STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555107	A. Building B. Wing	02/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Care Center	3541 Puente Avenue Baldwin Park, CA 91706

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 42781

Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for one of one sampled resident (Resident 194) in accordance to facility's policy titled Call Lights: Accessibility and Timely Response.

This failure had the potential for Resident 194 not to receive care or receive delayed services to meet the residents' needs and could result in a fall or injury.

Findings:

During a review of Resident 194's Admission Record (AR), the AR indicated Resident 194 was admitted to the facility on [DATE] with diagnoses that included epilepsy (a neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain) and dependence on supplemental oxygen.

During a review of Resident 194's Fall Risk Assessment (FRA- method of assessing a patient's likelihood of falling) dated 1/23/2025, the FRA indicated Resident 194 was assessed as high risk for fall due to being chair bound, required the use of assistive devices, took three or more medications and presence of predisposing disease condition.

During a review of Resident 194's Care Plan dated 1/24/2025, the Care Plan indicated Resident 194 was at risk for falls related to epilepsy. The Care Plan interventions indicated for nursing staff to anticipate and meet Resident 194's needs and follow facility fall protocol.

During a review of Resident 194's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/27/2025, the MDS indicated Resident 194 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 194 was dependent (helper does all of the effort) to staff for toileting hygiene, shower, lower body dressing, and putting on/taking off footwear.

During a review of Resident 194's Care Plan dated 2/6/2025, the Care Plan indicated Resident 194 had oxygen therapy related to respiratory illness. The Care Plan interventions indicated for the nursing staff to have an agreed method for the resident to call for assistance (e.g., call light, bell.)

(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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/14/2025 at 5:39 pm, Resident 194 was awake, lying in bed. Resident 194's call light was hanging on the left side of the bed. Resident 194 stated, I could not see my call light. During a concurrent observation and interview on 2/14/2025 at 5:42 pm, with the Director of Staff and Development (DSD), the facility DSD stated Resident 194's call light was hanging on the left side of the bed. The DSD stated Resident 194 could not reach the call light. The DSD stated the resident's call light needed to be within reach at all times so that if Resident 194 needed anything from the staff, Resident 194 could call for assistance. During an interview on 2/15/2025 at 4:05 pm with the facility's Director of Nursing (DON), the DON stated, residents call light needed to be within reach at all times for the residents to use for staff assistance. The facility DON stated the call light was the resident's mode of communication and to maintain resident's safety. During a review of the facility's Policy and Procedure (P&P) titled, Call Lights: Accessibility and Timely Response, dated 12/9/2022, the P&P indicated the facility staff will ensure the resident's call light was within reach of the resident and secured, as needed.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on interview and record review, the facility failed to ensure an Advance Directive (AD, a legal document indicating resident preference on end-of-life treatment decisions) was discussed and written information was provided to the resident and/or responsible party and a current copy of the AD was in the medical chart for two of two sampled residents (Residents 145 and 5), consistent with the facility's policy and procedure on AD. These failures had the potential for facility staff to provide medical treatment and services against the residents' will. Findings: a. During a review of Resident 145's Admission Record (AR), the AR indicated Resident 145 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control) and congestive heart failure (a heart disorder which causes the heart to not pump efficiently). During a review of Resident 145's Minimum Data Set (MDS, a resident assessment tool) dated 2/14/2025, the MDS indicated Resident 145 had an intact cognition (ability to understand). The MDS indicated Resident 145 required setup or clean-up assistance (helper sets up or cleans up, resident completes activity) with eating, oral and personal hygiene and dependent with toileting, and shower. During a concurrent interview and record review on 2/14/2025 at 7:30 pm with the Director of Nursing (DON), Resident 145's Physician Orders for Life-Sustaining Treatment (POLST, a form that contains written medical records for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of-life), dated 2/7/2025, was reviewed. The DON stated, the POLST indicated Resident 145 had no AD. The DON stated, there was no AD Acknowledgement Form to indicate information was provided to Resident 145 and/or his family member/responsible party on his rights to accept or refuse treatment and how to formulate an AD. The DON stated, a copy of AD should be in the resident's chart in case of emergency and for the staff to be able to provide care according to the resident's wishes and preferences. 40037 b. During a review of Resident 5's AR, the AR indicated Resident 5 was admitted to the facility on [DATE] with diagnoses that included cardiomyopathy (a group of diseases that affect the heart muscle) and epilepsy (a chronic brain disorder characterized by involuntary body movements). During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 had an impaired cognition and was dependent (helper does all the effort) with toileting hygiene, shower, and lower body dressing. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/14/2025 at 7:37 pm with Social Service Director (SSD), the SSD stated, Resident 5's AD Acknowledgement Form was completed incorrectly. The SSD stated Resident 5 did not execute an AD, but Resident 5's AD Acknowledgement Form indicated Resident 5 executed an AD. The SSD stated, an AD indicated resident's care and treatment choices, and it was important to follow the residents' wishes. The SSD stated, if the AD Acknowledgment Form was incorrectly completed, the nurses would not know the resident's choices during an emergency. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights Regarding Treatment and Advance Directive, revised 12/19/2022, the P&P indicated The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview, and record review, the facility failed to ensure to administer oxygen as ordered and in accordance with the facility's Policy and Procedure (P&P) on oxygen administration for two of two sampled residents (Residents 3 and 193). These failures had the potential to result in adverse consequences for Residents 3 and 193. Findings: a. During a review of Resident 3's Admission Record (AR), the AR indicated Resident 3 was readmitted to the facility on [DATE], with diagnoses that included acute respiratory failure (lung cannot adequately provide oxygen to the body) with hypoxia (low blood oxygen level) and immunodeficiency (the body's ability to fight infection and other diseases is reduced or absent). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 11/23/2024, the MDS indicated Resident 3 had clear speech, had the ability to understand others and to make self-understood. The MDS indicated Resident 3 was dependent (helper does all the effort) with toileting hygiene, shower, and chair/bed-to-chair transfer. During a review of Resident 3's Order Summary Report (OSR) for 2/2025, the OSR indicated Resident 3 was ordered continuous oxygen at 2 liters (L) per minute via nasal cannula (tube which on one end splits into two prongs, placed in the nostrils to deliver oxygen) to maintain oxygen saturation (the measure of how much oxygen the blood is carrying as a percentage of the maximum it could carry) above 92 percent (%). During an observation on 2/14/2025 at 5:51 pm, Resident 3 was sitting in a wheelchair in the hallway outside Resident 3' room. Resident 3 had NC tubing connected to an oxygen tank placed at the back of Resident 3's wheelchair. Resident 3's oxygen was off. During a concurrent interview, Licensed Vocational Nurse 2 (LVN 2) stated, Resident 3 was ordered continues oxygen at 2L per minute. LVN 2 stated, the oxygen for Resident 3 should not be turned off. LVN 3 stated, Resident 3 had history of desaturation (low blood oxygen level) which required licensed staff to administer continues oxygen to Resident 3 to maintain adequate oxygen saturation. LVN 3 stated, licensed nurses should follow the physician's order to provide continues oxygen to Resident 3. 42781 b. During a review of Resident 193's AR, the AR indicated Resident 193 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure (a condition when the lungs cannot get enough oxygen into the blood) with hypoxia and dependence on supplemental oxygen. During a review of Resident 193's OSR dated 1/28/2025, the OSR indicated for licensed staff to administer oxygen via NC at 2L/min, may titrate oxygen to maintain oxygen saturation greater or equal to 92 percent (%) every shift. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 193's MDS dated [DATE], the MDS indicated Resident 193 had intact cognition for daily decision making. The MDS indicated Resident 193 was dependent to staff for toileting hygiene, shower, lower body dressing and putting on/taking off footwear. During an observation in Resident 193's room on 2/14/2025 at 5:35 pm, Resident 193 was awake lying in bed with nasal cannula not placed on both nostrils. During a concurrent observation and interview on 2/14/2025 at 9:48 am, with the facility's Director of Staff and Development (DSD), the DSD stated Resident 193's nasal cannula was not placed in Resident 193's nostrils. The DSD stated, the resident's nasal cannula needed to be inside Resident 193's nostril for the resident to get adequate oxygen as ordered by the physician. The DSD stated, if the nasal prongs were not placed in both nostril, Resident 193 was getting less oxygen and the resident's oxygen saturation will drop. During an interview on 2/15/2024 at 4:04 pm with the facility's Director of Nursing (DON), the DON stated the resident's nasal cannula needed to be inside the resident's nostrils to get the right amount of oxygen needed. During a review of the facility's P&P titled, Oxygen Administration, revised 5/20/2024, the P&P indicated oxygen is administered to residents who need it, consistent with professional standards of practice.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to provide a resident on hemodialysis (a treatment to cleanse the blood of wastes through a machine when the kidneys failed) an emergency kit (E-kit, contains the main items needed in an emergency) at bedside for one of two sampled residents (Resident 15). This failure had the potential for Resident 15 not to receive or received delayed care and treatment for complications caused by unexpected bleeding from the hemodialysis access site. Findings: During a review of Resident 15's Admission Record (AR), the AR indicated Resident 15 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease (ESRD, irreversible kidney failure) and dependence on hemodialysis. During a review of Resident 15's Care Plan (CP), dated 10/4/2024, the CP indicated Resident 15 needed hemodialysis related to renal failure. The CP goal indicated Resident 15 would have immediate intervention should any signs and symptoms of complications from dialysis occur. During a review of Resident 15's Order Summary Report (OSR) dated 12/17/2024, the OSR indicated Resident 15 had a tunneled catheter (a thin, flexible tube that's inserted into a vein and the tunneled under the skin) hemodialysis access site on the right femoral groin. Resident 15 was scheduled for hemodialysis every Monday, Wednesday and Friday. During a review of Resident 15's Minimum Data Set (MDS, a resident assessment tool) dated 1/8/2025, the MDS indicated Resident 15 had intact cognition (ability to understand). The MDS indicated Resident 15 required setup or clean-up assistance (helper sets up or cleans up, resident completes the activity) with eating and oral hygiene and substantial/maximal assistance (helper did more than half of the effort) with toileting, shower and personal hygiene. During an observation on 2/14/2025 at 5:54 pm with the Minimum Data Set Coordinator (MDS C) inside Resident 15's room, Resident 15 just came back from dialysis treatment. Resident 15 had a tunneled catheter hemodialysis access site on the right femoral groin. The MDS C stated, Resident 15 had no E-kit at bedside. The MDS C stated all dialysis residents needed to have an E-kit at bedside to use in case of bleeding from the hemodialysis access site. During an interview on 2/15/2025 at 4:05 pm with the facility's Director of Nursing (DON), the DON stated all dialysis residents should have an E-kit at bedside for the staff to use to stop and control the bleeding in case bleeding from the hemodialysis access site occurs. (continued on next page)

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F 0698 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, Hemodialysis, revised 6/5/2023, the P&P indicated, The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice to include ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices.

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F 0700

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40438

Based on observation, interview, and record review, the facility failed to implement its Policy and Procedure (P&P) on the use of bed rails/siderails (adjustable metal or rigid plastic bars attached to the bed) and grab bars (bars installed on the side of the bed) for two of two sampled residents (Residents 145 and 9).

These failures placed Residents 145 and 9 at risk for entrapment (an event in which resident was caught, trapped, or entangled in the tight spaces around the bed) and injury from the use of siderails and grab bars.

Findings:

a. During a review of Resident 145's Admission Record (AR), the AR indicated Resident 145 was admitted to the facility on [DATE] with diagnoses that included peripheral vascular disease (a slow progressive narrowing of the blood flow to the arms and legs) and ulcer (a small open sore or wound generally found in the stomach or on the skin) of bilateral lower extremity.

During a review of Resident 145's Minimum Data Sheet (MDS, a resident assessment tool) dated 2/14/2025, the MDS indicated Resident 145 had intact cognition (ability to understand). The MDS indicated Resident 145 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating, oral and personal hygiene and dependent (helper did all the effort, resident did none of the effort to complete the activity) with toileting, and shower.

During a concurrent observation and interview on 2/14/2025 at 6:09 pm with Licensed Vocational Nurse 1 (LVN 1) inside Resident 145's room, Resident 145 was in bed, on his back with half siderail up on both sides of the bed. LVN 1 stated Resident 145 was alert and oriented.

During a concurrent interview and record review on 2/15/2025 at 9:54 am with the Minimum Data Set Coordinator (MDS C), Resident 145's medical record (chart) and PointClickCare (PCC, a cloud-based software) were reviewed. The MDS C stated, there was no documented evidence that appropriate alternative interventions were attempted and did not meet the needs of Resident 145 before the installation of bilateral half siderails.

b. During a review of Resident 9's AR, the AR indicated Resident 9 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (muscle weakness on one side of the body that can affect the arms, legs, and facial muscles), and history of falling.

During a review of Resident 9's MDS dated [DATE], the MDS indicated Resident 9 had moderately impaired cognition. The MDS indicated Resident 9 required substantial/maximal assistance (helper did more than half of the effort) with eating and oral hygiene and dependent with toileting, shower and personal hygiene.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/14/2025 at 6:16 pm with MDS C inside Resident 9's room, Resident 9 was sitting on the bed with grab bars on both sides of the bed. MDS C stated Resident 9 was alert with periods of confusion. During a concurrent interview and record review on 2/15/2025 at 9:33 am with the MDS C, Resident 9's chart and PCC were reviewed. The MDS C stated there was no documented evidence that appropriate alternative interventions used did not meet the needs of the resident before the installation of bilateral grab bars. The MDS C stated there was no copy of consent for the use of grab bars in the chart and in the PCC. The MDS C stated a consent should be obtained before the use of grab bars to ensure that risks and benefits on the use of grab bars were explained to the resident and/or family members and was understood. During an interview on 2/15/2025 at 4:05 pm with the facility's Director of Nursing (DON), the DON stated the least restrictive alternative interventions should have been attempted and failed to meet the needs of the resident before the use of siderails/bedrails or grab bars to prevent the potential of getting caught in between the bed and the rails or bars and to prevent injury to the resident. The DON stated a consent should be obtained before bedrails/siderails or grab bars were installed to ensure the resident/family member and/or responsible parties were informed of the risks and benefits on the use of bedrails/siderails or grab bars. The DON stated bedrails, siderails and grab bars belong to the same category. During a review of the facility's P&P titled, Proper Use of Bed Rails, revised 12/19/2022, the P&P indicated, The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bedrails. This information should be presented in an understandable manner, and consent given voluntarily, free from coercion.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on interview and record review, for two of five sampled residents (Residents 10 and 94), the facility failed to ensure: a. Resident 94's physician order for Lorazepam (medication used to treat anxiety disorders [a condition that involves excessive fear, worry, or dread that interferes with daily life]) had a stop date as indicated in the facility's policy and procedures (P&P) on the use of psychotropic medication (drugs that alter the brain chemistry and affect metal processes, emotions and behavior). b. Resident 10's target behavior was monitored for the use of Haloperidol (antipsychotic medication to treat serious mental disorder in which people interpret reality abnormally) as indicated in the facility's P&P on the use of psychotropic medication. These deficient practices had the potential to result in the use of unnecessary psychotropic medications, which may result in significant adverse (harmful) consequences to Residents 10 and 94. Findings: a. During a review of Resident 94's Admission Record, the AR indicated Resident 94 was admitted to the facility on [DATE], with diagnoses that included malignant neoplasm of the breast (breast cancer) and anxiety disorder. During a review of Resident 94's Order Summary Report (OSR) dated 2/15/2025, the OSR indicated Resident 94 had an order for Lorazepam oral tablet 0.5 milligram (mg), 1 tablet by mouth every six hours as needed (PRN) for anxiety. During an interview on 2/15/2025 at 11:56 am with the facility's Director of Nursing (DON), the DON stated, all PRN psychotropic medication order should have a duration of use. The DON stated, normally the first duration should be 14 days, and the ordering physician would reassess the effectiveness after 14 days to see if the medication order should be extended. The DON stated this measure was to prevent unnecessary psychotropic medication administered to residents which could affect their thought processing and safety. During a review of the facility's P&P titled Use of Psychotropic Medication, dated 12/19/2022, the P&P indicated PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and limited duration (i.e. 14 days). If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall documented their rational in the resident's medical record and indicated the duration for the PRN order. 42781 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 10's AR, the AR indicated Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included depression (a feeling of severe sadness or hopelessness) and dependence on supplemental oxygen. During a review of Resident 10's History and Physical (H&P) dated 1/17/2025, the H&P indicated Resident 10 had the capacity to understand and make decisions. During a review of Resident 10's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/29/2025, the MDS indicated Resident 10 was dependent (helper did all the effort and lifted or held trunk or limbs) to staff for toileting hygiene, shower, lower body dressing and putting on/taking off footwear. During a review of Resident 10's OSR dated 2/4/2025, the OSR indicated Resident 10 had an order for Sertraline Hydrochloride Oral (antidepressant [medication to treat depression, mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily functioning]) tablet 100 mg by mouth two times a day for depression manifested by inability to sleep. During an interview on 2/16/2025 at 9:16 am with the facility's Director of Nurses (DON), the DON stated the target behavior needed to be monitored and documented every shift as ordered to identify if the medication was effective or not. During a concurrent interview and record review on 2/16/2025 at 10:30 am with Licensed Vocational Nurse 1 (LVN 1) of Resident 10's medical record in PointClickCare (PCC, a cloud-based software used in long-term and post-acute care facilities), there was no documented monitoring for Resident 10's target behavior for depression manifested by inability to sleep from 2/5/2025 to 2/14/2025. LVN 1 stated, Resident 10's hours of sleep was not monitored for 10 days. LVN 1 stated it was important to monitor the target behavior of the residents to know if the medication was working or not. During a review of the facility's P&P titled, Use of Psychotropic Medication, revised 12/19/2022, the P&P indicated, the indications for initiating, withdrawing or withholding medications as well as the use of non-pharmacological approaches will be determined by assessing the resident's underlying condition, current signs, symptoms, expressions and preferences and goals for treatment. The P&P indicated, non-pharmacological interventions that have been attempted and the target symptoms for monitoring shall be included in the documentation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555107	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/16/2025
NAME OF PROVIDER OR SUPPLIER Victoria Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3541 Puente Avenue Baldwin Park, CA 91706	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to provide safe and sanitary environment to prevent the development and transmission of communicable diseases (one that is spread from one person to another) for two of five sampled residents (Residents 145 and 2) by failing to: a. Ensure Certified Nurse Assistant 3 (CNA 3) wore the required Personal Protective Equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) when providing care to Resident 145 who was on Enhanced Barrier Precautions (EBP, a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms [MDROs]). b. Ensure the Treatment Nurse (TN) who entered Resident 2's room and administered medication to Resident 2, wore a gown. Resident 2 was on EBP. These failures had the potential to result in the spread of infection from Residents 2 and 145 to staff members and other residents in the facility. Findings: a. During a review of Resident 145's Admission Record (AR), the AR indicated Resident 145 was admitted to the facility on [DATE] with diagnoses that included peripheral vascular disease (a slow progressive narrowing of the blood flow to the arms and legs) and ulcer (a small open sore or wound generally found in the stomach or on the skin) of bilateral lower extremity. During a review of Resident 145's Order Summary Report (OSR) dated 2/10/2025, the OSR indicated Resident 145 was placed on Enhanced Barrier Precautions related to wound/s. During a review of Resident 145's Care Plan (CP), dated 2/10/2025, the CP indicated Resident 145 was on EBP related to unhealed ulcers. The CP interventions included for staff to apply EBP to prevent the spread of infections for specific care activities such as toileting and changing incontinence briefs. During a review of Resident 145's Minimum Data Sheet (MDS, a resident assessment tool) dated 2/14/2025, the MDS indicated Resident 145 had intact cognition (ability to understand). The MDS indicated Resident 145 required setup or clean-up assistance (helper sets up or cleans up, resident completes activity) with eating, oral and personal hygiene and dependent (helper did all of the effort, resident did none of the effort to complete the activity) with toileting, and shower. During an observation on 2/14/2025 at 7:17 pm inside Resident 145's room, Certified Nurse Assistant 1 (CNA 1) was cleaning and changing Resident 145. CNA 1 was only wearing gloves. CNA 1 was not wearing gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/14/2025 at 7:19 pm with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated, Resident 145 was on EBP because of his wounds on both lower extremities. LVN 1 stated all staff should wear gown and gloves when providing care to residents on EBP to prevent the spread of infection. During an interview on 2/15/2025 at 4:05 pm with the facility's Director of Nursing (DON), the DON stated all staff should don (put on) gown and gloves before they enter the room of residents on EBP, when providing care, and doffed (remove PPE) before leaving the room, for infection control. 40037 b. During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on 3/18/2022, with diagnoses that included dysphagia (difficulty swallowing) and Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control). During a review of Resident 2's OSR dated 6/24/2024, the OSR indicated the physician ordered EBP for Resident 2 due to gastrostomy tube (GT, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment and screening tool) dated 12/26/2024, the MDS indicated Resident 2 had unclear speech, sometimes understood others, and sometimes made self-understood. The MDS indicated Resident 2 was dependent (helper does all of the effort) for personal hygiene and chair/bed-to-chair transfer. During an observation on 2/15/2025 at 8:03 am, outside Resident 2's room, there was a signage posted at the door indicating Resident 2 was on EBP. The Treatment Nurse (TN) entered Resident 2's room and administered medication to Resident 2 via GT. The TN did not wear a gown while in close contact with Resident 2. During an interview on 2/15/2025 at 8:52 am, the TN stated, the TN did not wear a gown while performing medication administration for Resident 2. The TN stated, EBP measure was to prevent Resident 2 from cross infections. The TN stated TN should have worn a gown as this measure was to protect both the resident and care givers. During an interview on 2/15/2025 at 10:43 am with the Infection Preventionist Nurse (IPN), the IPN stated, Resident 2 was on EBP due to GT, and the TN should wear a gown when administering medications which was in close contact care with Resident 2. The IPN stated, this was to prevent cross contaminations and protect both residents and care givers from infection. During a review of the facility's Policy and Procedure (P&P) titled, Enhanced Barrier Precautions, revised 6/17/2024, the P&P indicated, EBP/ESP are indicated for residents with any of the following: wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Make gowns and gloves available prior to performing task. PPE for EBP is only necessary when performing high-contact care activities. High-contact resident care activities include dressing, bathing/shower, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting and device care or use.

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NAME OF PROVIDER OR SUPPLIER: Victoria Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 3541 Puente Avenue Baldwin Park, CA 91706	

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview, and record review, the facility failed to provide resident rooms that measured at least 80 square feet per resident for 12 of 13 multiple resident bedrooms. Rooms 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, and 14, did not meet the minimum square footage of 80 square feet per resident. This deficient practice had the potential to result in insufficient space to deliver care and services to the residents, affecting their quality of life. Findings: During an initial tour of the facility on 2/14/2025 from 5:30 pm to 9:00 pm, 12 of 13 resident rooms (Rooms 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, and 14) did not meet the minimum requirement of 80 square feet of useable living space per resident in a multiple resident bedroom. The following were observed: For Rooms 1 - 2, four beds were occupied with four residents. For Rooms 3, four beds were occupied with three residents. For room [ROOM NUMBER], three of four beds were occupied with three residents. For room [ROOM NUMBER] - 7, four beds were occupied with four residents. For room [ROOM NUMBER], one of four beds was occupied with one resident. For room [ROOM NUMBER] - 12, four beds was occupied with four residents. For room [ROOM NUMBER], two of four beds were occupied with two residents. The above rooms had sufficient space for the residents and staff to move in and out of the room during delivery of care and there was enough space to store the resident's personal items. The residents in these rooms were able to move their wheelchairs while inside the room. There was enough space for the beds, dresser, closets, and other medical equipment. During an interview on 2/15/2025 at 8:11 am, the facility Administrator (ADM) stated the facility had 12 of 13 resident rooms that did not meet the 80 square feet per resident requirement and will continue to request a room waiver for the 12 rooms (Rooms 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, and 14). (continued on next page)

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F 0912

Level of Harm - Potential for minimal harm

Residents Affected - Some

During a review of the facility's room waiver request dated 2/14/2025, the request indicated the facility was requesting a waiver for Rooms 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, and 14. The room waiver request indicated the 12 rooms had four (4) beds to a room and all rooms measure 304 square feet each room. The room waiver request indicated although these rooms do not meet the current Federal requirements, their sizes do not adversely affect the resident's health and safety. The room waiver request indicated the special needs of the resident in these rooms were being met. The room waiver request indicated the rooms allow for adequate space for nursing care, comfort and privacy of the residents and there were sufficient rooms for the resident to maneuver around the rooms and there was enough space to enter and exit the room without hazard and despite the room requirements not being met, the residents care and comfort will not be compromised. The room waiver request indicated the residents were able to keep personal possession in their rooms, the room allowed for adequate space to ensure proper infection control measures and isolation issues of this nature should occur. The room waiver request indicated if a resident status should change, basic medical equipment or appliance such as suction machine, oxygen, intravenous poles, walkers, wheelchairs can be accommodated, and in case the resident required more medical equipment that the room can hold, they will be transferred to a room that will accommodate their needs. The room waiver request indicated the rooms were large enough to allow residents to have visitors, watch television, etc., therefore allowing them non-sleeping hours in their room if they wish.

During a review of the Client Accommodations Analysis dated 2/15/2025, the analysis indicated the following:

Room Sq. Ft. Beds

1 304 4

2 304 4

3 304 4

4 304 4

6 304 4

7 304 4

8 304 4

9 304 4

10 304 4

11 304 4

12 304 4

14 304 4

(continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 2/15/2025 at 1:49 pm with Resident 36 in room [ROOM NUMBER], Resident 36 was able to wheel himself with ease. Resident 36 stated, he had no complaint regarding the room space. During an interview on 2/15/2025 at 1:53 pm with Certified Nurse Assistant 2 (CNA 2), CNA 2 stated, she was able to move wheelchairs, shower chair and Hoyer lift (a mechanical device used to lift and/or transfer a person from place to place) around the rooms with ease. During an interview on 2/15/2025 at 2:46 pm with Resident 8 in room [ROOM NUMBER], Resident 8 was awake and sitting on her wheelchair next to her bed. Resident 8 stated, Resident 8 was able to wheel herself in and out of the room with no concerns or issues. Resident 8 stated the room space was enough for her. During an interview on 2/15/2025 at 2:57 pm with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated the room space was adequate and there were no issues with the staff and residents. LVN 3 stated, LVN 3 was able to provide care and move wheelchairs, walker and Hoyer lifts inside the room with no issues.