

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/17/2025
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: 1. Ensure that the physician's order for docusate sodium included the prescribed dosage and that nursing staff clarified the missing dosage prior to administration. As a result, Resident 17 received docusate sodium without a verified dosage from 12/10/2025 to 12/16/2025. This deficient practice had the potential to cause medication errors, including constipation if underdosed or diarrhea if overdosed. 2. Ensure the accuracy of the Antibiotic and Controlled Drug Record Count log for Resident 33, who was receiving Cephalexin (Keflex, an antibiotic used to treat bacterial infections in various parts of the body). 3. Ensure the Controlled Substances Shift Count log was completed and signed for 12/17/25. These deficient practices related to the facility's controlled drug records resulted in inaccurate shift count documentation and created a potential risk for medication diversio Findings: 1. During a review of Resident 17's admission Record (AR), the AR indicated that the facility originally admitted Resident 17 on 8/13/2025 and readmitted on [DATE] with diagnoses that included unspecified atrial fibrillation (A. FIB, abnormal heartbeat) and diabetes mellitus (a group of diseases that result in too much sugar in the blood). During a review of Resident 17's History and Physical Examination (H&P), dated 9/16/2025, the H&P indicated that Resident 17 did not have the capacity to understand and make decisions. During a review of Resident 17's Physician's Order, dated 12/9/2025, the order indicated that the physician ordered docusate sodium oral tablets, two tablets via gastrostomy tube, once daily for bowel management for Resident 17. The physician's order did not indicate the dosage of the tablets to be administered. During a review of Resident 17's Medication Administration Record (MAR), dated 12/2025, the MAR indicated that nurses administered docusate sodium oral tablets, two tablets via gastrostomy tube, once daily from 12/10/2025 to 12/16/2025. The MAR did not indicate the dosage of the tablets administered. During an observation of medication administration on 12/16/2025 at 8:33 AM, Licensed Vocational Nurse (LVN) 2 checked Resident 17's physician's order for docusate sodium and took out two tablets of docusate sodium from the facility's house supply bottle, which was labeled as 100 milligrams (mg) per tablet. LVN 2 crushed the two 100 mg tablets of docusate sodium. During an observation on 12/16/2025 at 8:54 AM, LVN 2 administered the two crushed tablets of (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	docusate sodium (100 mg per tablet) to Resident 17. During a concurrent interview and record review on 12/16/2025 at 10:02 AM with LVN 2, Resident 17's Physician's Order, dated 12/9/2025, and Resident 17's MAR, dated 12/2025, were reviewed. LVN 2 stated that the Physician's Order did not indicate the dosage for docusate sodium for Resident 17 and that there were two available dosages of docusate sodium in the facility's house supply: 100 mg per tablet and 250 mg per capsule. LVN 2 stated that because the Physician's Order indicated administration in tablet form, she had been administering two tablets of docusate sodium (100 mg per tablet) to Resident 17. LVN 2 stated she thought nurses did not need to write down the dosage for docusate sodium in the Physician's Order as long as the number of tablets was indicated. LVN 2 stated she was not sure why the dosage was not required and did not ask the DON about it. During a concurrent interview and record review on 12/16/2025 at 10:10 AM with the DON, Resident 17's Physician's Order, dated 12/9/2025, and Resident 17's MAR, dated 12/2025, were reviewed. The DON stated that the nurse did not clarify the dosage for Resident 17's docusate sodium upon receiving the physician's order. The DON stated that the nurse who administered docusate sodium to Resident 17 did not clarify the dosage before administration. The DON stated that the nurse should clarify the dosage of docusate sodium with the physician to prevent medication errors. The DON stated that the medication error had the potential to cause constipation for Resident 17 if underdosed or diarrhea if overdosed. During a review of the facility's P&P titled Medication Administration, dated 12/19/2022, the P&P indicated that nurses should compare the medication source with the MAR to verify resident name, medication name, form, dose, route, and time. 2. A review of Resident 33's admission Record (AR) indicated Resident 33 was admitted to the facility on [DATE] with diagnoses of encephalopathy (an alteration in consciousness caused due to brain dysfunction), traumatic subdural hemorrhage (a type of bleeding inside the head, blood collects beneath dura mater [outermost membrane surrounding the brain]) with loss consciousness, and Parkinson's Disease (movement disorder of the nervous system that worsens over time) with dyskinesia (involuntary uncontrolled muscle movements). A view of Resident 33's History and Physical Assessment (H&P) dated 10/30/2025, indicated Resident 3 had fluctuating capacity to understand and make decisions. A review of Resident 33's Minimum Data Set (MDS, a resident assessment tool), dated 3/19/2024, indicated, Resident 33 had moderately impaired cognition (mental process of acquiring knowledge and understanding through perception, attention, thought, and memory). A review of Resident 33's Order Summary Report, dated 12/8/2025 indicated a physician order for Keflex Oral Capsule (Cephalexin- antibiotic medication that inhibits the growth of or destroy microorganisms) give 500 milligram (mg, unit of measure) by mouth three times a day for abnormal urinalysis (test for urine that looks at appearance of urine, checks for blood cells, proteins, and other substances in the urine) for 10 days. During a review of Resident 33's Medication Administration Record (MAR) dated 12/2025 indicated Keflex Oral Capsule 500 mg was last given to Resident 33 on 12/17/2025 at 9 AM. During a concurrent observation of medication cart storage, interview and record review of Resident (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	33's Antibiotic or Controlled Drug Count log on 12/17/2025 at 10:48 AM, the Controlled Drug Record indicated the last dose of Keflex was administered on 12/17/2025 at 9 AM and signed by Licensed Vocational Nurse (LVN) 4. The Controlled Drug Record indicated a count of 4 remaining doses. Resident 33's Keflex Bubble pack was observed with 5 remaining doses. LVN 4 stated she would discuss with another nurse and indicate an error was made on the count log and then they would both sign the log. LVN 4 stated another nurse documented a dose was held on 12/15/2025 at 1 PM, which was why there was a discrepancy. LVN 4 stated the nurse should not have documented on the count log because signing the count log indicates medication was given. 3. During the same observation of medication cart storage, interview and record review of Medication Cart 1's Controlled Substances Shift Count log on 12/17/2025 at 10:55 AM, the log indicated shift count was not completed for 12/17/2025. The log instructions indicated licensed nurses coming on to shift must verify count of all controlled substances with the off-going shift or anytime medication cart keys are exchanged. The log instructions indicated licensed nurses must count the total number of cards/container and total number of count sheets. The log instructions indicated any discrepancies must be reported immediately to the Director of Nursing (DON) and Administrator (ADM). LVN 4 stated every shift change count is done between licensed nurses of the station. LVN 4 stated it was important for both nurses (off-going and oncoming) to sign the log to ensure the count is correct. LVN 4 stated she forgot to sign when she and the off-going nurse counted this morning. During an interview with the DON on 12/17/2025 at 2:35 PM, the DON stated LVN 4 verified with Resident 33's physician regarding the discrepancy of Keflex doses. The DON stated the count log for Keflex should not have been signed by the nurse if the medication was held. During the same interview with the DON, the DON stated controlled medications should be counted every shift and closely monitored. The DON stated the nurses should sign when they come and leave so that every medication was accounted for. The DON stated it should be done and signed when 2 nurses (off-going and oncoming) verify it is correct. A review of the facility's policy and procedure (P&P) titled Controlled Substance Administration & Accountability, dated 6/5/2023 indicated the facility would promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The P&P indicated the facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. The P&P indicated all controlled substances obtained from a non-automated medication cart or cabinet are record on the designated usage form, the written documentation must be clearly legible with all applicable information provided. The P&P indicated in all cases, the dose noted on the usage form or entered into the automated dispensing system must match the dose recorded on the Medication Administration Record (MAR), Controlled Drug Record, or other facility specified form and placed in the patient's medical record. The P&P indicated the Controlled Drug Record (or other specified form) serves the dual purpose of record both narcotic disposition and patient administration. The P&P indicated inventory verification for areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medication label for one of one resident (Resident 3) had an expiration/use by date. This deficient practice had the potential for Resident 3 to be administered expired medication. 1. During a review of Resident 3's admission Record (AR), the AR indicated an admission on [DATE] with hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (brain tissue death) affecting left non-dominant side, neoplasm (abnormal mass of tissue from uncontrolled cell growth) of unspecified behavior of brain, and hypertensive heart disease (problems with the heart that can develop if one has high blood pressure) with heart failure. ^ ^ During a review of Resident 3's History and Physical assessment dated [DATE], the H&P indicated Resident 3 did not have the capacity to understand and make decisions. ^ ^ During a review of Resident 3's Order Summary Report, the reported indicated a physician order dated [DATE], for Linzess Oral Capsule (Linaclotide, a prescription medication used to treat chronic constipation conditions such as irritable bowel syndrome with constipation [IBS-C, a chronic gut disorder causing abdominal pain, bloating, cramping, and hard, lumpy stools, where constipation is the main bowel issue]) give 145 micrograms (mcg, unit of measure) by mouth one time a day for chronic constipation, provided by family, give 30 minutes before first meal, may open capsule, do not crush or chew the contents. During a concurrent observation of medication cart storage 2 with Licensed Vocational Nurse (LVN) 3 on [DATE] at 10:33 AM, LVN 3 was observed verifying Resident 3's medication stored in the medication cart. LVN 3 stated she could not find the expiration/use by date on the medication label for Resident 3's Linzess medication. LVN 3 stated she would verify the order with the pharmacy and physician. LVN 3 stated the importance of checking medications for expiration/use by date was to make sure staff does not give resident expired medication. LVN 3 stated the medication would not be as effective if it was expired. During an interview with the Director of Nursing (DON) on [DATE] at 12:01 PM, the DON stated it was important to check medications expiration date prior to administering the medication to a resident because the medication could have less effectiveness or there might be side effects when a resident was administered an expired medication. A review of the facility's policy and procedure (P&P) titled Medication Administration dated [DATE] indicated the medications are administered by licensed nurses, or other staff who are legally authorized to do so in the this state as ordered by physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The P&P indicated to identify expiration date, if expired to notify nurse manager.		

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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. Based on observation, interview, and record review, the facility failed to properly store foods as evidenced by One open bag of dice broccoli in a freezer was not labeled and dated Two open cartons of milk in a refrigerator were not labeled and dated These deficient practices had the potential to result in residents being exposed to food borne illnesses (illnesses when a microorganism, such as bacteria, fungi, or a virus, enters a person's body and causes harm) and a widespread infection in the facility. During a concurrent observation and interview on 12/15/2025 at 8:50 AM, one open bag of diced broccoli did not have a label with date in the facility kitchen freezer. The Dietary Supervisor (DS) stated the dietary staff opened and used the diced broccoli, but it was not labeled and dated on the bag. During a concurrent observation and interview on 12/15/2025 at 8:51 AM, two open cartons of milk did not have a label with date in the facility kitchen refrigerator. The DS stated the dietary staff open and used these two cartons of milk, but there was no label or dated on the cartons. During an interview on 12/15/2025 at 8:55 AM with the DS, the DS stated the dietary staff did not label and dated the open the bag of diced carrots and the two cartons of milk. The DS stated it was important to label and date the open items when they were first opened, so other staff would know for how long the food items had been open and how long they would be good to prevent the spread of foodborne illness to the residents. During a review of the facility's policy and procedure (P&P) titled, Food Safety and Food Storage, dated 11/4/2024, the P&P indicated the practices to maintain safe refrigerated storage include labeling, dating refrigerated food.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to maintain documentation related to current Coronavirus 2019 (COVID-19, infectious respiratory disease easily spread from person to person) vaccination status for staff. This deficient practice had the potential to result in the facility's staff and residents contracting, transmitting, and experiencing complications related to COVID-19 such as difficulty breathing, persistent pain or pressure in the chest, or diarrhea. During a concurrent interview and record review of staff vaccination logs with the Director Staff Development (DSD) on 12/17/2025 at 11:30 PM, the DSD stated the only COVID-19 Vaccination log for the staff was from 2022. The DSD stated the last COVID-19 outbreak at the facility was in 10/2025 and he could not find an updated log of staff who consented to receive, or had been administered, the COVID-19 vaccine for 2025 - 2026 from the Infection Prevention Nurse (IPN). During the same interview on 12/17/2025 at 11:55 AM, the DSD stated the importance of maintaining an updated list of staff vaccinations was to know which employees to offer the COVID vaccine to and to prevent the spread of COVID. A review of the facility's policy and procedure (P&P) titled Employee COVID-19 Vaccinations revised on 3/13/2023 indicated the facility will track and securely document the vaccination status of each staff member (current and as new employees are onboarded). The P&P indicated each staff member's specific vaccine received, and the dates of each dose received, or the date of the next schedule dose for a multi-dose vaccine, and any staff member who has obtained any booster doses (include the specific vaccine booster received and the date of the administration of the booster).		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote dignity and respect for one of one sampled resident (Resident 5) when certified nurse assistant (CNA) 3 was observed standing over Resident 5 and assisting Resident 5 to eat. This deficient practice had the potential to cause a decline in the resident's individuality, self-esteem, and self-worth. A review of Resident 5's admission Record (AR) indicated the resident was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease (long-term condition when the kidneys are damaged and lose the ability to filter waste and fluid out of the blood), Alzheimer's Disease (type of dementia [loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life] that affects memory, thinking and behavior), and dementia. A review of Resident 5's Minimum Data Set (MDS, an assessment and screen tool) dated 11/17/2025, indicated the resident had moderately impaired cognitive skills for daily decision making. A review of Resident 5's Physician Orders dated 10/13/2025 indicated Resident 5 was ordered a regular diet liquidized (LQ3) texture and thin (TN0) consistency. During a dining observation on 12/15/2025 at 12:32 PM, CNA 3 was observed standing over Resident 5 and assisting Resident 5 eat lunch. Resident 5's bed was below CNA 3's waist and CNA 3 were not at eye level with the resident. During an interview with CNA 3 on 12/15/2025 at 12:35 PM, CNA 3 stated she was standing because she had back pain. CNA 3 stated it was important to feed resident at eye level so that the person assisting the resident to eat could see how the resident was while eating, and to make sure the resident was not choking while eating. During an interview with licensed vocational nurse (LVN) 2 on 12/15/2025 at 12:39 PM, LVN 2 stated the importance of being at eye level while feeding the resident was to have more contact with resident and to communicate with eyes. During an interview with the Director of Nursing on 12/17/2025 at 2:33 PM, the DON stated staff assisting to feed resident should be at eye level or seated with the resident to observe the resident while eating and to prevent the resident from aspirating (choking). A review of the facility's policy and procedure (P&P) titled Promoting/Maintaining Resident Dignity, dated 12/19/2022 indicated the practice of the facility was to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. The P&P indicated all staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the Minimum Data Set (MDS, a federal mandated resident assessment tool) assessment was accurate for one of five sampled residents (Resident 43). Resident 43's MDS did not reflect Resident 43's current diagnosis of Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in activities). This deficient practice resulted in lack of monitoring Resident 43's signs and symptoms of depression. During a record review of the admission record (AR), the AR indicated that Resident 43 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included Neuropathy (damage to the nerves outside your brain and spinal cord (peripheral nerves) that disrupts signals to your body, causing symptoms like numbness, tingling, weakness, and pain), Major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in activities). During a review of Resident 43's MDS dated [DATE], the MDS indicated Resident 43 had a Brief Interview for Mental Status (BIMS - a tool used to screen and identify the cognitive condition) score of 12 which indicated to be moderately impaired (problems with thinking/memory, may need assistance). During a review of Resident 43's Psychiatry Progress Notes (PPN) dated 10/12/2025, the PPN indicated Resident 43 had a history of Depression with an adjustment disorder diagnosis with the treatment plan to continue with Cymbalta (a prescription medication that is used to treat depression. During an interview and concurrent record review on 12/16/2025 at 3:29 PM of Resident 43's MDS with the MDS coordinator (MDSC), Resident 43's MDS dated [DATE] indicated Resident 43 had feelings of feeling down, depressed, or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or overeating, feeling bad about himself, trouble concentrating on things with a total severity score of 10. The MDSC stated Resident 43's diagnosis of Depression should have been entered on Resident's 43 MDS. MDSC stated the reason Resident 43's diagnosis was not entered on the MDS was because Resident 43 was not receiving antidepressant medication for depression. MDSC reviewed the RAI manual instructions and stated that the diagnosis should have been entered on Residents 43's MDS Assessment. During an interview on 12/17/2025 at 2:42 PM with the Director of Nurses (DON), the DON stated the MDS identifies potential residents' problems and should be accurate to direct and develop resident care planning. During a review of the facility's Policy and Procedure (P&P) titled, Resident Assessment - RAI dated 12/19/2022, the P&P indicated that the facility will make a comprehensive assessment of each resident's needs, strengths, goals, life history and preferences and that the assessment will include disease diagnosis and health conditions.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that two of two sampled residents (Resident 8 and Resident 43) reviewed for comprehensive care plans had their care plan interventions implemented by failing to: Implement Resident 8's antiplatelet care plan interventions for monitoring for bleeding or bruising. 2. Implement Resident 43's mood problem care plan interventions for monitoring feeling of sadness, loss of pleasure and interest in activities, feelings of worthlessness or guilt, change in appetite/eating habits; change in sleep patterns' dimmish ability to concentrate; change in psychomotor skills. These deficient practices had the potential to negatively affect the resident's well-being and delay delivery of care and services to Residents 8 and 43. a. During a review of Resident's 8 admission Record (AR), the AR indicated Resident 8 was admitted to the facility on [DATE] with diagnoses that included Cerebral Infarction (a stroke, loss of blood flow to a part of the brain), Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control), Pancytopenia (having low levels of red blood cells, white blood cells and platelets). During a review of Resident's 8 Minimum Data Set (MDS - a resident assessment tool) dated 11/16/2025, The MDS indicated Resident 8's Brief Interview for [NAME] Status (BIMS - a tool used to screen and identify the cognitive condition) score was of 6 which is severely impaired (Severe problems with thinking and memory). The MDS indicated that Resident 8 needs substantial/maximal assistance (helper does more than half the effort) with toileting, shower, lower body dressing, putting on/taking off footwear. The MDS indicated that Resident 8 required partial/moderate assistance (helper does less than half the effort) with upper body dressing. During a review of Resident's 8 Medication Administration Record (MAR) for the month of November and December, the MAR indicated Resident 8 had received Plavix (a medication used to prevent blood clots) 75 milligrams (mg - a unit of measurement), every day from 11/10/2025 to 12/17/2025. During a review of Resident's 8 care plan for Altered Cardiovascular Status, dated 11/10/2025, the Care Plan indicated to monitor/document/report adverse reactions of antiplatelet therapy such as skin discolorations/bruises, blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. During an observation on 12/15/2025 at 2:58 PM in Resident 8's room, Resident 8 was observed with a purplish discoloration and bruises on his bilateral forearms of irregular shape. When Resident 8 was interviewed he did not know or remember how he got the purplish discolorations on his upper extremities. During an interview and concurrent record review on 12/17/2025 at 9:26 AM with the MDS Coordinator (MDSC), the MDSC confirmed that there had been no documented evidence of monitoring for the possible side effects of Plavix (Clopidogrel) on Resident 8's medical record as indicated in Resident 8's care plan. b. During a record review of the admission record (AR), the AR indicated Resident 43 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Neuropathy (damage to the nerves outside your brain and spinal cord), Major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in activities). During a record review of Resident 43's MDS dated [DATE], the MDS indicated Resident 43 has a Brief Interview for Mental Status (BIMS - a tool used to screen and identify the cognitive condition) score of 12 moderately impaired (Problems with thinking/memory, may need assistance). The MDS indicated that Resident 43 had episodes of feeling down, depressed, or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or overeating, feeling bad about himself, trouble concentrating on things, such as reading the newspaper or watching television. During a record review of Resident 43's care plan Resident Has a Mood Care Plan Report dated 9/22/2025, the Care Plan indicated as an (continued on next page)		

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intervention to monitor/record/report to MD (medical doctor) acute episodes feelings or sadness, loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills. During a review of Resident 43's Psychiatry Progress Notes (PPN) dated 10/12/2025, the PPN indicated Resident 43 has a history of Depression. Currently stable with an adjustment disorder diagnosis. During an interview on 12/17/2025 with Director of Nurses (DON), the DON stated that it is important for Resident 43 and all residents to have a comprehensive care plan and for interventions such as monitoring feeling of sadness, loss of pleasure and interest in activities, feelings of worthlessness or guilt, change in appetite/eating habits; change in sleep patterns' dimmish ability to concentrate; change in psychomotor skills to be monitored by staff to prevent decline in residents' health status. During a review of the facility's Policy and Procedure (P&P) titled Comprehensive Care Plan dated 12/19/2022, the P&P indicated qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out interventions. The interventions listed on Resident's 8 and Resident's 43 care plan were not monitored.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a nutritional assessment was completed one of one sampled resident (Resident 4) when a significant weight loss (losing more than 5% of your body weight [around 10 pounds for many adults] within 6 to 12 months without trying) and a change in diet was identified. This deficient practice had the potential to result in Resident 4 to not receive the appropriate diet and nutritional needs required to address Resident 4's weight loss. A review of Resident 4's admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (brain tissue death) affecting right dominant side, dysphagia (difficulty swallowing), and aphasia (communication disorder from brain damage that impairs speaking, understanding, reading, or writing). A review of Resident 4's History and Physical Assessment (H&P) dated 9/7/2025 indicated Resident 4 did not have the capacity to understand and make decisions. A review of Resident 4's Order Summary Report indicated the following orders: On 10/15/2025, a physician prescription indicated NPO (nothing by mouth) diet, NPO texture, NPO consistency, discontinued. 2. On 10/15/2025, a physician prescription indicated regular diet pureed (pu4) texture, moderately thick (mo3) consistency, small portion of puree and moderately thick liquid at lunch and dinner for oral gratification 3. On 11/1/2025, a physician prescription indicated regular diet pureed (pu4) texture, moderately thick (mo3) consistency, small portion of puree and moderately thick liquid for breakfast lunch and dinner. 4. On 11/3/2025, a physician prescription indicated regular diet pureed (pu4) texture, moderately thick (mo3) consistency, regular portions, three times a day (TID). 5. On 11/6/2025, a physician prescription indicated to discontinue all Enteral Feed Orders (GT) due to family refusal to reinsert GT. 6. On 11/10/2025, a physician prescription indicated regular diet pureed (pu4) texture, moderately thick (mo3) consistency, regular portions, TID. A review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 9/29/2025, indicated Resident 4 had moderately impaired cognitive (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. The MDS indicated Resident 4 weighed 147 pounds (lbs, unit of measure). The MDS indicated Resident 4 was on a physician-prescribed weight loss regimen due to a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. A review of Resident 4's Weights and Vitals Summary dated 9/2025 to 12/2025 indicated the following weekly weights: On 9/27/2025, a weight of 147 lbs via mechanical lift. 2. On 10/6/2025, a weight of 150 lbs via Hoyer lift. 3. On 10/11/2025, a weight of 144 lbs via Hoyer lift. 4. On 10/18/2025, a weight of 143 lbs via Hoyer lift. 5. On 10/26/2025, a weight of 141 lbs via Hoyer lift. 6. On 11/2/2025, a weight of 142 lbs via Mechanical lift. 7. On 11/5/2025, a weight of 146 lbs via Hoyer lift. 8. On 11/12/2025, a weight of 145 lbs via Hoyer lift. 9. On 11/19/2025, a weight of 144 lbs via Hoyer lift. 10. On 11/26/2025, a weight of 144 lbs via Hoyer lift. 11. On 12/2/2025, a weight of 143 lbs via Hoyer lift. 12. On 12/10/2025, a weight of 140 lbs via Hoyer lift. 13. On 12/17/2025, a weight of 139 lbs via Hoyer lift. A review of Resident 4's care plans indicated an active care plan for alteration in nutritional status related to impaired physical/cognitive functions and disease process as evidenced by mechanically altered diet, therapeutic diet, and gastrostomy tube (GT, feeding tube placed directly into the stomach through the abdomen [belly wall] to deliver nutrition, fluids, and medication) initiated on 9/8/2025 and a revision date of 12/17/2025. The care plan indicated an intervention of a registered dietitian consult due to risk of malnutrition (an imbalance in nutrient intake). A review of Resident 4's Interdisciplinary Team (IDT) Care Conference indicated the following Weight Variance Care Conferences: On 10/9/2025, indicated Resident 4 weighed 147 lbs on 10/9/2025. The IDT indicated Resident 4 had a diet of NPO, tube feeding. The IDT indicated the resident was consistently pulling out GT. The IDT indicated a recommendation to continue GT feedings and weekly weights. 2. On 11/7/2025, indicated Resident 4 (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weighted 146 lbs on 11/5/2025. The IDT indicated Resident 4 had a regular diet, pureed (PU4) thin (TN0) liquid consistency with an average of 60% of meals eaten. The IDT indicated Resident 4 pulled out GT on 11/6/2025 and Resident 4's family member (FM) 1 did not want GT placement. The indicated recommendations for psychological consultation, family to help during meal time and weekly weights. 3. On 11/17/2025, indicated Resident 4 weighed 145 lbs on 11/12/2025. The IDT indicated Resident 4 had a regular diet, pureed (PU4) with mildly thick (MT2) liquid consistency with an average of 60% of meals eaten. The IDT indicated FM 1 requested not to insert GT and to continue current interventions. 4. On 12/8/2025, indicated Resident 4 weighed 143 lbs on 12/2/2025. The IDT indicated Resident 4 had a regular diet, pureed (PU4) with mildly thick (MT2) liquid consistency with an average of 90% of meals eaten. The IDT indicated there was no change in diet or condition. The IDT indicated recommendations of oral nutritional supplement of Boost daily and to continue current interventions. During a concurrent interview and record review of Resident 4's Nutritional Assessments on 12/17/2025 at 12:41 PM, Minimum Data Set Nurse (MDS) stated and confirmed only one Nutritional Assessment was completed for Resident 4 on 9/27/2025. MDS stated there was no other Nutritional Assessment done when Resident 4's diet changed or when his GT was discontinued. MDS stated Nutritional Assessments should be completed on admission, quarterly, and as needed when there is a change in nutritional status. During a concurrent interview and record review of Resident 4's Nutritional Assessments on 12/17/2025 at 1:02 PM, the Dietary Supervisor (DS) stated Nutritional Assessments are to be completed by the Registered Dietitian. The DS stated the purpose of a nutritional assessment was to provide medical staff a current picture of the resident. The DS stated nutritional assessments are done on admission and when there was any change in diet which should be completed immediately. The DS stated she could not find a current nutritional assessment for Resident 4. During an interview with the Director of Nursing (DON) on 12/17/2025 at 2:39 PM, the DON stated the RD completed a progress note for Resident 4. The DON stated the RD did not complete a nutritional assessment and that the nutritional assessment should have been completed. The DON stated she spoke with the RD to complete an assessment since Resident 4 had the GT pulled it out and his diet was changed. The DON stated she explained to RD to assess Resident 4 to give recommendations. The DON stated the importance of a nutritional assessment was to make sure if any nutrition affected resident's weight loss. A review of the facility's policy and procedure (P&P) titled Nutritional Management, dated 12/19/2022 indicated the facility provides care and services to each resident to ensure resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. The P&P indicated a Registered Dietitian will complete a comprehensive nutritional assessment within 14 days post-admission, corresponding to the MDS in progress sheet, annually, and upon significant change in condition. The P&P indicated the assessment shall clarify the resident's current nutritional status and individual risk factors for altered nutrition/hydration. The P&P indicated the dietitian shall use data gathered from the nutritional assessment to estimate the resident's calorie, nutrient, and fluid needs and whether intake is adequate to meet those needs		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that one of five sampled residents (Resident 8) was free from unnecessary drugs by failing to adequately monitor Resident 8's continuous need of Plavix (clopidogrel) (a medication used to treat and prevent blood clots) a medication that may increase the risk of bleeding. This deficient practice placed Resident 8 at risk of uncontrolled bleeding. During a review of Resident's 8 admission Record (AR), the AR indicated Resident 8 was admitted to the facility on [DATE] with diagnoses that included Cerebral Infarction (a stroke, loss of blood flow to a part of the brain), Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Pancytopenia (a blood condition where there's a significant drop in all three blood cell types: red blood cells, white blood cells, and platelets, often due to issues with bone marrow function, causing symptoms like fatigue, frequent infections, and easy bruising or bleeding. During a review of Resident's 8 Minimum Data Set (MDS - a resident assessment tool) dated 11/16/2025. The MDS indicated Resident 8's Brief Interview for [NAME] Status (BIMS - a tool used to screen and identify the cognitive condition) score of 6 severely impaired (Severe problems with thinking and memory). The MDS indicated that Resident 8 needs substantial/maximal assistance (helper does more than half the effort) with toileting, shower, lower body dressing, putting on/taking off footwear. The MDS also indicated that Resident 8 required partial/moderate assistance (helper does less than half the effort) with upper body dressing. During a review of Resident's 8 History and Physical Examination (H&P) dated 11/11/2025, the H&P indicated that Resident 8 does not have the capacity to understand and make decisions. During a review of Resident's 8 Medication Administration Record (MAR) for the month of November and December 2025, the MAR indicated Resident 8 had received Plavix (clopidogrel) 75 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount) once a day from 11/10/2025 to 12/17/2025. During a review of Resident's 8's Care Plan for Altered Cardiovascular Status, dated 11/10/2025, the Care Plan indicated to monitor/document/report Resident 8's adverse reactions of antiplatelet therapy such as skin discolorations/bruises, blood tinged or red blood in urine. During an observation on 12/15/2025 at 2:58 PM in Resident 8's room, Resident 8 was observed with a purplish discoloration and bruises on his bilateral forearms of irregular shape. When Resident 8 was interviewed he did not know or remember how he got the purplish discolorations on his upper extremities. During a concurrent record review and interview with the MDS Coordinator (MDC) on 12/17/2025 at 9:26 AM, the MDC confirmed that there was no documented evidence of monitoring or reassessment for the side effects of Plavix (Clopidogrel) on Resident 8's medical record since the Resident 8's admission. The MDC stated that ongoing medication Plavix (Clopidogrel) monitoring had not been followed for Resident 8's use of the medication. During a concurrent observation, interview on 12/17/2025 at 9:40 AM with the Director of Staff Development (DSD), the DSD stated he observed Resident 8 during physical therapy sitting on his wheelchair with bruise to left forearm. During a concurrent interview and record review on 12/17/2025 at 9:41 AM with the Director of Staff Development (DSD) of Resident 8's Skin Inspection Forms for the month of December, the DSD stated Resident 8's skin Inspection form was last completed on 12/11/2025, and there should have been a recent one completed but was not able to locate a recent skin inspection form. The DSD stated Resident 8's 12/11/2025 skin inspection form indicated no skin issues. The DSD stated this form should be completed by the Certified Nurse Assistants who are in assigned to the Residents on shower days or when there is a change in skin condition. During an interview on 12/17/2025 at 9:54 AM with Certified Nurse Assistant (CNA 1), CNA 1 stated that she provided care to Resident 8 on 12/16/2025 and 12/17/2025 7 AM - 3 PM. CNA 1 stated she did not remember seeing any skin discolorations on Resident's 8 forearms. CNA 1 stated that on 12/16/2025 the physical therapy department assisted Resident 8 to put his sweater on. CNA 1 stated that Resident 8 sometimes has (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	marks on his arms and that could be the reason she (CNA 1) did not notice the bruises on Resident 8 on 12/16/2025. CNA 1 stated that it is important to report skin discolorations or other skin conditions observed in a resident to the license nurses. During an interview on 12/17/2025 at 10:08 AM with CNA 2, CNA 2 stated that on Monday 12/15/2025 he provided care to Resident 8 from 7 AM - 3 PM. CNA 2 stated that he showered Resident 8 on 12/15/2025 and that he forgot to complete a skin inspection form. CNA 2 stated that he does not remember observing any skin discolorations or bruising on Resident's 8 skin. During an interview on 12/17/2025 at 10:38 AM with Occupational Therapist (OT 1), OT 1 stated that on 12/16/2025 she assisted Resident 8 to put his sweater on and did not observe any bruises on his arms. During an interview on 12/17/2025 at 2:42 PM with the Director of Nurses (DON), DON stated it is the facilities to monitor residents who are on anticoagulant medications. DON stated all residents who are on anticoagulants need to have a care plan that includes specific goals and interventions for possible side effects such as bruising or bleeding. DON stated that it is important for staff to monitor the effects of anticoagulant medication to prevent internal bleeding which can be a potential problem of these medications. The DON stated it is important for all of the CNAs to report skin changes to prevent decline in residents' health condition. During a review of the facility's Policy and Procedures (P&P) titled Skin Assessment, dated 12/19/2022, the P&P indicated that there will be a weekly or after a change of condition a skin assessment of full body, or head to toe skin assessment done by a licensed or registered nurse. During a review of the facility's Policy and Procedures (P&P) titled Notification of Changes, dated 12/19/22, the P&P indicated that the facility promptly notifies the resident, physician, resident's representative when there is a change in condition requiring notification.		

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

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F 0911 Level of Harm - Potential for minimal 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** Based on observation, interview, and record review, the facility failed to ensure resident bedrooms accommodate no more than four residents for seven (7) of eighteen (18) rooms (Rooms 16, 19, 20, 21, 22, 25, and 26) 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 an interview on 12/15/2025 at 2:09 PM, Administrator (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 12/15/2025, 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 12/15/2025 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, 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) 2. room [ROOM NUMBER] had 5 beds with 4 residents (1 unoccupied beds) 3. room [ROOM NUMBER] had 5 beds with 5 residents (0 unoccupied beds) 4. room [ROOM NUMBER] had 5 beds with 5 residents (0 unoccupied beds) 5. room [ROOM NUMBER] had 5 beds with 3 residents (2 unoccupied beds) 6. room [ROOM NUMBER] had 5 beds with 5 residents (0 unoccupied beds) 7. room [ROOM NUMBER] had 5 beds with 5 residents (0 unoccupied beds) During an interview on 12/17/2025 at 12:17 PM, Certified Nursing Assistant (CNA) 4 stated she had enough room in room [ROOM NUMBER] to get around and provide care to the residents. During an observation on 12/17/2025 at 12:37 PM, Family Member (FM) stated that room [ROOM NUMBER] had a total of 5 residents and there was enough space for staff to take care of his father. During a review of the facility's policy and procedure (P&P) titled Resident Rooms, revised on 12/2/2024 indicated resident bedrooms must be designed and equipped for adequate nursing care, comfort and privacy of residents.		