3136 North Del Mar Avenue Rosemead, CA 91770	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 30 ' s initial Fall risk assessment dated [DATE], indicated Resident 30 ' s fall risk score was 18 which indicated Resident 30 was at high risk for falls. During a review of Resident 30 ' s care plan for falls, initiated on 7/11/2024, the care plan indicated Resident 30 risk for falls related to impaired physical/cognitive functions. The care plan interventions included: Monitor motion alarm function and placement every shift, motion alarm when in bed or wheelchair to alert resident not to get out of bed or wheel unassisted and to remind the resident to wait for assistance with initiation date of 8/06/2024. During an observation on 11/08/2024 at 5:25 PM, Resident 30 was observed laying in bed. Resident 30 ' s bedside alarm was observed hanging from Resident 30 ' s bedframe and a white cable was observed laying on the floor under the bed alarm. During a concurrent interview and observation on 11/08/2024 at 5:26 PM with Licensed Vocational Nurse (LVN 2), LVN 2 stated Resident 30 ' s motion alarm in bed was disconnected. LVN 2 was observed picking up the white cable and connected it to the bed alarm, once connected, a green flashing light was observed coming from Resident 30 ' s motion alarm. LVN 2 stated the flashing green light indicated Resident 30 ' s motion alarm in bed was on and working. LVN 2 stated she did not notice how long Resident 30 ' s motion alarm in bed had been disconnected but it should be connected and on at all times as Resident 30 is a high fall risk with a history of falling from his bed. During an interview on 11/10/2024 at 4:10 PM, with the Director of Nursing (DON), the DON stated it is important for Resident 6 and Resident 30 to have their bed alarms in place and on at all times to alert the resident and staff when the residents attempt to get up unassisted to prevent any falls or injuries to the residents. During a review of the facility ' s P & P titled, Fall prevention program with a revision date of 12/19/2023, the P&P indicated each resident would be assessed for fall risk and receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on observation, interview, and record review, the facility failed to ensure one of three residents (Resident 44) is free from significant medication errors when Resident' 44 ' s medication Droxidopa Oral Capsule (medication used to treat symptoms dizziness, lightheadedness or fainting sensation) route of administration did not match Physicians order on Resident 44 ' s Medication Administration Record (MAR) with route of administration (this means by which medication is introduced in the body such as orally, injection or topical application). This deficient practice had the potential to result in Resident 44 to receive medications through the wrong route. Findings: A review of Resident 44 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated the resident was admitted to the facility on [DATE], with diagnoses that included Parkinson ' s (a progressive brain disorder that causes nerve cells in the brain to deteriorate) disease without dyskinesia (a movement disorder tat causes involuntary, abnormal or repeated muscle movements), Dysphagia (difficulty swallowing) following unspecified cerebrovascular disease (a group od conditions that affect blood flow to the vessels in the brain). During a review of Resident 44 ' s History and Physical [H&P] dated 12/12/2023, indicated Resident 44 does not have the capacity to understand and make medical decisions. During a review of Resident 44 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/28/2024, the MDS indicated the resident was dependent (helper does all of the effort) for activities such as eating, oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene. During a review of Resident 44 ' s Order summary report dated October indicated an order for the resident to receive Droxidopa Oral Capsule (Droxidopa) 200 milligrams (a unit of measure) via G-tube(a gastrostomy tube surgically inserted into the stomach used to deliver nutritional fluids, medications) three times a day for Neurogenic orthostatic hypotension (a condition that causes a drop in blood pressure when standing up) with an order date of 5/06/2024. During a medication pass observation, on 11/10/2024, from 8:48 AM to 9:36 AM, Licensed Vocational Nurse (LVN) 3 was observed removing two capsule of Droxidopa Oral Capsule 100 mg opening the capsules and pouring powder medication from the capsule into a clear plastic medication cup and dissolving with water. LVN 3 was then observed proceeding to Resident 44 ' s bedside to administer medication. During a concurrent interview and record review on 11/10/2024 at 9:46 AM with LVN 3 of Resident 44 ' s Medication of Droxidopa Oral Capsule 200 mg verifying Resident 44 ' s medication bottle and Resident 44 ' s MAR. LVN 3 verified Resident 44 ' s instructions for Droxidopa Oral Capsule administration medication label on Resident 44 ' s medication bottle did not match the physician ' s order on the Resident 44 ' s MAR. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Director of Nursing (DON) on 11/10/2024 at 1:45 PM, DON stated the Resident 44 ' s Primary physician was notified of the indication and route of administration for Resident 44 ' s medication that was brought into facility by Resident 44 ' s family. DON stated Primary physician was unaware of the discrepancy and changed the order for the medication that was able to be administered via G-tube for Resident 44. DON stated pharmacy was notified of new order an order was placed and scheduled to be delivered that day. DON stated it was important to clarify orders and make sure the matches the physician orders route of administration so that the nurses won ' t have any mistakes when administering the medications. DON stated all nurses should always check medication bottles and Physicians orders to make sure they match before administering medications to prevent any complications when giving medications to residents. A review of the facility ' s policy revised on 12/29/2022 titled Medication administration, indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice.11. Compare medication source (bubble pack, vial etc.) with MAR to verify resident name, medication name. form, dose, route, and time.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854 Based on observation, interview and record review, the facility failed to follow their policy and procedures to prevent food contamination and the spread of foodborne illness for one of one kitchen in the facility, when multiple food items in the kitchen ' s refrigerator were not labeled with the date and time the food was opened or prepared. This deficient practice had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and can lead hospitalization . Findings: 1. During an observation on [DATE] at 4:13 PM in the facility ' s kitchen, the following food items inside the kitchen ' s refrigerator were observed unlabeled: 4 Cups of Fruit Mix 1 Bowl of Fruit Mix During a concurrent observation and interview on [DATE] at 4:16 PM in the facility ' s kitchen with Assistant Kitchen Manager (AK), the AK stated that prepared and opened food items must be labeled with the date the item was opened and when the item is set to expire. The AK stated he is unsure of when the food items were opened or prepared. During a follow up interview on [DATE] at 12:45 PM with the Dietary Supervisor (DS), the DS stated opened items must have a label that indicated the product name, opened date, and the expiration date. The DS stated not following the facility ' s policy could cause harm in residents because the unlabeled foods could be expired. A review of the facility ' s policy and procedure (P&P) titled, Date Marking for Food Safety, revised [DATE], indicated the individual opening or preparing a food shall be responsible for date marking the food at the time the food was opened or prepared. The P&P also indicated the marking system shall include the date of opening, and the date the item must be consumed or discarded.		

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F 0911 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview, and record review, the facility failed to ensure the resident bedrooms accommodate no more than four residents for seven (7) of eighteen (18) rooms (Rooms 16, 19, 20, 21, 22, 25, and 26) and did not have more than four residents in one shared room. This deficient practice had the potential to limit care and services, and the ability to move easily in the room for residents and staff. Findings: During the facility ' s Recertification Survey Entrance Conference, on 11/8/2024 at 5 PM, in the presence of the Administrator (ADM), the ADM stated the facility had rooms with variances and will continue to apply for the Room Waiver. During a review of the room waiver letter submitted by the ADM on 11/8/2024, the letter indicated Rooms 16, 19, 20, 21, 22, 25, and 26, had adequate space for nursing care and multiple beds per room would not adversely affect the health and safety of the residents. During a review of the Client Accommodation Analysis form submitted by the facility on 11/9/2024, the Client Accommodation Analysis form indicated the following rooms had more than four beds: room [ROOM NUMBER] with 5 beds, room [ROOM NUMBER] with 5 beds, room [ROOM NUMBER] with 5 beds, room [ROOM NUMBER] with 5 beds, room [ROOM NUMBER] with 5 beds, and room [ROOM NUMBER] with 5 beds. On 11/8/2024 to 11/10/2024, during the recertification survey, the following were observed: room [ROOM NUMBER] had 5 beds with 5 residents (0 unoccupied beds) room [ROOM NUMBER] had 5 beds with 5 residents (0 unoccupied beds) room [ROOM NUMBER] had 5 beds with 5 residents (0 unoccupied beds) room [ROOM NUMBER] had 5 beds with 5 residents (0 unoccupied beds) room [ROOM NUMBER] had 5 beds with 4 residents (1 unoccupied beds) room [ROOM NUMBER] had 5 beds with 5 residents (0 unoccupied beds) room [ROOM NUMBER] had 5 beds with 5 residents (0 unoccupied beds) During an interview on 11/8/2024 at 5:33 PM, Family Member (FM) 1 stated that room [ROOM NUMBER] had a total of 5 residents and there was enough space for staff to take care of Resident 42. (continued on next page)		

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F 0911 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/9/2024 at 11:08 AM, Resident 1 was observed being pushed in a wheelchair from room [ROOM NUMBER] ' s resident bathroom to his bed with no issues. During a review of the facility ' s policy and procedure (P&P) titled Resident Rooms, dated 12/19/2022 indicated resident bedrooms must be designed and equipped for adequate nursing care, comfort and privacy of residents. The P&P indicated resident bedrooms will not accommodate more than four residents.		