

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679</b></p> <p>Based on interview and record review, the facility failed to inform one of three sampled residents' (Resident 34) Family Member (FM) 3, who was Resident 34's emergency contact, of an unwitnessed fall on 2/22/2025.</p> <p>This deficient practice resulted in FM 3 being unaware of Resident 34's fall which resulted in Resident 34's family being concerned of Resident 34's well-being.</p> <p>Findings:</p> <p>During a review of Resident 34's Admission Record (Face Sheet), the Face Sheet indicated Resident 34 was admitted to the facility on [DATE] with diagnoses that included nontraumatic subdural hemorrhage (a collection of blood that accumulates between the brain the inner lining of the skull without any prior head trauma), dementia (a progressive state of decline in mental abilities), and urinary tract infection ([UTI], an infection in the bladder/urinary tract).</p> <p>During a review of Resident 34's Minimum Data Set ([MDS], dated 2/12/2025, the MDS indicated Resident 34's cognitive skills (process of thinking) for daily decision making was severely impaired. The MDS indicated Resident 34 was dependent on staff's assistance with eating, oral hygiene, toileting, bathing, dressing, personal hygiene, and moving from a sit to stand position.</p> <p>During a review of Resident 34's History and Physical Examination (H&amp;P), dated 2/7/2025, the H&amp;P indicated Resident 34 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 34's Situation, Background, Assessment, Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents) report, dated 2/22/2025, the SBAR report indicated on 2/22/2025 at 9:40 p.m., Resident 34 had an unwitnessed fall and was found sitting on the floor next to his bed.</p> <p>During a review of Resident 34's Interdisciplinary Team ([IDT], a group of healthcare professionals with various areas of expertise who work together towards the goals of the residents) Note, dated 2/23/2025, the IDT Note indicated, Upon further investigation, it was found that the family had not been notified of the fall incident [on 2/22/2025]. The family expressed concern regarding the events.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 555112	If continuation sheet Page 1 of 29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/13/2025 at 11:32 a.m., with the Director of Nursing (DON), the DON stated Resident 34 had an unwitnessed fall on 2/22/2025. The DON stated Resident 34 was scheduled to discharge from the facility on 2/23/2025 and FM 1 and FM 2 arrived at the facility to bring Resident 34 home. The DON stated upon their arrival to the facility, FM 1 and FM 2 were upset FM 3 was not notified of Resident 34's fall on 2/22/2025. The DON stated FM 3 was listed as Resident 34's first emergency contact and should have been notified. The DON stated notifying FM 3 was important so FM 3 could be aware of what was going on with Resident 34. The DON stated by not notifying FM 3 of the resident's fall, FM 3 was unaware of the incident and caused FM 3 to lose trust in the facility's ability to care for Resident 34.</p> <p>During an interview on 3/13/2025 at 4:10 p.m., with FM 2, FM 2 stated it was the facility's responsibility to notify her of any incident regarding Resident 34's health and well-being. FM 2 stated FM 3 was not notified of Resident 34's fall on 2/22/2025 and FM 1 and herself (FM 2) were unaware of the incident, upon their arrival to the facility to take Resident 34 home, until Resident 34's roommate informed FM 2.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Fall Management Program, revised 3/13/2021, the P&amp;P indicated, after a fall incident, the licensed nurse will notify the Resident's attending physician and Resident's responsible party of the fall incident.</p> <p>45009</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	

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)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47679</p> <p>Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 34) had a safe discharge by failing to follow Resident 34's care and whereabouts after Resident 34 was transferred to general acute care hospital (GACH) 1 after an unwitnessed fall.</p> <p>This deficient practice resulted in the facility being misinformed of Resident 34's whereabouts and had the potential to result in Resident 34's discharge needs being unmet.</p> <p>Findings:</p> <p>During a review of Resident 34's Admission Record (Face Sheet), the Face Sheet indicated Resident 34 was admitted to the facility on [DATE] with diagnoses that included nontraumatic subdural hemorrhage (a collection of blood that accumulates between the brain the inner lining of the skull without any prior head trauma), dementia (a progressive state of decline in mental abilities), and urinary tract infection ([UTI], an infection in the bladder/urinary tract).</p> <p>During a review of Resident 34's Minimum Data Set ([MDS], dated 2/12/2025, the MDS indicated Resident 34's cognitive skills (process of thinking) for daily decision making was severely impaired. The MDS indicated Resident 34 was dependent on staff's assistance with eating, oral hygiene, toileting, bathing, dressing, personal hygiene, and moving from a sit to stand position.</p> <p>During a review of Resident 34's History and Physical Examination (H&amp;P), dated 2/7/2025, the H&amp;P indicated Resident 34 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 34's situation, background, assessment, recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 2/22/2025, the SBAR indicated on 2/22/2025 at 9:40 p.m., Resident 34 had an unwitnessed fall and was found sitting on the floor next to his bed.</p> <p>During a review of Resident 34's Nurse's Notes, dated 2/23/2025 and timed at 10 a.m., the Nurse's Notes indicated Family Member (FM) 1 was informed of Resident 34's fall on 2/22/2025 and FM 1 requested for Resident 34 to be sent to GACH 1 for further evaluation.</p> <p>During a review of Resident 34's Nurse's Notes, dated 2/23/2025 and timed at 10:30 a.m., the Nurse's Notes indicated Physician 1 ordered to send Resident 34 to GACH 1 for further evaluation due to Resident 34 falling and Resident 34's history of having a subdural hemorrhage (a collection of blood that accumulates between the brain and the outermost layer of tissue covering the brain).</p> <p>During a review of Resident 34's Progress Notes, dated 2/23/2025 and timed at 1:20 p.m., the Progress Note indicated Resident 34 was transferred to GACH 1.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	
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)		
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/13/2025 at 4:10 p.m., with FM 2, FM 2 stated on 2/23/2025, she and FM 1 went to the facility to bring Resident 34 home because Resident 34 was being discharged . FM 2 stated when they arrived at the facility, they became aware of Resident 34's fall on 2/22/2025. FM 2 stated the facility was unable to give them details of Resident 34's fall, therefore, FM 1 and FM 2 requested for the facility to send Resident 34 to the GACH for further evaluation. FM 2 stated FM 1 and FM 2 did not sign the discharge paperwork because Resident 34 was being transferred to GACH 1. FM 2 stated Resident 34 was transferred to GACH 1 in the afternoon on 2/23/2025 where GACH 1's physician recommended Resident 34 to be transferred to GACH 2 for a neurosurgery (surgical specialty that focuses on the diagnosis and treatment of disorders and injuries affecting the brain, spinal cord, and nerves) consult due to subdural hemorrhage. FM 2 stated on the evening of 2/23/2025, Resident 34 was transferred from GACH 1 to GACH 2. FM 2 stated when Resident 34 was evaluated at GACH 2, the neurosurgeon informed FM 2 that surgery was not recommended to treat Resident 34's subdural hemorrhage in order to maintain the resident's quality of life. FM 2 stated on the evening of 2/25/2025, Resident 34 was discharged from GACH 2 to home.</p> <p>During an interview on 3/13/2025 at 4:54 p.m., with the Admission Coordinator (AC), the AC stated when a resident was transferred to the GACH, she was responsible for calling the GACH the following day to gather information on the resident's status, whether the resident was admitted to the GACH, and the expected discharge date . The AC stated gathering this information was essential to know of the resident's well-being and to ensure the resident was safe. The AC stated after Resident 34 transferred to GACH 1 on 2/23/2025, she called GACH 1 on 2/25/2025 to inquire on Resident 34's status. The AC stated the case manager at GACH 1 informed her that Resident 34 was discharged home. The AC stated after she was informed of Resident 34's discharge, she informed the Director of Nursing (DON), but did not call Resident 34's family to follow up on Resident 34's well-being. The AC stated after being notified that Resident 34 was discharged home, she should have called Resident 34's family to ensure Resident 34 was well and to provide any assistance the resident may need after Resident 34's stay at GACH 1. The AC stated Resident 34 was not officially discharged from the facility and the facility was responsible for ensuring Resident 34 was safe. The AC stated because she did not conduct a follow-up call to Resident 34's family. The AC stated she was unaware that Resident 34 was transferred to GACH 2. The AC stated GACH 2 called the facility, on 2/26/2025, to inquire if Resident 34 previously resided in the facility. The AC stated she did not find out why GACH 2 inquired about Resident 34's previous residency. The AC stated due to Resident 34's transfer to GACH 2, the facility was responsible for calling GACH 2 for Resident 34's status and to assist in Resident 34's discharge needs. The AC stated she did not conduct a follow-up with Resident 34's family when she was misinformed of Resident 34's discharge to home because Resident 34 was initially due to discharge home from the facility on 2/23/2025 and all medical devices and appointments were confirmed. The AC stated because the facility did not conduct the necessary follow-ups with Resident 34's family, the facility was unaware of Resident 34's transfer to GACH 2 and of any additional needs and assistance Resident 34 may have needed on his discharge home on 2/25/2025. The AC stated conducting necessary follow-ups and following Resident 34's transfer from GACH 1, to GACH 2, then to his home, would ensure Resident 34 had a safe discharge. The AC stated due to the lack of follow-ups and inappropriate discharge, Resident 34 was at risk of not receiving assistance and post-discharge care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	

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)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/13/2025 at 5:08 p.m., with the Director of Nursing (DON), the DON stated Resident 34 was scheduled for discharge from the facility on 2/23/2025, however, was transferred to GACH 1 per FM 1 and FM 2's request. The DON stated at the time, she did not feel a follow-up call to Resident 34's home was necessary due to Resident 34's prior discharge plan. The DON stated because Resident 34 was discharged from GACH 1, any additional discharge needs would be fulfilled by GACH 1. The DON stated the facility was responsible for Resident 34's well-being because Resident 34 was not officially discharged from the facility on 2/23/2025. The DON stated the facility should have called Resident 34's family to ensure Resident 34 was safe and did not require any additional assistance. The DON stated when the AC received a call from GACH 2, the AC should have inquired further about Resident 34's status. The DON stated this was a missed opportunity to gain knowledge of Resident 34's transfer to GACH 1 to GACH 2. The DON stated because there was no follow-up on Resident 34's status, the facility was unaware of Resident 34's transfer to GACH 2. The DON stated the facility was responsible for ensuring it was appropriate and safe for Resident 34 to be discharged home. The DON stated the sole purpose of following Resident 34's whereabouts was to ensure Resident 34 was safe. The DON stated because the facility did not follow-up on Resident 34's whereabouts, Resident 34 was at risk of being discharged inappropriately and unsafely.</p> <p>During an interview on 3/13/2025 at 5:41 a.m., with the Administrator (ADM), the ADM stated the facility did not have a policy that indicated how to follow-up with a resident's transfer from the facility to the GACH and to home. The ADM stated it was the standard of practice to follow up with the resident throughout all aspects of care after transfer and to discharge.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Notice of Transfer/Discharge, revised 10/2017, the P&amp;P indicated the facility may not transfer or discharge the resident unless the transfer or discharge is appropriate because the resident's health as improved sufficiently so the resident no longer needs the services provided by the facility.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009</b></p> <p>Based on interview and record review, the facility failed to develop a care plan addressing a resident's diagnosis of clostridioides difficile ([C. diff], a germ that causes diarrhea and inflammation of the colon [organ in the digestive system that stores and processes waste before it's eliminated from the body]) for one out of eight sampled residents (Resident 56).</p> <p>This deficient practice had the potential to delay and negatively affect the delivery of care for Resident 56.</p> <p>Findings:</p> <p>During a review of Resident 56's Admission Record, the admission record indicated Resident 56 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses of respiratory failure (serious condition that makes it difficult to breathe, lungs cannot get enough oxygen into the blood) and atrial fibrillation (heart's upper chambers (atria) beat out of coordination with the lower chambers (ventricles), can lead to blood clots in the heart).</p> <p>During a review of Resident 56's History and Physical (H&amp;P) dated 1/26/2025, the H&amp;P indicated Resident 56 had the capacity to understand and make decisions.</p> <p>During a review of Resident 56's Minimum Data Set (MDS), (a resident assessment tool), dated 3/7/2025, the MDS indicated Resident 56's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was moderately impaired. The MDS indicated Resident 56 required moderate assistance (helper does less than half the effort) for lower body dressing, toileting hygiene and personal hygiene. The MDS indicated Resident 56 required supervision for oral hygiene and upper body dressing.</p> <p>During a review of Residents 56's electronic medical record, unable to locate a completed care plan for Resident 56's diagnosis of clostridioides difficile (C. diff).</p> <p>During an interview on 3/13/2025 at 11:02 a.m. with the Infection Preventionist Nurse (IPN), the IPN stated Resident 56 was diagnosed with C. diff on 3/7/2025. The IPN stated a care plan should have been developed for Resident 56's new diagnosis of C.diff. The IPN stated a care plan was used to monitor residents and the care plan had interventions and goals for staff to follow for residents' plan of care. The IPN stated a C. diff care plan should include a goal to minimize signs and symptoms of C. diff, have interventions to prevent further signs and symptoms of C. diff and prevent dehydration. The IPN stated a care plan should have target dates of when goals and interventions will be met.</p> <p>During an interview on 3/13/2025 at 12:27 p.m. with the Director of Nursing (DON), the DON stated a care plan was developed to provide a plan of care for each resident. The DON stated residents' orders and medical conditions were care planned. The DON stated a care plan had interventions that must be followed and whose effectiveness must be checked. The DON stated Resident 56's new diagnosis of C. diff needed a care plan to provide guidance and a plan of care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's Policy and Procedure (P&amp;P) titled Comprehensive Person-Centered Care Planning, dated 11/2028, the P&amp;P indicated the facility would provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being. The P&amp;P indicated the comprehensive care plan will be reviewed and revised when there was an onset of new problems, change of condition and when there was a change in care.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45009</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care per the physician's orders for three residents (Residents 35, 55, and 124) out of 16 sampled residents by failing to ensure:</p> <ol style="list-style-type: none"> <li>1. Resident 124's blood sugar level was monitored.</li> <li>2. Resident 55's surgical dressing was changed.</li> <li>3. Licensed Vocational Nurse (LVN) 3 administered regular insulin (a hormone that removed excess sugar from the blood, could be produced by the body or given artificially via medication) 30 minutes prior to Resident 35's meal.</li> </ol> <p>These deficient practices had the potential to not meet Resident's 35, 55, and 124's overall healthcare needs.</p> <p>Findings:</p> <p>1. During a review of Resident 124's Admission Record, the admission record indicated Resident 124 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus ([DM], a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high sugar level) and multiple fractures (broken bones) of the ribs.</p> <p>During a review of Resident 124's History and Physical (H&amp;P) dated 3/6/2025, the H&amp;P indicated Resident 124 was alert and oriented. The H&amp;P indicated Resident 124 had a Glasgow Coma Scale score of 15 ([GCS] indicates a patient is fully awake, responsive, and has no problems with thinking or memory, representing the highest possible score).</p> <p>During a review of Resident 124's Minimum Data Set (MDS), (a resident assessment tool), dated 3/13/2025, the MDS indicated Resident 124's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 124 required supervision for upper body dressing and oral hygiene. The MDS indicated Resident 124 required set up assistance for eating.</p> <p>During a review of Resident 124's Order Summary Report, dated 3/9/2025, the order summary report indicated the following orders:</p> <ol style="list-style-type: none"> <li>1. If Resident 124's blood glucose (level of sugar in the bloodstream) was below 70 or above 350 to call the doctor.</li> <li>2. Monitor for any episodes of hyperglycemia (high blood sugar level in the bloodstream).</li> <li>3. Monitor for any episodes of hypoglycemia (low blood sugar level in the bloodstream).</li> </ol> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Administer Metformin HCl (medication used to lower blood sugar levels) tablet 500 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth two times a day for DM.</p> <p>During a review of Resident 124's electronic medical record, unable to locate doctors orders indicating to monitor and check Resident 124's blood sugar levels.</p> <p>During a review of Resident 124's Care Plan for DM, dated 3/9/2025, the care plan indicated Resident 124's goal was to be free from any signs and symptoms of hyperglycemia or hypoglycemia. The interventions indicated to administer metformin as ordered, document for side effects and effectiveness, and inform the doctor if the blood glucose was below 70 or above 350.</p> <p>During an interview on 3/11/2025 at 9:34 a.m. with Resident 124, in Resident 124's room, Resident 124 stated the licensed nurses did not want to check his blood sugar levels. Resident 124 stated he checked his blood sugar level every day when he was at home. Resident 124 stated he did not understand why the licensed nurses wanted to give him medication for his DM without knowing what his blood sugar level was. Resident 124 stated he asked the licensed nurses to check his blood sugar, and they told him there was no need to check it. Resident 124 stated he wanted his blood sugar checked because he wanted to know if his blood sugar was high.</p> <p>During an interview on 3/11/2025 at 9:58 a.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated she had given Resident 124 metformin that morning (3/11/2025) at 9:00 a.m. LVN 1 stated she did not know Resident 124's blood sugar level for 3/11/2025. LVN 1 stated she did not need to know Resident 124's blood sugar level. LVN 1 stated she did not know how to check for Resident 124's blood sugar level and needed to request help from staff. LVN 1 stated Resident 124 did not have an order to check his blood sugar level and that was why it was not checked.</p> <p>During an interview on 3/13/2025 at 12:19 p.m. with the Director of Nursing (DON), the DON stated it was important to check all diabetic residents blood sugar levels to make sure their medication was effective. The DON stated if residents blood sugar levels are not checked staff would not be aware if the residents' blood sugar levels was high or low. The DON stated licensed nurses should check blood sugar levels for residents taking metformin at least once a day. The DON stated licensed nurses must make sure the order for checking blood sugar levels are available.</p> <p>2. During a review of Resident 55's Admission Record, the admission record indicated Resident 55 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with end stage of renal disease ([ESRD] irreversible kidney failure) and chronic kidney disease (gradual loss of kidney function, kidneys are unable to filter wastes and excess fluids from blood).</p> <p>During a review of Resident 55's MDS, dated [DATE], the MDS indicated Resident 55's cognitive skills for daily decision making was intact. The MDS indicated Resident 55 required moderate assistance (the helper does less than half the effort) for upper body dressing, eating and oral hygiene. The MDS indicated Resident 55 required maximal assistance (helper does more than half the effort) for toileting hygiene, shower/bathing and lower body dressing.</p> <p>During a review of Resident 55's electronic medical record, unable to locate doctors order to change Resident's left arm surgical dressing.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/10/2025 at 10:52 a.m. with Resident 55, Resident 55 stated she was concerned about her surgical dressing because it had not been changed since she had surgery. Resident 55 stated the dressing looked dirty and wanted it to be changed. Resident 55 stated she had surgery over 10 days ago and had the same dressing. Resident 55 stated staff did not offer to change the dressing.</p> <p>During an interview on 3/12/2025 at 1:33 p.m. with Treatment Nurse (TN) 1, TN 1 stated Resident 55's dressing was not changed because she did not have orders. TN 1 stated licensed nursing staff should have followed up with the doctor to ask how often he wanted Resident 55's dressing to be changed. TN 1 stated it was important to change the dressing to prevent infection.</p> <p>During an interview on 3/13/2025 at 12:48 p.m. with the DON, the DON stated post-surgical residents dressing must be changed according to the doctors' orders. The DON stated if a resident did not have an order for a dressing change, she expected her licensed nurses to call the doctor to get orders for a dressing change. The DON stated Resident 55's dressing should have been changed every day.</p> <p>49900</p> <p>3. During a review of Resident 35's Admission Record, the admission record indicated Resident 35 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnosis of DM, anemia (a condition where the body did not have enough healthy red blood cells), and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 35's MDS, dated [DATE], the MDS indicated Resident 35's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 35 required supervision with eating; moderate assistance with oral and personal hygiene; and maximal assistance with toileting hygiene, showering/bathing self, transferring in and out of bed, and walking.</p> <p>During a review of Resident 35's H&amp;P, dated 1/23/2025, the H&amp;P indicated Resident 35 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 35's Order Summary Report, dated 1/24/2025, the report indicated an order to administer regular insulin subcutaneously (beneath the skin) before meals for DM.</p> <p>During a review of the facility's mealtime schedule, undated, the schedule indicated lunch should arrive at Resident 35's station at 12:55 p.m.</p> <p>During a medication pass observation on 3/11/2025 at 11:31 a.m., with LVN 3, observed LVN 3 administer regular insulin 4 units to Resident 35. Resident 35 had no food, snack, or juice after receiving the medication.</p> <p>During an observation on 3/11/2025 at 12:11 p.m. in Resident 35's room, there was no food, snack, or juice observed at Resident 35's bedside.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/11/2025 at 12:16 p.m. with LVN 3, LVN 3 stated Resident 35's lunch had not yet arrived. LVN 3 stated the regular insulin's onset time (when the medication first began to take effect) was 30 minutes to 60 minutes. LVN 3 stated she should administer the regular insulin to Resident 35 around 12:15 p.m. because lunch arrived around 12:45 p.m., to prevent hypoglycemia. LVN 3 stated Resident 35 was prone to develop hypoglycemia with signs and symptoms of sweating, excessive thirst, and confusion.</p> <p>During an interview on 3/12/2025 at 2:53 p.m. with the DON, the DON stated the regular insulin onset time was 30 minutes, and the nurse should administer regular insulin 30 minutes before meals. The DON stated Resident 35 should have something to eat within 30 minutes of regular insulin administration to prevent hypoglycemia. The DON stated it was the standard of practice.</p> <p>During an interview on 3/12/2025 at 4:51 p.m. with the Administrator (ADM), the ADM stated there were no policy specified that nurse should administer regular insulin 30 minutes prior to meals because it was the standard of practice.</p> <p>During a review of facility's policy and procedure (P&amp;P) titled Quality of Care dated 11/2019, the P&amp;P indicated it was the facility's purpose to ensure residents received treatment and care in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and physiological needs.</p> <p>During a review of the facility's P&amp;P titled Diabetic Management dated 1/2021, the P&amp;P indicated the purpose for the diabetic management program was to address the resident 's individual needs with respect to disease management and nutritional approaches and interventions and to monitor and evaluate resident outcome. The P&amp;P indicated upon admission the licensed nurse will need to assess residents blood sugar testing experience. The P&amp;P indicated for managing diabetes, licensed nurses must check blood sugars and encourage a standing order for blood sugars testing managing physician or licensed independent providers.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	
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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49900</p> <p>Based on observation, interview, and record review, the facility failed to ensure the interventions to prevent formation and/ or worsening of pressure ulcers/injuries (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) were implemented for two of two residents (Resident 54 and 56) when the following occurred:</p> <ol style="list-style-type: none"> <li>1. Resident 54's low air loss mattress (LALM, a mattress designed to distribute body weight over a broad surface area to help prevent skin breakdown) did not reflect the resident's correct weight on 3/10/2025.</li> <li>2. Resident 56's LALM did not reflect the resident's correct weight.</li> </ol> <p>This deficient practice placed Resident 54 and 56 at risk for worsened condition of their exiting pressure injuries, and/ or the development of new pressure injuries.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During an observation on 3/10/2025 at 10:02 a.m., in Resident 54's room, Resident 54 was observed lying on a low air loss mattress (LALM, a mattress designed to distribute body weight over a broad surface area to help prevent skin breakdown). The LALM was set for 340 pounds (lbs., a unit of measuring mass) to 520 lbs.</li> </ol> <p>During an observation on 3/10/2025 at 12:31 a.m., in Resident 54's room, Resident 54 was observed lying on a LALM. The LALM was set for 340 pounds to 520 lbs.</p> <p>During a review of Resident 54's Admission Record (face sheet), the face sheet indicated Resident 54 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnosis of diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), and anemia (a condition where the body did not have enough healthy red blood cells).</p> <p>During a review of Resident 54's Minimum Data Set (MDS - a resident assessment tool), dated 2/26/2025, the MDS indicated Resident 54's cognitive (ability to think, remember, and reason) skills for daily decision making was severely impaired. The MDS indicated Resident 54 was dependent (helper did all the effort) for self-care (eating, oral hygiene, toileting hygiene, and showering/bathing self) and mobility. The MDS indicated Resident 54 had impairments on the lower extremities (legs) and used a wheelchair for mobility. The MDS indicated Resident 54 was at risk of developing pressure injuries and had one unstageable pressure injury (a wound where the true depth and stage could not be determined because the base of the wound was covered by slough [yellow, tan, gray, green, or brown] and/or eschar [tan, brown, or black]). The MDS indicated Resident 54 had a pressure reducing device for the bed and pressure injury care.</p> <p>During a review of Resident 54's History and Physical (H&amp;P), dated 11/4/2024, the H&amp;P indicated Resident 54 did not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	

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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 54's Braden Scale (a tool helped determine the risk of a resident developing a pressure injury), dated 2/26/2025, the scale indicated Resident 54 was at high risk of developing a pressure injury.</p> <p>During a review of Resident 54's Order Summary Report dated 3/12/2025, the report indicated a physician order dated 3/9/2025, LALM every shift for wound management and prevention.</p> <p>During a review of Resident 54's Weight Summary Record, dated 3/12/2025, the record indicated Resident 54 weighed 163 lbs. on 3/4/2025.</p> <p>During a review of Resident 54's Wound Assessment (by the wound specialist), dated 3/4/2025, the assessment indicated Resident 54 had an unstageable pressure injury and remained at high risk for wound decline and delayed healing.</p> <p>During a concurrent interview and picture review on 3/12/2025 at 9:52 a.m. with Treatment Nurse (TN) 1, the picture taken of Resident 54's LALM pump setting on 3/10/2025 at 10:05 a.m. was reviewed. TN 1 stated the picture revealed Resident 54's LALM was set up for a weight between 340 lbs. to 520 lbs. TN 1 stated the LALM's purpose was to minimize pressure for residents at high risk of developing wounds. TN 1 stated the LALM was for hospice (compassionate care for people who were near the end of life provided at the person's home or within a health care facility) residents, and residents with hip fractures (broken bone), immobility concerns, and pressure injuries. TN 1 stated the LALM aided healing and prevention of further development of pressure injuries and health decline for residents. TN 1 stated the LALM setting was according to the resident's weight and comfort. TN 1 stated Resident 54 received a LALM because Resident 54 had a small wound which was not closing. TN 1 stated the LALM setting should reflect Resident 54's weight. TN 1 stated she checked the LALM settings three times a shift by checking that the LALM pump settings reflect the resident's weight. TN 1 stated maybe the nurse changed Resident 54's LALM setting. TN 1 stated the wrong LALM setting increased the risk of pressure injury development for residents. TN 1 stated incorrect settings affected the quality of care and was not good for the resident's skin. TN 1 stated incorrect settings was not an acceptable standard of practice.</p> <p>During an interview on 3/12/2025 at 2:53 p.m. with the Director of Nursing (DON), the DON stated the LALM would not be effective with the wrong setting. The DON stated the negative outcome of having the wrong LALM setting would cause worsening of the resident's wound. The DON stated the licensed nurses and treatment nurse were responsible for ensuring the correct LALM settings.</p> <p>45009</p> <p>2. During an observation on 3/10/2024 at 12:10 p.m., in Resident 56's room, Resident 56's LALM was observed at 220 pounds.</p> <p>During an observation on 3/11/2024 at 10:48 a.m., in Resident 56's room, Resident 56's LALM was observed to 220 pounds.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	

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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 56's face sheet, the face sheet indicated Resident 56 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses of respiratory failure (serious condition that made it difficult to breathe, lungs could not get enough oxygen into the blood) and atrial fibrillation (heart's upper chambers [atria] beat out of coordination with the lower chambers [ventricles], could lead to blood clots in the heart).</p> <p>During a review of Resident 56's MDS, dated [DATE], the MDS indicated Resident 56's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 56 required moderate assistance for lower body dressing, toileting hygiene and personal hygiene. The MDS indicated Resident 56 required supervision for oral hygiene and upper body dressing.</p> <p>During a review of Resident 56's H&amp;P dated 1/26/2025, the H&amp;P indicated Resident 56 had the capacity to understand and make decisions.</p> <p>During a review of Resident 56's Weight and Vital Summary, dated 3/4/2025, the weight and vital summary indicated Resident 56 weighed 130 pounds.</p> <p>During an interview on 3/10/2025 at 12:12 p.m. with Resident 56, Resident 56 stated she did not know what the mattress was for. Resident 56 stated her bed felt uncomfortable. Resident 56 stated it was hard for her to move around in bed.</p> <p>During an interview on 3/12/2025 at 1:56 p.m. with TN 1, TN 1 stated she was not aware Resident 56's LALM was set to 220 pounds. TN 1 stated the LALM should be set between 120 to 150 pounds. TN 1 stated Resident 56's LALM setting was not beneficial for the resident and would not prevent skin breakdown. TN 1 stated if the LALM was overinflated, it would cause LALM to be hard and it would be like a regular mattress. TN 1 stated if the LALM was underinflated the resident would be touching the bed frame, be uncomfortable, and there would be a high level of pressure to Resident 56's skin. TN 1 stated if the LALM was not set correctly, the LALM would not be beneficial for skin maintenance or skin injury prevention.</p> <p>During an interview on 3/13/2025 at 1:27 p.m. with the DON, the DON stated all LALMs must be checked every day by all staff entering resident's rooms. The DON stated staff must make sure the LALM was set according to the residents' weight.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Mattresses, dated 1/1/2012, the P&amp;P indicated the purpose for the LALM would be explained to resident. The P&amp;P indicated the staff would make sure LALM was inflating properly.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	

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)
<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679</b></p> <p>Based on observation, interview, and record review, the facility failed to label one of one sampled resident's (Resident 69) peripheral intravenous line's ([IV], a soft, flexible tube placed inside a vein to administer medications or fluids) dressing with the date and time of insertion and the initial of the inserting nurse.</p> <p>This deficient practice had the potential to result in Resident 69's IV to be left in place longer than seven days, which could cause preventable infection.</p> <p>Findings:</p> <p>During a review of Resident 69's Admission Record (Face Sheet), the Face Sheet indicated Resident 69 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included presence of an artificial right knee joint (surgical procedure where the damaged knee joint is replaced with metal and plastic), end stage renal disease ([ESRD], irreversible kidney damage), AND arthritis (joint inflammation).</p> <p>During a review of Resident 69's Minimum Data Set ([MDS], a resident assessment tool), dated 2/9/2025, the MDS indicated Resident 69's cognition (process of thinking) was intact. The MDS indicated Resident 69 required maximal assistance (helper does more than half the effort) with oral hygiene, bathing, upper body dressing, and personal hygiene. The MDS indicated Resident 69 had a knee replacement. The MDS indicated Resident 69 took an antibiotic (medication used to treat a bacterial infection).</p> <p>During a review of Resident 69's History and Physical (H&amp;P), dated 2/3/2025, the H&amp;P indicated Resident 69 had the capacity to understand and make decisions.</p> <p>During a review of Resident 69's Physician's Orders, dated 2/2/2025, the Physician's Orders indicated to:</p> <p>a. Give cefazolin (an antibiotic, used to treat infections) 1 gram (unit of measurement), intravenously (into the vein), every day for six weeks, for an infected right knee arthroplasty (surgery to restore the function of a joint).</p> <p>b. Rotate peripheral IV site every seven days and as needed.</p> <p>During an observation on 3/10/2025 at 9:37 a.m., in Resident 69's room, observed Resident 69's peripheral IV. The peripheral IV was inserted in her right hand with a dressing over the peripheral IV site without a date, time, and initial.</p> <p>During an interview on 3/12/2025 at 11:19 a.m., with Registered Nurse (RN) 1, RN 1 stated the RNs were responsible for changing a resident's peripheral IV according to the physician's order. RN 1 stated after a peripheral IV was inserted, the RN was responsible for labeling the dressing with the date and time of insertion and the initial of the RN. RN 1 stated labeling the dressing allowed the RNs to know when it was inserted and when the peripheral IV site needed to be changed.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	

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)
<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/13/2025 at 10:40 a.m., with the Director of Nursing (DON), the DON stated when a resident had a peripheral IV, the site would be rotated, every three or seven days, according to the physician's order. The DON stated when a new peripheral IV site was started, the RN was responsible for labeling the dressing with the date, time, and their initial. The DON stated labeling the dressing was important for the RNs to keep track of how long the peripheral IV site was in place and to change the site when needed. The DON stated without the necessary label, Resident 69 was at risk of having her peripheral IV site in longer than it was supposed to, which could lead to infection.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, IV Peripheral Therapy, undated, the P&amp;P indicated after a peripheral IV was inserted, the dressing must be labeled with the date, time, size of catheter, and initials.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	

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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49900</p> <p>Based on observation, interview, and record review, the facility failed to display a No Smoking sign on the inside and outside of the resident's room for one of eight sampled resident's (Resident 14) use of an oxygen concentrator (a medical device that extracted oxygen from the air and delivered it to resident for breathing).</p> <p>This deficient practice had the potential to cause fire hazards to all residents, families, visitors, staff, and residents' properties, and result in serious harm and injury.</p> <p>Findings:</p> <p>During observations on 3/10/2025 at 9:33 a.m., on 3/10/2025 at 1:31 p.m., and on 3/12/2025 at 9:05 a.m., outside Resident 14's room, there was no No Smoking signage observed on the room entrance door. Resident 14 was observed lying in bed with an oxygen concentrator at the bedside. There was no No Smoking signage observed in the room.</p> <p>During a review of Resident 14's Admission Record (face sheet), the face sheet indicated Resident 14 was admitted to the facility on [DATE]. Resident 14's diagnoses included pneumonia (an infection/inflammation in the lungs), pain, and anxiety (feelings of fear, dread, and uneasiness).</p> <p>During a review of Resident 14's Minimum Data Set (MDS, a resident assessment tool), dated 2/3/2025, the MDS indicated Resident 14's cognitive (the ability to think and process information) skills for daily decision making was severely impaired. The MDS indicated Resident 14 required maximal assistance (helper did more than half the effort) in eating and oral hygiene and was dependent (helper did all the effort, resident did none of the effort to complete the activity) for toileting hygiene, showering/bathing, personal hygiene, and transferring in and out of bed.</p> <p>During a review of Resident 14's History and Physical (H&amp;P) dated 1/30/2025, the H&amp;P indicated Resident 14 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 14's Order Summary report, as of 3/12/2025, the summary indicated an order, dated 3/11/2025, to administer oxygen 2 to 5 liters (L, a unit for measuring the volume of a liquid) to maintain oxygen saturation (a measure of how much oxygen was in blood) 94 percent (%) or above as needed for shortness of breath (SOB).</p> <p>During a concurrent observation and interview on 3/11/2025 at 2:22 p.m. with Registered Nurse (RN) 1, outside Resident 14's room, observed there was no No Smoking signage on the room entrance door. Resident 14 was observed lying in bed with the oxygen concentrator at the bedside. There was no No Smoking sign observed inside the room. RN 1 stated the oxygen concentrator was considered oxygen and needed to have the No Smoking signage for safety precautions. RN 1 stated it could be dangerous if people did not notice the oxygen concentrator. RN 1 stated an accident might happen because oxygen was a fire hazard. RN 1 stated the charge nurses and the RNs were responsible with ensuring the No Smoking sign was on the room entrance door.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	
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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/12/2025 at 2:53 p.m. with the Director of Nursing (DON), the DON stated there should be a No Smoking sign outside the door when the oxygen concentrator was stored at the bedside, even though the oxygen concentrator was not in use. The DON stated the purpose of the oxygen concentrator was to administer oxygen to the resident. The DON stated the negative outcome would be possible fire hazard and smoke inhalation. The DON stated all staff were responsible for ensuring safety.</p> <p>During a review of the facility policy and procedure (P&amp;P) titled, Oxygen Therapy, revised on 11/2017, the P&amp;P indicated a No Smoking sign would be prominently displayed wherever oxygen was being stored or administered.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45009</p> <p>Based on observation, interview, and record review, the facility failed to ensure the safe administration of medications for two of 20 sampled residents (Residents 125 and 29) by failing to:</p> <ol style="list-style-type: none"> <li>1. Ensure Licensed Vocational Nurse (LVN) 1 did not leave medications at Resident 124's bedside and failing to ensure Resident 124 took all his medications.</li> </ol> <p>This deficient practice had the potential to result in Resident 124 self-administering his own medications unsafely or potentially leading to another resident self-administering medications not prescribed to them.</p> <ol style="list-style-type: none"> <li>2. Ensure Resident 29's Ativan (an antianxiety medication used to treat anxiety [condition characterized by excessive and persistent worry or fear]) was accurately documented in the Medication Administration Record ([MAR], a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) on 3/10/2025.</li> </ol> <p>This deficient practice had the potential to result in Resident 29's anxiety being mismanaged and the Ativan dosage being increased unnecessarily.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During an observation on 3/11/2025 at 9:42 a.m. in Resident 124's room, observed one white pill directly on top of the bedside table, one empty medicine cup, and a half-filled water cup.</li> </ol> <p>During an observation on 3/11/2025 at 10:20 a.m. in Resident 124's room, observed Resident 124 walk to the restroom. Observed an orange pill on Resident 124's bed.</p> <p>During a review of Resident 124's Admission Record, the admission record indicated Resident 124 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus ([DM], a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high sugar level) and multiple fractures (broken bones) of ribs.</p> <p>During a review of Resident 124's History and Physical (H&amp;P) dated 3/6/2025, the H&amp;P indicated Resident 124 was alert and oriented. The H&amp;P indicated Resident 124 had a Glasgow Coma Scale score of 15 ([GCS] indicates a patient is fully awake, responsive, and has no problems with thinking or memory, representing the highest possible score).</p> <p>During a review of Resident 124's Minimum Data Set (MDS), (a resident assessment tool), dated 3/13/2025, the MDS indicated Resident 124's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 124 required supervision for upper body dressing and oral hygiene. The MDS indicated Resident 124 required set up assistance for eating.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 124's Care Plan for DM, dated 3/9/2025, the care plan indicated Resident 124's goal was to be free from any signs and symptoms of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar). The care interventions indicated to administer metformin (used to treat DM) medication as ordered and to document for side effects and effectiveness.</p> <p>During a review of Resident 124's Care Plan for Pain, dated 3/9/2025, the care plan indicated Resident 124's goal was for Resident 124 not to have an interruption of normal activities due to pain. The interventions indicated to administer analgesia (pain medication) per doctor's orders, and give methocarbamol (type of muscle relaxant) tablet as ordered.</p> <p>During a review of Resident 124's Order Summary Report, dated 3/9/2025, the order summary report indicated Resident 124 was to receive metformin HCl tablet 500 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth two times a day for DM.</p> <p>During a review of Resident 124's Order Summary Report, dated 3/9/2025, the order summary report indicated Resident 124 was to receive methocarbamol oral tablet 500 mg, give 1 tablet by mouth four times a day for muscle pain.</p> <p>During a review of Resident 124's Medication Administration Record (MAR), dated 3/11/2025, the MAR indicated Resident 124 received metformin HCl tablet 500 mg and methocarbamol oral tablet 500 mg at 9:00 a.m.</p> <p>During an interview on 3/11/2025 at 9:44 a.m. with Resident 124, in Resident 124's room, Resident 124 stated the nurse left a cup of pills at his bedside. Resident 124 stated he told the nurse that he did not want to take the pills and the nurse told Resident 124 that she was leaving the pills on his bedside table and he could take the medication when we was ready. Resident 124 stated he was not sure how many pills the nurse left on the bedside table but that one had fallen.</p> <p>During an interview on 3/11/2025 at 9:52 a.m. with Licensed Vocational Nurse (LVN) 1 in Resident 124's room, LVN 1 stated on 3/11/2025 she gave two medications to Resident 124. LVN 1 stated she gave Resident 124 one metformin pill and a methocarbamol tablet. LVN 1 stated Resident 124 swallowed both pills. LVN 1 stated she did not know how the metformin pill was on the bedside table because she thought the resident took his medication. LVN 1 stated she knew Resident 124 took the methocarbamol pill but was not sure if he took the metformin pill. LVN 1 stated she was supposed to watch Resident 124 swallow the medication but she did not. LVN 1 stated because Resident 124 did not take his metformin pill, he could potentially become hyperglycemic or hypoglycemic. LVN 1 stated if Resident 124 did not take his methocarbamol medication his pain would not be relieved. LVN 1 stated she was not supposed to leave medications at Resident 124's bedside table.</p> <p>During an interview on 3/13/2025 at 12:36 p.m. with the Director of Nursing (DON), the DON stated part of the medication administration process was for the licensed nurse to watch residents swallow the medication. The DON stated it was important for residents to take their medications to help their medical condition. The DON stated it was not a safe practice to leave medication at the bedside unattended because the nurse would be unable to determine if the resident took the medication and that another resident could potentially take the medication. The DON stated LVN 1 should have administered the medication to Resident 124 and watch the resident swallow his medication.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's Policy and Procedure (P&amp;P), titled Medication Dispensing System, dated 2023, the P&amp;P indicated part of the medication administration procedure was to ensure the resident swallowed all of the medications.</p> <p>47679</p> <p>2. During a review of Resident 29's Admission Record (Face Sheet), the Face Sheet indicated Resident 29 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included anxiety disorder, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) affecting the left non-dominant side following a cerebral infarct (also known as stroke, a loss of blood flow to a part of the brain).</p> <p>During a review of Resident 29's MDS, dated [DATE], the MDS indicated Resident 29's cognition was moderately impaired. The MDS indicated Resident 29 was dependent on staff's assistance with toileting, bathing, lower body dressing, and personal hygiene. The MDS indicated Resident 29 received antianxiety medication.</p> <p>During a review of Resident 29's H&amp;P, dated 3/7/2024, the H&amp;P indicated Resident 29 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 29's Order Recap Report, dated 3/1/2025 through 3/31/2025, the Order Recap Report indicated to:</p> <p>a. Give Ativan 0.5 mg, two times a day, for anxiety manifested by verbalization of uneasiness due to feeling overwhelmed with family member's current health condition, as exhibited by episodes of seeking attention. The order date was 3/9/2025 to start on 3/10/2025.</p> <p>b. Give Xanax (an antianxiety medication) 0.5mg, by mouth, two times a day for anxiety manifested by the inability to relax. Discontinue medication order when Ativan arrives. The order date was 3/10/2025.</p> <p>During a concurrent interview and record review on 3/13/2025 at 11 a.m., with the DON, Resident 29's MAR, dated 3/1/2025 through 3/31/2025, was reviewed. The DON stated according to Resident 29's MAR, it seemed that Resident 29 received Ativan and Xanax on 3/10/2025 at 9 a.m. The DON stated Ativan and Xanax were both antianxiety medication and should not be administered together. The DON stated Resident 29's Ativan was not delivered to the facility until 3/11/2025. The DON stated Xanax was administered to Resident 29 on 3/10/2025 per the physician's order because the Ativan was not available. The DON stated LVN 1 was supposed to mark the Ativan as hold or medication not available. The DON stated the inaccurate documentation of Resident 29's Ativan had the potential for inaccurate information relayed to Resident 29's healthcare team and might seem like she is being chemically restrained (using medication to control a person's behavior or restrict their movement).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/13/2025 at 11:27 a.m., with LVN 1, LVN 1 stated Resident 29's Ativan was unavailable on 3/10/2025. LVN 1 stated when she was documenting on Resident 29's MAR, she accidentally marked the Ativan as given instead of documenting the medication was unavailable. LVN 1 stated ensuring accurate documentation of Ativan was important because Ativan was ordered to treat Resident 29's anxiety and if Resident 29 exhibited behaviors related to her anxiety, it may seem the Ativan was ineffective. LVN 1 stated this could cause Resident 29's physician to increase the dosage unnecessarily.</p> <p>During a review of the facility's P&amp;P titled, Medication- Administration, revised 1/1/2012, the P&amp;P indicated, Whenever a medication is held for any reason, the hour it was held must be initialed in the MAR by the responsible Licensed Nurse.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49900</p> <p>Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 46 and 65) were free from significant medication error (one which caused the resident discomfort or jeopardizes his or her health and safety) when:</p> <p>1. Staff did not instruct Resident 65 to rinse his mouth thoroughly after administering Budesonide-Formoterol Fumarate inhaler (a medication to relax airway muscles, making breathing easier).</p> <p>This deficient practice had the potential to result in mouth discomfort and development of oral thrush (a fungal infection of the mouth, resulting in white, raised patches, that could be painful and cause discomfort) for Resident 65.</p> <p>2. Resident 46 was administered Metoprolol (medication used to treat high blood pressure) outside of the ordered parameters (specific instructions that dictate whether the medication is safe to administer).</p> <p>This deficient practice had the potential to result in Resident 46 becoming hypotensive (low blood pressure) that could cause dizziness, fainting, weakness, and confusion.</p> <p>Findings:</p> <p>1. During a review of Resident 65's Admission Record (face sheet), the face sheet indicated Resident 65 was admitted to the facility on [DATE]. The face sheet indicated Resident 65 had the following diagnoses which included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and depression (a persistent low mood, loss of interest or pleasure in activities).</p> <p>During a review of Resident 65's Minimum Data Set ([MDS], a resident assessment tool), dated 1/31/2025, the MDS indicated Resident 65's cognition (the ability to think, remember and reason) was intact. The MDS indicated Resident 65 required setup assistance with eating and oral hygiene, and partial assistance (helper does less than half the effort) for toileting hygiene, showering/ bathing, personal hygiene, and transferring in-and-out of bed.</p> <p>During a review of Resident 65's History and Physical (H&amp;P), dated 1/25/2025, the H&amp;P indicated Resident 65 had the capacity to understand and make decisions.</p> <p>During a review of Resident 65's Order Summary Report, dated 3/12/2025, the order summary report indicated Resident 65 had an active order started on 1/24/2025 to inhale budesonide-formoterol fumarate 2 puffs orally two times a day for shortness of breath (SOB).</p> <p>During a medication pass observation on 3/11/2025 at 8:53 a.m., with Licensed Vocational Nurse (LVN 1), observed LVN 1 hand the budesonide-formoterol fumarate inhaler to Resident 65. Resident 65 took 2 puffs of the inhaler and swallowed the oral medications with water. LVN 1 did not instruct Resident 65 to rinse her mouth thoroughly after using the inhaler.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 3/11/2025 at 9:00 a.m., with LVN 1 Resident 65's budesonide-formoterol fumarate inhaler label instructions was reviewed. The inhaler instructions indicated to rinse mouth thoroughly after each use. LVN 1 stated the purpose of rinsing the mouth thoroughly after each use of the budesonide-formoterol fumarate inhaler was to prevent oral thrush. LVN 1 stated without rinsing her mouth after using the inhaler, Resident 65 might have discomfort to her mouth. LVN 1 stated Resident 65 did not spit out the water after using the inhaler.</p> <p>During an interview on 3/11/2025 at 12:37 p.m. with Resident 65, in resident's room, Resident 65 stated staff never instructed her to rinse mouth after using the budesonide-formoterol fumarate inhaler. Resident 65 stated she swallowed water with the medication after using the inhaler.</p> <p>During an interview on 3/12/2025 at 2:53 p.m. with the Director of Nursing (DON), the DON stated staff should instruct residents to rinse their mouth after using the budesonide-formoterol fumarate inhaler to prevent oral thrush. The DON stated the resident might have changes in appetite and weight from the development of oral thrush. The DON stated it was a medication error that staff did not instruct Resident 65 to rinse her mouth thoroughly after using the inhaler.</p> <p>During a review of the manufacture instructions for the budesonide-formoterol fumarate inhaler, undated, the manufacture instructions indicated to advise the resident to rinse their mouth with water without swallowing following inhalation, to help reduce the risk of oropharyngeal candidiasis (known as oral thrush).</p> <p>47679</p> <p>2. During a review of Resident 46's Admission Record (Face Sheet), the Face Sheet indicated Resident 46 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebral infarction (stroke, loss of blood flow to a part of the brain), atrial fibrillation (condition where the heart beats irregularly and too fast), and hypertensive heart disease (caused by chronic high blood pressure that leads to the heart working harder) with heart failure (condition where the heart does not pump enough blood to meet the body's needs).</p> <p>During a review of Resident 46's MDS, dated [DATE], the MDS indicated Resident 46's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 46 required maximal assistance (helper does more than half the effort) with eating, oral hygiene, toileting, bathing, and dressing.</p> <p>During a review of Resident 46's H&amp;P, dated 1/30/2025, the H&amp;P indicated Resident 46 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 46's Order Summary Report, order dated 1/28/2025, the Order Summary Report indicated to administer Metoprolol 100 milligrams (mg, unit of measurement), by mouth, every eight hours for hypertension (high blood pressure). Hold (not to give) the medication if the systolic blood pressure ([SBP], the top number in a blood pressure reading, representing the pressure in the arteries when the heart beats and pumps blood out) was less than 110 millimeters of mercury (mm Hg, unit of pressure measurement) or heart rate was less than 60 beats per minute.</p> <p>During a review of Resident 46's Care Plan, dated 4/29/2023, the Care Plan indicated Resident 46 had hypertension. The staff interventions indicated to give Metoprolol tablet as ordered.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 3/12/2025 at 3:44 p.m., with LVN 2, Resident 46's Medication Admission Record ([MAR], a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 3/1/2025 through 3/31/2025, was reviewed. LVN 2 stated Resident 46 was administered Metoprolol on 3/1/2025 when Resident 46's SBP was 106 mm Hg, on 3/3/2025 when Resident 46's SBP was 95 mm Hg, and on 3/7/2025 when Resident 46's SBP was 98 mm Hg. LVN 2 stated Resident 46 should not have been administered Metoprolol on those days. LVN 2 stated she administered Metoprolol to Resident 46 on 3/7/2025 when Resident 46 did not meet the ordered parameter for the SBP. LVN 2 stated administering Resident 46 Metoprolol when the SBP was lower than 110 mm Hg was inappropriate and could cause Resident 46's blood pressure to decrease lower than it already was.</p> <p>During an interview on 3/13/2025 at 10:56 a.m., with the DON, the DON stated the purpose of the SBP parameters on blood pressure medication was to safely administer the blood pressure medication to prevent hypotension. The DON stated on 3/1/2025, 3/3/2025, and 3/7/2025, Resident 46's Metoprolol should have been held and Resident 46's blood pressure monitored. The DON stated due to the inappropriate administration of Metoprolol, Resident 46 was at risk for hypotension that could cause dizziness, fainting, weakness, and confusion.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Medication-Administering, revised on 1/1/2012, the P&amp;P indicated, Medication and treatments will be administered as prescribed to ensure compliance with dose guidelines.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49900</p> <p>Based on observation, interview, and record review, the facility failed to remove three bags of expired intravenous (IV -given directly into the blood stream) fluid solution from inside the IV emergency kit (e-kit), in one of one inspected medication room (Medication Room Nursing Station 1).</p> <p>This deficient practice increased the risk that residents could have received medications that were expired and/or ineffective, possibly leading to health complications such as infection (the invasion and multiplication of microorganisms [like bacteria, viruses, etc.] in body tissues, potentially causing illness or harm) and electrolyte imbalance (an abnormal level of electrolytes in the body fluids, like blood and urine, which could disrupt vital functions like nerve and muscle activity, and fluid balance).</p> <p>Findings:</p> <p>During a concurrent observation and interview on [DATE] at 11:40 a.m. with Licensed Vocational Nurse (LVN) 4, in Medication Room Nursing Station 1, three bags of expired IV solution were observed stored in the IV e-kit. One bag of 0.9 percent (%) sodium chloride (NS, a common IV solution used to replace fluids and electrolytes) IV solution was observed with an expired label dated ,d+[DATE]. Two bags of 5% dextrose and 0.45% NS IV solution (treatment of dehydration or low blood sugar) were observed with an expired label dated ,d+[DATE]. LVN 4 stated the IV bags were expired and the registered nurse (RN) was responsible for checking the IV e-kit.</p> <p>During an interview on [DATE] at 11:40 a.m. with RN 1, RN 1 stated the RN was responsible for checking the IV e-kit every night shift and calling the pharmacy to replace if expired. RN 1 stated the negative outcome was unable to administer the expired IV solutions, which would increase the risk of danger and harm to residents. RN 1 stated the 0.9% NS IV solution was for dehydration and improving blood flow. RN 1 stated the 0.5% dextrose and 0.45 % NS IV solution was to maintain blood sugar level.</p> <p>During an interview on [DATE] at 2:53 p.m. with the Director of Nursing (DON), the DON stated the purpose of the IV e-kit was so IV medications could be administered timely. The DON stated the RN was responsible for checking the IV e-kit once a shift. The DON stated the negative outcome of having the expired IV solution was that the IV solution was not available. The DON stated the expired 0.9% NS IV sodium solution could cause sodium overload that lead to a change in the resident's mentation and electrolyte imbalance. The DON stated the expired 5% dextrose and 0.45% NS IV solution could elevate a resident's blood sugar with signs and symptoms of increase of thirst, urination, and hunger.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled Emergency Drugs and Supplies, dated , d+[DATE], the P&amp;P indicated that On a daily basis, the facility personnel will check the status of the e-kits .If the e-kit is used or expired and a red lock is in place, the facility shall call the pharmacy for a replacement.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	

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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&amp;P titled Medication Return and Disposal of Medications, undated, the P&amp;P indicated that all medications that were expired would be removed from the medication room.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45009</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary practices in the kitchen that affected 67 residents out of 67 sampled residents when:</p> <ol style="list-style-type: none"> <li>1. The refrigerator contained food with no in date (the date when the food was placed in the refrigerator) and no use by date (date the food item must be consumed by).</li> <li>2. The freezer had food that was not labeled with an in date and a use by date.</li> <li>3. Food items in the refrigerator and freezer that were removed from original packaging were not labeled with what it was.</li> <li>4. Refrigerator and freezer temperatures were not within acceptable range.</li> <li>5. Dietary [NAME] (DC) 1 did not remove gloves when moving to another task.</li> </ol> <p>These failures had the potential to result in harmful bacteria growth and cross contamination that could lead to foodborne illness in residents that are medically compromised residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During the initial kitchen tour on 3/10/2025 at 8:40 a.m., the food in the refrigerator did not have a use by date.</li> </ol> <p>During the initial kitchen tour on 3/10/2025 at 8:49 a.m., the food in the freezer did not have a use by date. The freezer had opened food packages without an open date and a use by date.</p> <p>During the initial kitchen tour on 3/10/2025 at 9:00 a.m., the refrigerator had food containers that were not labeled with what was inside the container.</p> <p>During an interview on 3/10/2025 at 9:16 a.m. with the Dietary Supervisor (DS), the DS stated all food in the refrigerator and freezer must be dated with the received date and an opened date. The DS stated if the food item was opened it needed to be dated with a use by date. The DS stated food items must be labeled with the type of food it was.</p> <ol style="list-style-type: none"> <li>2. During the initial kitchen tour on 3/10/2025 at 8:54 a.m., there was a thermometer inside the refrigerator that displayed a temperature reading of 44 degrees Fahrenheit (F, measure of temperature). The thermometer inside the freezer displayed a temperature reading of 10 degrees F.</li> </ol> <p>During a concurrent observation and interview on 3/10/2025 at 9:24 a.m. with DS, in the kitchen, the inside temperature of the refrigerator was 44 degrees F and the inside temperature of freezer was 10 degrees F. The DS stated the inside temperature of the refrigerator should be less than 40 degrees</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  El Rancho Vista Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  8925 Mines Avenue Pico Rivera, CA 90660	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>F to maintain food quality. The DS stated the inside temperature of the freezer should be less than zero degrees to maintain food quality.</p> <p>3. During an observation on 3/13/2025 at 7:38 a.m., Dietary [NAME] (DC) 1 was observed cooking fried eggs, plating food, handling food request slips, and touching her eyeglasses. DC 1 did not remove her gloves and wash her hands when moving from one task to another task.</p> <p>During an interview on 3/13/2025 at 7:47 a.m. with the DS, in the kitchen, the DS stated staff must remove gloves when moving to a new task. The DS stated staff must wear new gloves when they touch food. The DS stated it was important for staff to change gloves to prevent cross contamination.</p> <p>During an interview on 3/13/2025 at 7:55 a.m. with DC 1, in the kitchen, DC 1 stated she forgot to remove her gloves when she moved to another task. DC 1 stated she was not supposed to touch food with soiled gloves. DC 1 stated touching food with dirty gloves could potentially cause cross contamination and cause residents to get sick.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Glove Use, dated 2023, the P&amp;P indicated gloves are single use items and should be discarded after each use, and especially before handling clean food items. The P&amp;P indicated gloves needed to be changed before beginning a new task.</p> <p>During a review of the facility's P&amp;P titled Cold Storage Temperature Monitoring and Record Keeping, dated 2023, the P&amp;P indicated food and nutrition services staff will check the inside temperature of refrigerators and freezers. The P&amp;P indicated the refrigerator temperature goal was to keep the temperature between 34 to 39 degrees, allowing for a two degree rise in temperature when the door is opened throughout the day. The P&amp;P indicated the freezer temperature standards are zero degrees or below.</p> <p>During a review of the facility's P&amp;P titled Labeling and Dating of Foods, dated 2023, the P&amp;P indicated all food items in the storage room, refrigerator, and freezer needed to be labeled and dated. The P&amp;P indicated all food must be marked with a received date. The P&amp;P indicated open food items must be closed and labeled with an open date and a used by date.</p>		