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	04/09/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of two sampled residents' (Residents 6 and 51) Minimum Data Set (MDS- standardized assessment and care planning tool) reflected an accurate assessment by failing to: a. Ensure Resident 51, who was discharged to home under the care of home health (wide range of health care services that can be given at home for an illness or injury) service was coded in the MDS assessment accurately.b. Ensure Resident 6's hearing impairment was coded in MDS assessment. These deficient practices resulted in inaccurate reporting to the Centers of Medicare and Medicaid (CMS, a federal agency that administers the Medicare program and works with state governments to administer the Medicaid and health insurance portability standards) agency and had the potential to result in Residents 6 and 51 not receiving interventions to address specific care concerns. Findings: a. During a review of Resident 51's admission Record (AR), the AR indicated the facility admitted Resident 51 on 11/28/2025 with diagnoses including difficulty in walking, hypertension (high blood pressure) and other symptoms and signs involving the musculoskeletal system. During a review of Resident 51's Order Summary Report (OSR) dated 2/19/2026, the OSR indicated to discharge Resident 51 to home under home health with Licensed Nurse for Medication reconciliation and Physical Therapy (PT)/Occupational Therapy (OT) for safety evaluation. During a review of Resident 51's Post Discharge Plan of Care and Summary (PDPOCS) dated 2/19/2026, the PDPOCS indicated Resident 51 would benefit from Home Health Services to safely transition to home environment. During a review of Resident 51's MDS dated [DATE], the MDS indicated Resident 51 was discharged to home/community instead of discharge home under care of organized home health service organization. During an interview on 4/8/2026 at 3:13 pm, with the facility's Minimum Data Set Nurse (MDSN), the MDSN stated Resident 51 was discharged to home on 2/20/2026 under home health with Licensed Nurse for medication reconciliation and PT/OT for safety eval. The MDSN stated Resident 51's MDS assessment was coded discharged to home/community. The MDSN stated Resident 51's MDS assessment should have been coded discharged to home under care of organized home health service organization and not just home/community. The MDSN stated Resident 51's MDS assessment should have been coded accurately to give accurate information to the Centers for Medicare and Medicaid services (CMS). During an interview on 4/9/2026 at 1:03 pm with Director of Nursing (DON), the DON stated MDS assessment needed to be coded accurately to give accurate information to CMS for CMS to know the (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care and services needed to provide to the residents. The DON stated Resident 51 was discharged to home under home health and should have been coded discharged to home under care of organized home health service organization in the MDS. During a review of the facility's Policy and Procedure (P&P) titled, Resident Assessment- RAI, revised 12/19/2022, P&P indicated, The facility makes a comprehensive assessment of each resident's needs, strengths, goals, life history and preferences using the resident assessment instrument (RAI) specified by CMS. The assessment will include at least the following: Identification and demographic information. b. During a review of Resident 6's AR, the AR indicated the facility admitted Resident 6 on 12/17/2021 with diagnoses including polyneuropathy (many nerves in the body were damaged, causing numbness, weakness, or pain) and hearing loss. During a review of Resident 6's History and Physical (H&P) dated 10/29/2025, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Resident 6's Ear, Nose, and Throat Physician Progress Note (ENTPPN) dated 2/13/2026, the ENTPPN indicated Resident 6 had chronic hearing loss. During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 had adequate (no difficulty in normal conversation, social interaction, listening to television) hearing. The MDS indicated Resident 6 had severely impaired cognition (ability to understand). The MDS indicated Resident 6 was independent on eating. The MDS indicated Resident 6 was dependent (helper did all the effort) on staff with toileting hygiene, showering/ bathing, and bed-to-chair transferring. During a concurrent observation and interview with Resident 6 on 4/7/2026 at 11:05 AM, Resident 6 was pointing at Resident 6's ears and stated both of Resident 6's ears could not hear well. Surveyor had to remove facial mask and speak loudly next to Resident 6's ears. During a concurrent record review and interview with the MDS Coordinator (MDSC) on 4/8/2026 at 2:04 PM, Resident 6's MDS dated [DATE] was reviewed. The MDSC stated the MDS indicated Resident 6 had adequate hearing and it was not an accurate assessment. The MDSC stated the MDS nurse should have coded Resident 6's hearing assessment based on the MDS nurse's observation and the ENTPPN. The MDSC stated it was important to have accurate MDS assessment because the MDS assessment represented the residents' health information. The MDSC stated inaccurate MDS assessment would send inaccurate health information to CMS. During a review of the facility's P&P titled, Resident Assessment - RAI revised on 12/19/2022, the P&P indicated the facility should make a comprehensive assessment of each resident's needs, strengths, goals, life history and preferences using the resident assessment instrument (RAI) specified by Centers for Medicare & Medicaid Services (CMS). During a review of the facility's P&P titled, Documentation in Medical Record revised on 12/19/2022, the P&P indicated the documentation should be accurate, relevant, and complete, containing sufficient details about the resident's care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement specific, comprehensive, and individualized person-centered care plans to meet the residents' needs for three of three sampled residents (Residents 6, 31 and 38) by failing to: a. Implement Resident 31's care plan of turning and repositioning schedule every two (2) hours. b. Developed a care plan to address Resident 6's hearing loss and use of Gabapentin (a medication for nerve pain and used to control seizures). c. Developed a care plan to address Resident 38's current gastrostomy tube (GT, a medical device inserted through the abdomen directly into the stomach to deliver nutrition, fluids, and medications) feeding formula. These failures had the potential for Residents 6, 31, and 38 not to receive necessary care, treatment, and services specific to their needs. Findings: a. During a review of Resident 31's admission Record (AR), the AR indicated the facility admitted Resident 31 on 9/28/2009 and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline of mental abilities), contracture (a stiffening/shortening at any point, that reduces the joint's range of motion) of the right hand, and generalized muscle weakness (reduced muscle strength). During a review of Resident 31's untitled Care Plan (CP) dated 8/19/2021, the CP indicated Resident 31 had activities of daily living (ADL) self-care performance deficit and Resident 31 required total care (dependent). The CP interventions included turning and repositioning Resident 31 every 2 hours and to keep skin clean and dry. During a review of Resident 31's Minimum Data Set (MDS, a resident assessment tool) dated 3/6/2026, the MDS indicated Resident 31 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 31 was dependent (helper did all the effort, resident did none) on staff with oral hygiene, toileting, shower, upper/lower body dressing and personal hygiene. The MDS indicated Resident 31 was at risk of developing pressure ulcers/injuries (localized damage to the skin and/or underlying tissue usually over a bone prominence). During a review of Resident 31's Braden Scale Scoring (BSS, assessment tool that predicts a resident's risk of developing pressure injuries) dated 3/12/2026, the BSS indicated Resident 31 had a score of 9 (severe or very high risk of developing pressure injuries/sores). During an observation inside Resident 31's room on 4/8/2026 at 8:26 am, Resident 31 was lying on Resident 31's right side facing the door. During an observation inside Resident 31's room on 4/8/2026 at 9:42 am, Resident 31 was lying on Resident 31's right side facing the door. During an observation inside Resident 31's room on 4/8/2026 at 10:15 am, Resident 31 was lying on Resident 31's right side facing the door. During an observation inside Resident 31's room on 4/8/2026 at 11:15 am, Resident 31 was lying on Resident 31's right side facing the door. During an observation inside Resident 31's room on 4/8/2026 at 12:08 pm, Resident 31 was lying on (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 31's right side facing the door. During a concurrent observation inside Resident 31's room and interview on 4/8/2026 at 12:56 pm with Certified Nurse Assistant 1 (CNA 1), Resident 31 was lying on Resident 31's right side facing the door. CNA 1 stated Resident 31 should have been turned and reposition every 2 hours to prevent bed sores. During an interview on 4/8/2026 at 2:00 pm with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 31 was at risk for developing pressure ulcers and should be turned and repositioned every 2 hours to prevent skin breakdown and developing pressure injuries. During an interview on 4/9/2026 at 1:01 pm with the Director of Nursing (DON), the DON stated dependent and total care residents needed to be turned and repositioned every 2 hours and as necessary to prevent development or worsening of pressure injury. During a review of facility's Policy and Procedure (P&P) titled, Turning and Repositioning, revised 11/27/2023, the P&P indicated, Residents at risk of, or with existing pressure injuries, will be turned and repositioned, frequently, as tolerated, unless it is contraindicated due to a medical condition. In this case, small shifts in repositioning will be employed. The facility has established routine turning and repositioning schedules consisting of every 2-4 hours on the even hour. A maximum of thirty minutes before or after the scheduled time will be allotted for compliance with the schedule. b.1. During a review of Resident 6's AR, the AR indicated the facility admitted Resident 6 on 12/17/2021 with diagnoses including polyneuropathy (nerves in the body were damaged, causing numbness, weakness, or pain) and hearing loss. During a review of Resident 6's History and Physical (H&P) dated 10/29/2025, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Resident 6's Ear, Nose, and Throat Physician Progress Note (ENTPPN) dated 2/13/2026, the ENTPPN indicated Resident 6 had chronic (long term) hearing loss. During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 had severely impaired cognition. The MDS indicated Resident 6 was independent on eating. The MDS indicated Resident 6 required moderate assistance (helper did less than half the effort) from staff with personal hygiene. The MDS indicated Resident 6 required maximal assistance (helper did more than half the effort) from staff with oral hygiene. The MDS indicated Resident 6 was dependent on staff with toileting hygiene, showering/ bathing, and bed-to-chair transferring. During an interview with Resident 6 on 4/7/2026 at 11:05 AM, Resident 6 stated both of Resident 6's ears could not hear well. During a concurrent record review and interview with the MDS Coordinator (MDSC) on 4/8/2026 at 2:04 PM, all of Resident 6's care plans (CP) were reviewed. The MDSC stated there was no specific CP initiated to address Resident 6's hearing loss. The MDSC stated the licensed nurse should initiate a CP as soon as the problem was identified. The MDSC stated the licensed nurse should have initiated the care plan to address Resident 6's hearing loss on 2/13/2026, following the ENTPPN indicating Resident 6 had chronic hearing loss. The MDSC stated it was important to have a specific resident-centered CP because the CP was individualized for each resident's problems/needs. The (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDSC stated the CP was used to determine if the intervention was effective. b. 2. During a review of Resident 6's Order Summary Report (OSR) dated 4/8/2026, the OSR indicated Resident 6 had an active order of gabapentin (a medicine that helped calm nerves to reduce pain) for neuropathy. The order was dated 10/15/2024. During a concurrent record review and interview with the MDSC on 4/8/2026 at 2:36 PM, all of Resident 6's CPs were reviewed. The MDSC stated there was no specific CP initiated to address Resident 6's use of gabapentin for neuropathy. c. During a review of Resident 38's AR, the AR indicated the facility admitted Resident 38 on 3/18/2025 and readmitted on [DATE] with diagnoses including dysphagia (difficulty swallowing) and gastrostomy (a surgical opening fitted with a device to allow feedings/medication to be administered directly to the stomach). During a review of Resident 38's Physician Order (PO) dated 3/4/2026, the PO indicated continuous gastrostomy tube feeding (GTF) with Peptamen AF 1.2 (high-protein GTF that provided 1.2 kilocalorie [kcal, a unit of energy] per milliliter [ml, a unit to measure small volumes of liquid]) every shift for Resident 38. During a review of Resident 38's H&P dated 3/6/2026, the H&P indicated Resident 38 did not have the capacity to understand and make decisions. During a review of Resident 38's MDS dated [DATE], the MDS indicated Resident 38 had severely impaired cognition. The MDS indicated Resident 38 required maximal assistance from staff with oral and personal hygiene. The MDS indicated Resident 38 was dependent on staff with toileting hygiene, showering/ bathing, and bed-to-chair transferring. During an observation on 4/7/2026 at 10:59 AM, at Resident 38's bedside, Resident 38 was receiving GTF Peptamen AF 1.2 via GT while in bed. During a concurrent record review and interview with the MDSC on 4/8/2026 at 2:36 PM, Resident 38's CP for GT Feeding dated 4/7/2026 was reviewed. The CP indicated an intervention for licensed nursing staff to provide tube feeding as ordered. The MDSC stated the CP intervention was not specific and should indicate the specific GTF Peptamen AF 1.2. During an interview with the Director of Nursing (DON) on 4/9/2026 at 1:13 PM, the DON stated the resident's CP reflected the plan of care based on the resident's need. The DON stated the licensed nurses should develop specific and resident-centered CP. The DON stated the intervention of providing tube feeding as ordered was general and not specific to Resident 38. During a review of the facility's P&P titled, Comprehensive Care Plans, revised 12/2022, the P&P indicated the facility should develop and implement a comprehensive resident-centered CP for each resident to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the resident's comprehensive assessment. The P&P indicated the comprehensive CP should be developed within seven days after the completion of the comprehensive MDS assessment. The P&P indicated the CP should address the factors identified by the interdisciplinary team. The P&P further indicated the CP should have specific interventions that reflected the resident's needs and preferences.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise the care plans (CP) for two of two sampled residents (Residents 7 and 10) when:a. Resident 7's gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach) tube was removed.b. Resident 10 did not take medication for edema (swelling caused when extra fluid leaked from blood vessels and collected in body tissues). These deficient practices had the potential for Residents 7 and 10 to not receive appropriate care, treatment and/or services. Findings: a. During a review of Resident 7's admission Record (AR), the AR indicated the facility admitted Resident 7 on 12/12/2018 and readmitted on [DATE] with diagnoses including Parkinson's disease (a progressive disease marked by tremor, muscular rigidity, and slow, imprecise movements) and dysphagia (difficulty swallowing). During a review of Resident 7's History and Physical (H&P) dated 2/16/2026, the H&P indicated Resident 7 did not have the capacity to understand and make decisions. During a review of Resident 7's Nursing Progress Notes (NPN) dated 2/23/2026, the NPN indicated the physician removed Resident 7's gastrostomy tube (GT) on 2/23/2026 at 3:03 PM. During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool) dated 2/27/2026, the MDS indicated Resident 7 had intact cognition (ability to understand and process information). The MDS indicated Resident 7 was dependent (helper does all the effort) on staff with oral hygiene, oral hygiene, toileting hygiene, showering/ bathing, personal hygiene, and bed-to-chair transferring. During a review of Resident 7's Order Summary Report (OSR) with active orders as of 4/8/2026, the OSR indicated Resident 7 did not have an active order of tube feeding nor water flushing. During a review of Resident 7's Care Plan (CP) for nutritional problems with target date of 6/11/2026, the CP indicated as of 9/11/2025, Resident 7 no longer had tube feeding and was taking meals orally. The CP intervention indicated for nursing staff to provide tube feeding and water flush as ordered. During a concurrent record review and interview with the MDS Coordinator (MDSC) on 4/8/2026 at 2:50 PM, Resident 7's CP for nutritional problem was reviewed. The MDSC stated the licensed nurse should have revised Resident 7's CP when the GT was removed to reflect Resident 7's current health condition and dietary needs. During an interview with Licensed Vocational Nurse 4 (LVN 4) on 4/9/2026 at 10:49 AM, LVN 4 stated it was not acceptable for Resident 7's CP intervention to provide GT feeding (GT) because Resident 7 did not have active GT or GT feeding. LVN 4 stated the licensed nurse should revise the CP when there was a change on the resident's medication and tube feeding. LVN 4 stated it was important to have specific and up-to-date CP for residents. b. During a review of Resident 10's AR, the AR indicated the facility admitted Resident 10 on 1/23/2025 and readmitted on [DATE] with diagnoses including cerebral palsy (a group of permanent disorders affecting a resident's ability to move, maintain balance, and manage posture) and hydronephrosis (the swelling of one or both kidneys caused by a buildup of urine). During a review of Resident 10's CP for edema dated 2/6/2025 with target date of 5/6/2026, the CP intervention indicated for licensed nursing staff to provide medication as ordered. During a review of Resident 10's H&P dated 6/9/2025, the H&P indicated Resident 10 did not have the capacity to understand and make decisions. During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10 had severely impaired cognition. The MDS indicated Resident 10 required supervision from staff with eating. The MDS indicated Resident 10 required maximal assistant (helper did more than half the effort) from staff with bed-to-chair transferring. The MDS indicated Resident 10 was dependent on staff with oral hygiene, toileting hygiene, showering/ bathing, and personal hygiene. During a concurrent record review and interview with the MDSC on 4/8/2026 at 2:22 PM, Resident 10's OSR dated 4/8/2026 was reviewed. The MDSC stated the OSR indicated Resident 10 did not have an active medication order for edema. The MDSC stated the licensed nurse should have removed the intervention to provide medication in Resident 10's CP for (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	edema because Resident 10 was not taking any medication for edema. The MDSC stated the licensed nurse should have revised the CP as soon as the physician discontinued the medication for edema. The MDSC stated inaccurate nursing intervention could affect the continuity of resident care. During an interview with the Director of Nursing (DON) on 4/9/2026 at 1:13 PM, the DON stated the resident's CP should reflect the plan of care based on the resident's current needs. The DON stated the licensed nurse should revise the CP when residents (in general) had a change in condition. During a review of the facility's Policy and Procedure (P&P) titled, Care Plan Revisions Upon Status Change, revised 12/19/2022, the P&P indicated the facility should reviewed and revised the comprehensive CP as necessary, when a resident experiences a status change. The P&P further indicated that the MDSC and designated staff would update the CP with the new or modified interventions as needed.

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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** Based on observation, interview, and record review, the facility failed to provide necessary care and services for residents receiving oxygen therapy (treatment that provided extra oxygen) in accordance with professional standards of practice for two of the two sampled residents (Residents 8 and 10) by failing to: a. Ensure Resident 10's nasal cannula tubing (a flexible plastic tubing used to deliver oxygen through the nostrils), oxygen humidifier (a small bottle that adds moisture to oxygen), and oxygen storage bag (a plastic bag that stores oxygen supplies for a resident) were properly labeled.b. Ensure Resident 8's nasal cannula tubing, oxygen humidifier, and oxygen storage bag were properly labeled. These failures placed Residents 8 and 10 at risk of complications related to the use of oxygen.Findings: a. During a review of Resident 10's admission Record (AR), the AR indicated the facility admitted Resident 10 on 1/23/2025 and readmitted on [DATE] with diagnoses including acute respiratory failure with hypoxia (sudden breathing problem when the lungs do not get enough oxygen) and dependence on supplemental oxygen. During a review of Resident 10's History and Physical (H&P) dated 6/9/2025, the H&P indicated Resident 10 did not have the capacity to understand and make decisions. During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool) dated 1/20/2026, the MDS indicated Resident 10 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 10 required supervision from staff with eating. The MDS indicated Resident 10 required maximal assistant (helper did more than half the effort) from staff with bed-to-chair transferring. The MDS indicated Resident 10 was dependent (helper did all the effort) on staff with oral hygiene, toileting hygiene, showering/ bathing, and personal hygiene. During a review of Resident 10's Order Summary Report (OSR) active as of 4/8/2026, the OSR indicated for nursing staff to change oxygen tubing as needed and administer oxygen to Resident 10 every shift. During a concurrent observation and interview on 4/7/2026 at 10:41 AM with the Director of Nursing (DON), Resident 10 was lying in bed, awake with ongoing oxygen at 2 liters per minute (LPM) via nasal cannula. The DON stated Resident 10's nasal cannula tubing, oxygen storage bag, and oxygen humidifier were dated 3/5/2026 and should be dated 4/5/2026. The DON stated the facility change resident's nasal cannula tubing, oxygen storage bag, and oxygen humidifier every Sunday of the week. During an interview on 4/9/2026 at 10:36 AM with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated the oxygen nasal cannula tubing and oxygen storage bag needed to be changed and labeled by the registered nurse every Sunday of the week. LVN 4 stated it was not acceptable to see labels of 3/5/2026 instead of 4/7/2026 because the oxygen nasal cannula tubing and oxygen storage bag could not have been changed timely and placed the residents at risk of upper respiratory infection. LVN 4 stated the licensed nurse should make rounds during the shift to ensure the oxygen nasal cannula tubing and oxygen storage bag were labeled correctly and changed. LVN 4 stated nursing staff should have informed the registered nurse to change the oxygen nasal cannula tubing and oxygen storage bag if the labels were dated 3/5/2026. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/20/2024, the P&P indicated staff should administer oxygen to residents consistent with professional standards of practice. The P&P indicated staff should change oxygen cannula tubing and humidifier bottle weekly for infection control. b. During a review of Resident 8's AR, the AR indicated the facility admitted Resident 8 on 2/11/2025 and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-type of obstructive lung disease characterized by long-term poor airflow), chronic respiratory failure (a condition when the lungs cannot get enough oxygen into the blood) and dependence on supplemental oxygen. During a review of Resident 8's Order Summary Report (OSR) dated 1/14/2026, the OSR indicated for staff to change Resident 8's oxygen tubing as needed. During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8 had intact cognition. The MDS indicated Resident 8 required partial/moderate assistance (helper did less than half the effort) from staff with toileting, shower, lower body dressing and putting on/taking off footwear. During a concurrent observation in Resident 8's room and interview on 4/7/2026 at 9:50 am with Licensed Vocational Nurse 3 (LVN 3), Resident 8 was lying in bed, awake with ongoing oxygen at two liters per minute (LPM) via nasal cannula. LVN 3 stated Resident 8's nasal cannula tubing, plastic bag and humidifier were dated 3/5/2026. LVN 3 stated the oxygen bag, nasal cannula tubing and humidifier should be changed every Sunday of the week or as needed for infection control. During an interview on 4/7/2026 at 2:13 pm, with Registered Nurse 1 (RN 1), RN 1 stated licensed nurses were responsible for changing the oxygen tubing, humidifier, and oxygen bag every Sunday of the week for infection control. During an interview on 4/8/2026 at 1:44 pm with the DON, the DON stated oxygen nasal cannula tubing, bag and humidifier needed to be changed every Sunday of the week or as needed by licensed nurses for infection control. The DON stated oxygen cannula tubing, bag and humidifier should be labeled with the date when it was changed. During a review of the facility's P&P titled, Oxygen Administration, revised 5/20/2024, the P&P indicated Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. Change humidifier bottle when empty, weekly or per facility policy.

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	555107	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Care Center	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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure to post the actual nurse staffing information at the beginning of each shift in a prominent location readily accessible to residents, visitors, and staff for viewing for two of three recertification survey days (4/7/2026 and 4/8/2026). These failures had the potential to mislead the residents, visitors, and staff of the actual staffing in the facility that may affect the quality of nursing care provided to the residents.Findings: During a concurrent observation in the facility's lobby, hallways, and reception area and interview on 4/7/2026 at 10:57 am with the Facility Receptionist (FR), there was no daily nurse staffing information posted in the lobby, hallways, and reception area. The FR stated the nurse staffing information was only posted in the nurse station. The facility had only one nurse station. During a concurrent observation in the nurse station and interview on 4/7/2026 at 11:00 am with Licensed Vocational Nurse 1 (LVN 1), the nurse staffing information was posted on the side of a shelf in the nurse station. There were two medication carts parked in front of the nurse station. The letter fonts used to print the nurse staffing information were not readable from the hallway. LVN 1 stated the residents and visitors would have a hard time seeing and reading the nurse staffing information on its current location. LVN 1 stated the residents and visitors could not move closer to the nurse station because of the parked medication carts. During a concurrent interview and record review on 4/8/2026 at 1:45 pm with the Director of Staff Development (DSD), the nurse staffing information dated 4/7/2026 and 4/8/2026 were reviewed. The DSD stated the hours indicated in the nurse staffing information for 4/7/2026 and 4/8/2026 were projected hours and not actual hours of staff working for each shift. The DSD stated the nurse staffing information should reflect the actual hours of staff working for each shift and posted in a visible and accessible location for the residents, visitors, and staff to see and know the facility had enough staffing to meet the nursing hours provided per patient care as reported to the Center for Medicare and Medicaid Services (CMS, a federal agency responsible for administering the Medicare and Medicaid programs) and to meet the residents' individual needs. During an interview on 4/9/2026 at 12:46 pm with the Director of Nursing (DON), the DON stated the nurse staffing information should be posted in a prominent location, visible and accessible for the residents, visitors, and staff to know the facility had sufficient staffing to provide appropriate care to the residents. The DON stated the nursing staff information should also reflect the actual hours of the licensed and unlicensed staff working for each shift to ensure the facility had enough staff to take care of the residents' needs in the facility. During a review of the facility's Policy and Procedure (P&P) titled, Nurse Staffing Posting Information revised 3/10/2025, the P&P indicated, The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. The facility will post the Nurse Staffing Sheet at the beginning of each shift. The information posted will be presented in a clear and readable format, in a prominent place readily accessible to the staff, residents, and visitors.

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Victoria Care Center	3541 Puente Avenue Baldwin Park, CA 91706

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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 ensure safe food storage and handling practices in two of two facility kitchen refrigerators (Refrigerators 1 and 2), by failing to:a. Label a tray with four (4) heads of lettuce in Refrigerator 1 with received date.b. Discard an open plastic container of 2% milk, around one-fourth (1/4) full, past its use-by-date (relating to food safety) in Refrigerator 2.c. Discard an open plastic container of prune juice, around half (1/2) full, past its use-by-date in Refrigerator 2.These failures had the potential to result in food-borne illnesses (illness caused by ingesting contaminated food or beverages) for the residents.Findings:a. During an observation in the kitchen on 4/7/2026 at 9:22 am with the Dietary Supervisor (DS), a tray containing 4 heads of lettuce in Refrigerator 1 did not have a date when the lettuces were received. b. During an observation in the kitchen on 4/7/2026 at 9:24 am with the DS, an open plastic container of 2 % milk, around 1/4 full, had a preparation date of 3/31/2026 and a use-by-date of 4/4/2026 in Refrigerator 2.c. During an observation in the kitchen on 4/7/2026 at 9:24 am with the DS, an open plastic container of prune juice, around half full, had a preparation date of 2/24/2026 and a use-by-date of 3/24/2026 in Refrigerator 2.During an interview on 4/7/2026 at 9:32 am with DS, the DS stated all food items received should be labeled with a received date to determine when the food items were of highest quality and when they needed to be discarded to ensure foods served to the residents were safe and palatable.During an interview on 4/8/2026 at 12:56 pm with the Director of Nursing (DON), the DON stated all food, and beverages should be labeled with received date and not to be consumed past the best by date and use-by-date to prevent stomach reaction like diarrhea and vomiting.During a review of the facility's Reference Guide (RG) on Refrigerated Storage, dated 1/2026, the RG indicated that a washed and thoroughly drained head of lettuce should be kept in a crisper or moisture resistant wrap or bags and had a recommended storage time of three to five (3-5) days. The RG indicated that an opened liquid whole, or low-fat milk had a recommended storage time of one (1) week. The RG indicated that opened bottled, reconstituted, frozen, and canned juices had a recommended storage time of 1 week. During a review of the facility's Policy and Procedure (P&P) titled, Food Safety and Food Storage, revised 11/4/2024, the P&P indicated, Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food was received from the vendor and ends with delivery of the food to the resident. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by-date, or frozen (where applicable)/discarded, and keeping foods covered or in tight containers.

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Victoria Care Center	3541 Puente Avenue Baldwin Park, CA 91706

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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** Based on observation, interview, and record review, the facility failed to ensure the call light (an alerting device to assist a resident when needed) was within reach for one of one sampled resident (Residents 45). This failure had the potential to delay meeting Resident 45's needs or result in a fall or accident/injury.Findings: During a review of Resident 45's admission Record (AR), the AR indicated the facility originally admitted Resident 45 on 1/23/2020 and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body, usually caused by damage to the brain) following cerebral infarction (part of the brain did not get enough blood, which caused brain cells to die) affecting left non-dominant side. During a review of Resident 45's fall risk care plan (CP) initiated on 2/23/2023, the CP intervention indicated for nursing staff to place the call light within Resident 45's reach. During a review of Resident 45's History and Physical (H&P) dated 10/29/2025, the H&P indicated Resident 45 did not have the capacity to understand and make decisions. The H&P indicated Resident 45 had right eye blindness and left eye cataract (a condition where the lens of the eye became cloudy and caused blurry vision). During a review of Resident 45's Minimum Data Set (MDS, a resident assessment tool) dated 1/28/2026, the MDS indicated Resident 45 had severely impaired cognition (ability to understand). The MDS indicated Resident 45 required setup assistance from staff with eating. The MDS indicated Resident 45 required supervision from staff with mobility. The MDS indicated Resident 45 required moderate assistance (helper did less than half the effort) from staff with oral hygiene, toileting hygiene, showering/ bathing, and personal hygiene. During a concurrent of observation and interview with Resident 45 on 4/7/2026 at 10:47 AM, at Resident 45's bedside, Resident 45 was awake and lying on bed. Resident 45's call light for was on the floor, positioned near the left side of the bed. Resident 45 stated Resident 45 needed help with the cellphone and was unable to locate the call light. During an interview with Licensed Vocational Nurse 2 (LVN 2) on 4/8/2026 at 9:24 AM, LVN 2 stated the resident's call light should be within easy reach so the resident (in general) could call for help when needed. LVN 2 stated it was important to ensure the call lights were within residents' reach. During a concurrent picture review and interview with Certified Nurse Assistant 3 (CNA 3) on 4/9/2026 at 10:11 AM, the picture dated 4/7/2026 at 10:48 AM was reviewed. CNA 3 stated Resident 45's call light was on the floor and the resident could not reach. CNA 3 stated the call light should be placed on Resident 45's chest or very close to the resident so the resident could reach easily for safety. CNA 3 stated the call light was used for resident's safety and as a means to communicate between the residents and staff. During an interview with the Director of Nursing (DON) on 4/9/2026 at 1:13 PM, the DON stated it was important to ensure the call light was within the resident's reach for safety precaution and fall prevention. The DON stated staff could not attend to residents' needs timely if the residents needed to look for the call light. The DON stated the call light on the floor was not within Resident 45's reach. During a review of the facility's Policy and Procedure (P&P) titled, Call Lights: Accessibility and Timely Response, revised 12/2022, the P&P indicated the facility staff should ensure the call light was within reach of the resident while in bed.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility staff failed to elevate the resident's head of the bed (HOB) while the resident was receiving formula through the gastrostomy tube (GT - a tube inserted through the abdomen that delivers nutrition/medication directly into the stomach) in accordance with the resident's care plan and physician's order for one of three sampled residents (Resident 32). This deficient practice had the potential to result in aspiration (inhalation of foreign materials) and respiratory complications for Resident 32. Findings: During a review of Resident 32's admission Record (AR), the AR indicated the facility admitted Resident 32 on 8/14/2025 with diagnoses including encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support), dysphagia (difficulty in swallowing) and dependence on supplemental oxygen. During a review of Resident 32's untitled Care Plan (CP) dated 9/2/2025, the CP indicated Resident 32 required tube feeding related to dysphagia and swallowing problem, The care plan interventions included for nursing staff to elevate Resident 32's HOB at least 30 to 45 degrees during and thirty minutes after tube feeding and to provide tube feeding to Resident 32 as ordered. During a review of Resident 32's Order Summary Report (OSR) dated 1/9/2026, the OSR indicated for staff to elevate Resident 32's HOB at 30 to 45 degrees at all times for aspiration precaution every shift for tube feeding. During a review of Resident 32's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 2/19/2026, the MDS indicated Resident 32 had severely impaired cognition (ability to understand). The MDS indicated Resident 32 was dependent (helper did all the effort) on staff for oral hygiene, toileting, shower, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 32's OSR dated 4/3/2026, the OSR indicated continuous GT feeding of Isosource 1.5 (formula) rate at 40 milliliters (ml, unit of measurement) per hour (hr.). Start at 2 pm, stop at 10 am or until 800 ml has been infused for Resident 32. During an observation on 4/7/2026 at 9:41 am, Resident 32 was lying flat in bed, in supine position with ongoing GT feeding formula running at 40 ml/hr. An unidentified Certified Nurse Assistant (CNA) was at Resident 32's bedside. During a concurrent observation and interview on 4/7/2026 at 9:43 am, together with Licensed Vocational Nurse 3 (LVN 3), Resident 32 was awake, lying in bed, in supine position with ongoing GT feeding and the resident's HOB was not elevated at 30 to 45 degrees. LVN 3 stated Resident 32's HOB should have been elevated at 30 to 45 degrees while receiving GT feeding to prevent aspiration. LVN 3 stated the licensed nurse should turn off the GT feeding if Resident 32 was flat on bed. During an interview on 4/7/2026 at 2:25 pm, with Registered Nurse 1 (RN 1), RN 1 stated Resident 32's HOB needed to be elevated while the resident was receiving GT feeding to prevent aspiration. During an interview on 4/8/2026, at 1:45 pm, with the Director of Nursing (DON), the DON stated Resident 32's HOB needed to be elevated at least 30 degrees while receiving GT feeding to prevent aspiration.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure medication regimen review (MRR) irregularity identified by the facility's Pharmacy Consultant was acted upon for one of five sampled resident (Resident 5) in accordance to facility's policy and procedure Consultant Pharmacist Report.This deficient practice had the potential for harm due to the missed opportunity by the physician and the licensed staff to act upon the reported irregularities for Resident 5. Findings:During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted Resident 5 on 11/24/2025 with diagnoses including encephalopathy (disease that affects the function or structure of the brain) and unspecified dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning).During a review of Resident 5's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/28/2026, indicated, Resident 5 had severely impaire cognition (mental action or process of acquiring knowledge and understanding) for daily decision making The MDS indicated, Resident 5 needed maximum assistance (helper does more than half the effort) to staff for toileting, shower, lower and upper body dressing and putting on/taking off footwear.During a record review of Resident 5's Order Summary Report (OSR), dated 2/26/2026, the OSR indicated to administer diphenhydramine hydrochloride oral (used primarily to treat allergy symptoms [sneezing, itching, runny nose] and as a sleep aid due to its strong sedative [substance that includes sedation] effects) tablet 25 milligram (mg, unit of measurement) one tablet by mouth every six hours as needed for itchiness.During a review of a facility document titled, Note to Attending Physician/Prescriber, dated 3/6/2026, completed by the facility's pharmacist consultant, the note indicated Patient is on PRN (as needed) Benadryl. Federal guidelines can view the use of Diphenhydramine (Benadryl) as unnecessary due to its potential for anticholinergic (i.e. constipation, orthostasis, urinary retention) and sedative side effects. If appropriate and effective, topical instead of oral diphenhydramine should be considered. If an oral agent is clinically necessary for long term use, perhaps other alternatives (for example, Allegra or Claritin [used to relieve allergy symptoms]) could be considered. The Note indicated, physician agreed to discontinue Benadryl PRN.During a concurrent interview and record review on 4/8/2026 at 2:39 pm, with the facility's Director of Nursing (DON), of Resident 5's medical records (PointClickCare - PCC, a cloud-based software used in long-term and post-acute care facilities and chart), the DON stated, the MRR was a monthly recommendation from the pharmacy consultant that licensed nurses should carry out. The Facility's DON stated, the purpose of MRR was for the pharmacy consultant to review if residents were receiving proper medications and to eliminate unnecessary medication use. The DON stated, Medical Doctor (MD) agreed to discontinue Benadryl PRN as ordered. The DON stated, Diphenhydramine hydrochloride tablet 25 mg, one tablet by mouth every six hours as needed for itchiness was not discontinued as recommended by pharmacist. The DON stated, Licensed Nurse (LN) received the order from MD on 3/31/2026 to discontinue Benadryl order and LN might forgot to discontinue the order.During a review of the Policy and Procedure (P&P), titled, Medication Regimen Review, revised 12/19/2022, the P&P indicated The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.

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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** Based on observation, interview and record review, the facility failed to provide a minimum of 80 square feet (sq. ft., unit of measurement) per resident area for twelve (12) out of thirteen (13) resident rooms (Rooms 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, and 14). This deficient practice had the potential to impact the ability to provide safe nursing care and privacy to the residents.Findings: During an interview with the facility's Administrator (ADM) on 4/9/2026 at 12:14 PM, the ADM stated the facility would like to request a room waiver (a document recording the waiving of a right or claim) for Rooms 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, and 14. The ADM stated nothing was changed and the number of bed occupancy in the 12 rooms. During a review of the facility's letter to request for room waiver dated 4/7/2026, the room waiver request indicated there was ample room to accommodate wheelchairs (a chair fitted with wheels for use as a means of transport by a person who was unable to walk as a result of illness, injury, or disability) and other medical equipment, as well as space for mobility and movement of ambulatory residents. The letter indicated there was adequate space for nursing care, and the health and safety of residents occupying these rooms were not in jeopardy. The letter further indicated these rooms were in accordance with the special needs of the residents, and did not have an adverse effect on the residents' health and safety or impedes the ability of any resident in the rooms to attain his or her highest practicable well-being. The room waiver letter indicated the following: Room Sq. Ft. Beds1 304 42 304 43 304 4 4 304 46 304 47 304 4 8 304 4 9 304 410 304 411 304 412 304 4 14 304 4 During the Health Recertification Survey conducted from 4/7/2026 to 4/9/2026, Rooms 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, and 14 had adequate space, nursing care and comfort, and privacy was provided to the residents. The residents were observed to have enough space to move freely inside the rooms. There was adequate room for the operation and use of wheelchairs, walkers (a device that gave additional support to maintain balance or stability while walking), and Hoyer lift (a mechanical device used to lift and/or transfer a person from place to place). Each resident inside the affected rooms had beds and bedside tables with drawers. The room size did not affect the care and services provided by the staff to the residents when staff were observed providing care to the residents. During a concurrent observation and interview with Resident 7 on 4/7/2026 at 10:38 AM, in Resident 7's room (room [ROOM NUMBER]), Resident 7 was sitting in wheelchair. Observed two certified nurse assistants (CNA, unidentified) were moving the Hoyer lift out of room [ROOM NUMBER] with no concerns. Resident 7 stated Resident 7 had enough space in the room to move around with no concerns. During an interview with CNA 3 on 4/9/2026 at 12:30 PM, CNA 3 stated CNA 3 had enough space to move around in all the rooms to provide resident care. CNA 3 stated she did not have any incident of bumping CNA 3 into any room furniture or getting hurt in the residents' rooms.