

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555130	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/19/2024
NAME OF PROVIDER OR SUPPLIER  Maywood Skilled Nursing & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE  6025 Pine Ave Maywood, CA 90270	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858</b></p> <p>Based on interview and record review, the facility failed to respect the rights and provide dignity to two of six sampled residents (Resident 95 and Resident 75) by failing to:</p> <ol style="list-style-type: none"> <li>1. Obtain a public guardian (a legally appointed person who manages the care and finances of individuals who are unable to do so for themselves) or conduct an interdisciplinary team (IDT, group of different disciplines working together towards a common goal for a resident) meeting to facilitate the care and medical treatments provided for Resident 75.</li> <li>2. Follow its policy and procedure (P&amp;P) titled Catheter - Care of, to provide a dignity bag (a bag used to cover and hold the catheter drainage/collection bag, so it is not visible) for Resident 95 who had both a left and right nephrostomy (a tube that lets urine drain from the kidney through an opening in the skin on the back) bag.</li> </ol> <p>This failure resulted in Resident 75 receiving medical treatment and antipsychotics (medications that affect the mind, emotions, and behavior) that had not been explained to nor consented by an appointed decision-maker on Resident 75's behalf. This failure also had the potential to affect Resident 95's self-worth and self-esteem. Cross Reference F552.</p> <p>Findings:</p> <p>a. During a review of Resident 75's Admission Record, the Admission Record indicated Resident 75 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including schizophrenia disorder (a mental illness that can affect thoughts, mood, and behavior), depressive disorder (low mood and loss of interest in activities for a long period of time), and anxiety (feeling of uneasiness).</p> <p>During a review of Resident 75's Minimum Data Set ([MDS], a resident assessment tool), dated 11/1/2024, the MDS indicated Resident 75's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 75 was dependent on staff for activities for daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a review of Resident 75's History and Physical (H&amp;P), dated 10/26/2024, the H&amp;P indicated Resident 75 had the capacity to make needs known, but not make medical decisions.</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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 75's Social Services Progress Notes, dated 2024, there was a lack of documentation to indicate that the facility made a good-faith attempt to find surrogate (is a person who makes medical decisions for a patient when the resident is unable to do so themselves) family members, held an IDT meeting to establish the IDT as surrogate decisionmakers, nor applied for public guardianship for Resident 75.</p> <p>During a concurrent interview and record review, on 12/17/2024, at 1:33 p.m., with the Social Services Director (SSD), all of Resident 75's Social Services Progress Notes, dated 2024, were reviewed. The SSD stated a resident would need a public guardian if the resident did not have the capacity to make medical decisions. The SSD stated she would typically refer to the resident's H&amp;P to determine if the resident had the capacity to make medical decisions. The SSD stated that it was important to obtain a public guardian right away, especially if the resident did not have any family members. The SSD stated she did not know that Resident 75 did not have any family members to act as a responsible party. The SSD stated that she was not aware that there had been a change in Resident 75's medical decision-making capacity [after Resident 75 was readmitted ] but was aware that his cognition had been worsening throughout his stay at the facility. The SSD stated that she should have checked Resident 75's H&amp;P or should have been made aware by the licensed nursing staff so that she could proceed to apply for public guardianship for Resident 75 in a timely manner. The SSD stated that it was Resident 75's right to have a public guardian so that his medical care and services could be handled by an appropriate designee.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P), titled, Locating a Resident's Surrogate Decision Maker, dated 6/27/2024, the P&amp;P indicated the following:</p> <ol style="list-style-type: none"> <li>a. Efforts to locate the Resident's surrogate decision-maker should be completed within the first thirty days of admission.</li> <li>b. The IDT would act as the Resident's surrogate decision-maker until the resident's representative(s) were located.</li> <li>c. The IDT should include the Resident's attending physician, the registered nurse responsible for the Resident and other appropriate disciplines as determined by the resident's needs.</li> <li>d. A referral would be made to the Public Guardian for evaluation for conservatorship.</li> </ol> <p>48131</p> <p>b. During a review of Resident 95's Admission Record, dated 12/18/2024, the admission record indicated Resident 95 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 95's diagnoses included chronic kidney disease (CKD - a longstanding disease in which the kidneys are damaged and cannot filter blood as well as they should leading to renal failure), acute kidney failure (the sudden and rapid loss of the kidney's ability to filter waste and balance fluid in blood), hydronephrosis (a condition where one or both kidneys swell due to a buildup of urine), malignant neoplasm of the bladder (bladder cancer), and retention of urine definition (a condition that makes it difficult to empty the bladder).</p> <p>During a review of Resident 95's H&amp;P, dated 8/9/2024, the H&amp;P indicated Resident 95 had the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 95's MDS dated [DATE], the MDS indicated Resident 95's cognition was intact. The MDS indicated Resident 95 had an indwelling catheter and required supervision with eating, toileting and personal hygiene, and toileting.</p> <p>During a review of Resident 95's Care Plan titled Nephrostomy Placement Bilateral (both sides) Surgery, initiated on 10/10/2024 and revised on 11/13/2024, the care plan indicated Resident 95's bladder would be adequately emptied without complication as evidenced by no bladder distention, pain/discomfort and no signs and symptoms of urinary tract infection (UTI - an infection in the bladder/urinary tract). The care plan interventions indicated to provide nephrostomy care per protocol daily and as needed.</p> <p>During an observation on 12/16/2024 at 2:44 p.m., in Resident 95's room, Resident 95 was observed sitting in a wheelchair with both left and right nephrostomy bags lying on his bed, uncovered by a dignity bag.</p> <p>During a concurrent observation, and interview on 12/17/2024 at 1:47 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 observed Resident 95's nephrostomy bag and nephrostomy tubing. LVN 2 acknowledged Resident 95's nephrostomy tubing was rolled up in the resident's pants pockets and the right pocket was saturated from urine leaking from the right nephrostomy bag. LVN 2 agreed it was inappropriate for Resident 95 to keep his nephrostomy bags and tubing rolled up inside of his pockets. LVN 2 stated the nephrostomy bags should be positioned to gravity and covered with a dignity bag to maintain the resident's dignity.</p> <p>During a concurrent interview and record review on 12/17/2024 at 3:09 p.m., with Treatment Nurse (TN) 1, Resident 95's nursing care plan and nephrostomy monitoring log was reviewed. TN 1 stated she was under the impression Resident 95 refused a dignity bag. TN 1 stated if Resident 95 did refuse a dignity bag, it should have been documented and care planned. TN 1 stated she could not find any documentation in the nursing progress note or a care plan that indicated Resident 95 refused a dignity bag. TN 1 stated she would make sure Resident 95 received a dignity bag for both nephrostomy bags.</p> <p>During a concurrent observation and interview on 12/19/2024 at 8:04 a.m., with TN 1 and Resident 95, Resident 95's nephrostomy dressing changes were observed by TN1. Resident 95 had both nephrostomy bags lying on his bed, uncovered by a dignity bag, while he (Resident 95) sat at the edge of his bed. TN 1 stated the bags were uncovered because she was in the process of setting Resident 95 up for his nephrostomy dressing changes. Resident 95 stated he did not use the dignity bags because when he needed to urinate because it took too long to get the bags out of the dignity bag. Resident 95 stated if he waited on a nurse to remove the nephrostomy bags, it was usually too late. TN 1 stated Resident 95 needed more education regarding his nephrostomy bags because he did not have to touch the bags when he urinated. TN 1 stated, since Resident 95 could urinate from his penis, he only needed to use the urinal (container used to collect urine for people who are unable to use a bathroom toilet) to urinate. TN 1 was observed providing education to Resident 95 in Spanish that he did not need to do touch his nephrostomy bags when he needed to urinate. TN 1 also explained to Resident 95 the importance of keeping the bags to gravity and not in his pocket to prevent infection. TN 1 explained that the dignity bag was for his protection and dignity. TN 1 was observed placing both nephrostomy bags into a dignity bag. Resident 95 shook his head in agreement and did not refuse the dignity bags.</p> <p>(continued on next page)</p>

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/19/2024 at 10:36 a.m., with the Director of Nursing, the DON stated there should be a dignity bag to protect the resident and if someone saw the urine in Resident 95's bag they might find it gross. The DON stated Resident 95 would be embarrassed and cause a negative body image for the resident.</p> <p>During review of the facility's P&amp;P titled, Catheter - Care of, revised on 6/10/2021, the P&amp;P indicated the resident's dignity would be protected by placing a cover over the drainage bag when the resident is out of bed.</p>

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858</b></p> <p>Based on interview and record review, the facility failed to obtain updated informed consents (a voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) prior to the administration of psychotropic (medications that affect the mind, emotions, and behavior) medications for one out of six sampled residents (Resident 75).</p> <p>This failure had the potential to place Resident 75 at risk for avoidable harm from unwanted adverse effects (a harmful and undesired effect resulting from a medication or intervention) related to psychotropic medication use during the two months he was deemed to be unable to make medical decisions. Cross Reference F550.</p> <p>Findings:</p> <p>During a review of Resident 75's Admission Record, the Admission Record indicated Resident 75 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that can affect thoughts, mood, and behavior), depressive disorder (low mood and loss of interest in activities for a long period of time), and anxiety (feeling of uneasiness).</p> <p>During a review of Resident 75's Minimum Data Set ([MDS], a resident assessment tool), dated 11/1/2024, the MDS indicated Resident 75's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 75 was dependent on staff for activities for daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a review of Resident 75's History and Physical (H&amp;P), dated 10/26/2024, the H&amp;P indicated Resident 75 had the capacity to make needs known, but not make medical decisions.</p> <p>During a review of Resident 75's Order Summary Report, dated 12/2024, the report indicated Resident 75 was ordered the following psychotropic medications on the following dates:</p> <ol style="list-style-type: none"> <li>1. Haloperidol Oral Tablet (Haloperidol) 10 milligrams ([MG]-a unit of measurement), two times a day, for schizophrenia manifested by command auditory hallucinations as evidenced by hearing voices to harm himself on 10/26/2024.</li> <li>2. Buspirone Hydrochloride Oral Tablet 20 MG, two times a day, for anxiety manifested by increased worry on 10/26/2024.</li> <li>3. Sertraline Hydrochloride Oral Tablet 125 MG, one time a day, for depression manifested by verbalization of constant worries about health on 10/26/2024.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 75's Medication Administration Record (MAR), dated 10/1/2024 to 12/17/2024, the MAR indicated Resident 75 was administered Haloperidol Oral Tablet twice a day, Buspirone Hydrochloride Oral Tablet 20 MG twice a day, and Sertraline Hydrochloride Oral Tablet 125 MG by mouth once a day every day from 10/2/2024 to 12/17/2024.</p> <p>During a review of Resident 75's Informed Consents, dated 2024, the following consent forms indicated verification of informed consent was obtained from Resident 75 on the following dates for the following medications:</p> <ol style="list-style-type: none"> <li>1. Haloperidol - on 10/25/2024.</li> <li>2. Buspirone Hydrochloride - on 10/28/2024 (two days after Resident 75 was deemed unable to make medical decisions).</li> <li>3. Sertraline Hydrochloride - on 10/25/2024.</li> </ol> <p>There was no documentation to indicate the facility obtained consent from a responsible party, public guardian (a legally appointed person who manages the care and finances of individuals who are unable to do so for themselves), nor the facility's interdisciplinary team (IDT, group of different disciplines working together towards a common goal for a resident).</p> <p>During a concurrent interview and record review, on 12/17/2024, at 2:45 p.m., with Licensed Vocational Nurse (LVN) 4, Resident 75's H&amp;P, dated 10/26/2024, informed consents, dated 10/2024, and Physician Orders, dated 12/2024, were reviewed. LVN 4 stated that the facility's process was to obtain verification of informed consent from the responsible party or public guardian if a resident was unable to make medical decisions for him or herself. LVN 4 stated that it was important to obtain verification of informed consent because it was the resident's right to be made aware of the risks and benefits of a treatment. LVN 4 stated the facility should have acted immediately in obtaining a public guardian for Resident 75 or conducting an IDT meeting regarding the medical decision making process for Resident 75. LVN 4 state this was important so that the risks and benefits and the medical necessity of the three psychotropics that Resident 75 was prescribed could be relayed to an individual who would be able to make sound and just medical decisions on the behalf of Resident 75.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P), titled, Informed Consent, dated 6/27/2024, the P&amp;P indicated the following:</p> <ol style="list-style-type: none"> <li>a. The resident's physician would determine the resident's capacity to make decisions.</li> <li>b. If the Resident was determined to have capacity, the Resident would be able to provide informed consent.</li> <li>c. If the resident lacked capacity to provide informed consent, the surrogate decision- maker will provide informed consent.</li> <li>d. If the resident lacked capacity to provide informed consent and did not have a surrogate decision-maker, the facility would convene a surrogate interdisciplinary team.</li> </ol>		

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<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**</b> 47679</p> <p>Based on interview and record review, the facility failed to notify the physician of one of 24 sampled residents' (Resident 259) abuse allegation when Resident 259 felt uncomfortable by Certified Nursing Assistant (CNA) 2 during a bed bath.</p> <p>This deficient practice resulted in Resident 259's physician being unaware of the abuse allegation and delayed any necessary care to be provided to Resident 259.</p> <p>Findings:</p> <p>During a review of Resident 259's Admission Record (Face Sheet), the Face Sheet indicated Resident 259 was initially admitted to the facility on [DATE] and on 12/11/2024 with diagnoses the included urinary tract infection (UTI, an infection in the bladder/urinary tract), sepsis (a life-threatening blood infection), and ), type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 259's Minimum Data Set ([MDS], a resident assessment tool), dated 9/26/2024, the MDS indicated Resident 259's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 259 required supervision with eating and oral hygiene and required substantial assistance (helper does more than half the effort) with dressing and personal hygiene.</p> <p>During a review of Resident 259's History and Physical Examination (H&amp;P), dated 12/13/2024, the H&amp;P indicated Resident 259 had the capacity to understand and make decisions.</p> <p>During an interview on 12/18/2024 at 10 a.m., with Resident 259, Resident 259 stated he felt uncomfortable with CNA 2 when CNA 2 gave him a bath. Resident 259 stated [CNA 2] touched me inappropriately, it felt like [CNA 2] was masturbating (stimulating genitals for sexual pleasure) me. Resident 259 stated he recalled telling another nurse of the incident.</p> <p>During an interview on 12/18/2024 at 1:25 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 259 felt uncomfortable with the way CNA 2 gave him (Resident 259) a bed bath. LVN 3 stated when she went to Resident 259's room, Resident 259 told her that he did not want CNA 2 touching him down there and that [CNA 2] is jacking me off (stimulating genitals for sexual pleasure). LVN 3 stated she took the initiative to reassign CNA 2 to another resident and for a different CNA to be assigned to Resident 259. LVN 3 stated, I had it under control and I solved the concern of [Resident 259]. LVN 3 stated, I did not feel like I needed to take it to the physician because I solved the problem.</p> <p>During an interview on 12/18/2024 at 2:03 p.m., with Registered Nurse (RN) 2, RN 2 stated any abuse allegation was considered a change of condition because interventions would need be to be implemented to care for the resident. RN 2 stated Resident 259 made an abuse allegation against CNA 2 and Resident 259's physician should have been notified of the abuse allegation. RN 2 stated there would be monitoring for emotional distress and they would have to carry out any orders the physician may give them.</p> <p>(continued on next page)</p>

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<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 12/18/2024 at 3:14 p.m., with the Director of Nursing (DON), the DON stated Resident 259's physician should have been informed of Resident 259's abuse allegation so the physician could determine what assessments and further interventions needed to be put in place. The DON stated Resident 259's physician would want to know if there was any physical or emotional trauma from the alleged incident and would refer Resident 259 to a psychiatrist or psychologist.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Abuse- Reporting &amp; Investigations, revised 3/2018, the P&amp;P indicated, Upon receiving allegations of sexual abuse, the Administrator or designated representative will notify the Attending Physician to promptly examine the resident.</p> <p>During a review of the facility's P&amp;P titled, Change of Condition Notification, undated, the P&amp;P indicated, The licensed nurse in charge of resident's care shall be responsible for immediate notification of resident (as applicable), resident's primary care physician, family member(s), and/or legal representative of any change in a resident's status and condition [such as] any incident or accident involving the resident which results in injury and/or has the potential for requiring physician intervention.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</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 report abuse allegations to the State Agency (Department of Public Health), ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and the police department for two of 24 sampled residents (Residents 88 and 259) when:</p> <ol style="list-style-type: none"> <li>1. Responsible Party (RP) 1 informed Registered Nurse (RN) 1 that Certified Nursing Assistant (CNA) 2 said hurtful things to Resident 88.</li> <li>2. Resident 259 informed Licensed Vocational Nurse (LVN) 3 that CNA 2 had made him feel uncomfortable during a bed bath.</li> </ol> <p>These deficient practices resulted in a delay of an onsite inspection by the State Agency and had the potential for potential ongoing abuse. Cross Reference F610.</p> <p>Findings:</p> <p>a. During a review of Resident 88's Admission Record (Face Sheet), the Face Sheet indicated Resident 88 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 88's diagnoses included urinary tract infection (UTI, an infection in the bladder/urinary tract), type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder (a mood disorder that causes persistent feeling of sadness and loss of interest).</p> <p>During a review of Resident 88's Minimum Data Set ([MDS], a resident assessment tool), dated 10/13/2024, the MDS indicated Resident 88's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 88 was dependent on staff's assistance with eating, oral hygiene, toileting, bathing, and dressing.</p> <p>During a review of Resident 88's History and Physical Examination (H&amp;P), dated 10/8/2024, the H&amp;P indicated Resident 88 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 88's Progress Notes, dated 9/3/2024 and timed at 5:31 p.m., the Progress Note indicated, on 9/3/2025 at 5:30 p.m., Resident 88's Responsible Party (RP 1) called the facility to report that Resident 88 was confused and claimed that CNA 2 had been saying hurtful things to the resident, which made Resident 88 upset and affected her eating. The Progress Note indicated a supervisor and nurse went to Resident 88's room to speak with the resident, and Resident 88 repeated the same concerns. The Progress Note indicated the Director of Staff Development (DSD) was consulted, and it was confirmed that CNA 2 had not been assigned to Resident 88 for over a month. The Progress Note indicated Resident 88's physician was informed and RP 1 was informed of the situation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/16/2024 at 11:10 a.m., with RP 1, RP 1 stated Resident 88 had a CNA that did not treat the resident well. RP 1 stated she called the facility to inquire if that CNA was still taking care of Resident 88. RP 1 stated she had spoken to someone at the facility and was informed that an investigation had been initiated and the CNA described had not taken care of Resident 88 for some time.</p> <p>During an interview on 12/18/2024 at 9:41 a.m., with Registered Nurse (RN) 1, RN 1 stated RP 1 was at the facility during dinner time on 9/3/2024, and RP 1 had told her that Resident 88 stated CNA 2 was saying hurtful things to her a few days prior. RN 1 stated Resident 88 told her and another nurse the same story. RN 1 stated RP 1 raised the concern and wanted to know if the allegation was true. RN 1 stated she initiated the investigation by speaking to the DSD to find out that CNA 2 had not been assigned to Resident 88 for a month. RN 1 stated she called RP 1 and explained that CNA 2 had not been assigned to Resident 88, therefore probably did not interact with Resident 88. RN 1 stated her role as a mandated reporter was to report to the Administrator (ADM) and the Director of Nursing (DON), however, she was also mandated to report to the outside agencies that included the police department, ombudsman, and the State Agency. RN 1 stated she did not report to the three outside agencies because she recalled reporting to the DON and thought it would be handled from there. RN 1 stated reporting to the three agencies ensured that the allegation, whether it was real or not, was investigated within the facility, but also by another entity to ensure the residents involved were safe and no other potential abuse occurred.</p> <p>During an interview on 12/18/2024 at 11:34 a.m., with the DSD, the DSD stated an abuse allegation needed to be reported to the ADM and to the three outside agencies, whether those with knowledge of the allegation believe it to be true or not. The DSD stated any staff member had the ability to report to the police department, ombudsman, and the State Agency if they had any knowledge of an abuse allegation. The DSD stated any abuse allegation needed to be reported within two hours and an internal investigation by the ADM would begin. The DSD stated reporting abuse allegations to the outside agencies would ensure the initiation of another investigation to validate whether the allegation was true or not and to determine if the facility acted correctly. The DSD stated she was consulted whether CNA 2 had been assigned to Resident 88 during the alleged time frame. The DSD stated she was unaware whether the allegation was reported to the ADM or the three outside agencies. The DSD stated the lack of reporting had the potential to subject other residents to abuse by CNA 2.</p> <p>b. During a review of Resident 259's Admission Record (Face Sheet), the Face Sheet indicated Resident 259 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 259's diagnoses included UTI, sepsis (a life-threatening blood infection), and type two diabetes mellitus.</p> <p>During a review of Resident 259's MDS, dated [DATE], the MDS indicated Resident 259's cognition was moderately impaired. The MDS indicated Resident 259 required supervision with eating and oral hygiene and required substantial assistance (helper does more than half the effort) with dressing and personal hygiene.</p> <p>During a review of Resident 259's H&amp;P, dated 12/13/2024, the H&amp;P indicated Resident 259 had the capacity to understand and make decisions.</p> <p>During an interview on 12/18/2024 at 9:05 a.m., with CNA 3, CNA 3 stated Resident 259 refused to have CNA 2 assigned to him and stated Resident 259 stated he (Resident 259) did not want to see CNA 2 and to get CNA 2 out of his room. CNA 3 stated she informed LVN 3 and the DSD.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555130	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/19/2024
NAME OF PROVIDER OR SUPPLIER  Maywood Skilled Nursing & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE  6025 Pine Ave Maywood, CA 90270	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/18/2024 at 10 a.m., with Resident 259, Resident 259 stated he felt uncomfortable with CNA 2 when CNA 2 gave him a bath. Resident 259 stated [CNA 2] touched me inappropriately, it felt like [CNA 2] was masturbating (stimulating genitals for sexual pleasure) me. Resident 259 stated he recalled telling another nurse of the incident.</p> <p>During an interview on 12/18/2024 at 10:26 a.m., with LVN 3, LVN 3 stated Resident 259 had an issue with CNA 2 and that Resident 259 stated, Get [CNA 2] out of my room. LVN 3 stated the alleged incident occurred on Resident 259's shower day and Resident 259 preferred a bed bath than going to the shower room. LVN 3 stated when she went to Resident 259's room, Resident 259 had told her that he did not want CNA 2 touching him down there and that [CNA 2] is jacking me off (stimulating genitals for sexual pleasure). LVN 3 stated due to Resident 259 being uncomfortable with the care CNA 2 provided to him, LVN 3 informed the DSD and switched the CNA assignment. LVN 3 stated she informed the DSD and assumed the DSD would inform the superiors such as the DON and ADM. LVN 3 stated abuse allegations were reported to the ADM, then to the police department, ombudsman, and the State Agency. LVN 3 stated she did not report to the three outside agencies because she felt that she reported to her superiors and they would handle the rest of the reporting.</p> <p>During an interview on 12/18/2024 at 11:48 a.m., with the DSD, the DSD stated she and LVN 3 decided to change CNA 2's assignment so Resident 259 would be more comfortable. The DS stated after she and LVN 3 changed the CNA assignment for Resident 259, Resident 259 no longer had any concerns regarding his care. The DSD stated Resident 259's allegations were not reported. The DSD stated Resident 259's allegation against CNA 2 should have been reported to the police department, ombudsman, and the State Agency due to Resident 259's statements of possible sexual abuse.</p> <p>During an interview on 12/18/2024 at 3:14 p.m., with the DON, the DON stated if a staff member were to have knowledge of any kind of abuse allegation, they were responsible for informing the ADM, the DON, and the three outside agencies. The DON stated immediate reporting would ensure proper investigation was conducted and to protect the residents during and after the investigation.</p> <p>During an interview on 12/18/2024 at 3:41 p.m., the ADM stated once a staff member had knowledge of an abuse allegation, they were expected to report it to him. The ADM stated everyone had the ability to report any abuse allegations to the police department, ombudsman, and the State Agency. The ADM stated an allegation could be true or false, however, the allegation needed to be reported so a thorough investigation could be conducted internally and by the State Agency.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Abuse- Reporting &amp; Investigations, revised 3/2018, the P&amp;P indicated regarding allegations of abuse with no serious bodily injury, the Administrator or designated representative would notify, via telephone and written form, the State Agency, ombudsman, and the police department within two hours.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</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 thoroughly investigate abuse allegations and implement interventions to prevent further potential abuse for two of 24 sampled residents (Residents 88 and 259) when:</p> <ol style="list-style-type: none"> <li>1. Responsible Party (RP) 1 informed Registered Nurse (RN) 1 that Certified Nursing Assistant (CNA) 2 had said hurtful things to Resident 88.</li> <li>2. Resident 259 informed Licensed Vocational Nurse (LVN) 3 that CNA 2 made him feel uncomfortable during a bed bath.</li> </ol> <p>These deficient practices had the potential to result in unidentified abuse in the facility and failure to protect residents from further potential abuse. Cross Reference F609.</p> <p>Findings:</p> <p>a. During a review of Resident 88's Admission Record (Face Sheet), the Face Sheet indicated Resident 88 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 88's diagnoses included urinary tract infection (UTI, an infection in the bladder/urinary tract), type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder (a mood disorder that causes persistent feeling of sadness and loss of interest).</p> <p>During a review of Resident 88's Minimum Data Set ([MDS], a resident assessment tool), dated 10/13/2024, the MDS indicated Resident 88's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 88 was dependent on staff's assistance with eating, oral hygiene, toileting, bathing, and dressing.</p> <p>During a review of Resident 88's History and Physical Examination (H&amp;P), dated 10/8/2024, the H&amp;P indicated Resident 88 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 88's Progress Notes, dated 9/3/2024 and timed at 5:31 p.m., the Progress Note indicated, on 9/3/2025 at 5:30 p.m., Resident 88's Responsible Party (RP 1) called the facility to report that Resident 88 was confused and claimed CNA 2 was saying hurtful things to the resident, which made Resident 88 upset and affected her eating. The Progress Note indicated a supervisor and nurse went to Resident 88's room to speak with the resident, and Resident 88 repeated the same concerns. The Progress Note indicated the Director of Staff Development (DSD) was consulted, and it was confirmed that CNA 2 was not assigned to Resident 88 for over a month. The Progress Note indicated Resident 88's physician was informed, and RP 1 was informed of the situation.</p> <p>During an interview on 12/16/2024 at 11:10 a.m., with RP 1, RP 1 stated Resident 88 had a CNA that did not treat the resident well. RP 1 stated she called the facility to inquire if that CNA was still taking care of Resident 88. RP 1 stated she spoke to someone at the facility and was informed that an investigation was initiated and the CNA described had not taken care of Resident 88 for some time.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/18/2024 at 9:41 a.m., with Registered Nurse (RN) 1, RN 1 stated RP 1 was at the facility during dinner time on 9/3/2024. RN 1 stated RP 1 told her that Resident 88 stated CNA 2 was saying hurtful things to her a few days prior. RN 1 stated Resident 88 told her and another nurse the same story. RN 1 stated RP 1 raised the concern and wanted to know if the allegation was true. RN 1 stated she initiated the investigation by speaking to the DSD to find out that CNA 2 was not assigned to Resident 88 for a month. RN 1 stated she called RP 1 and explained that CNA 2 was not assigned to Resident 88, therefore probably did not interact with Resident 88. RN 1 stated after the incident, she did not recall if any other actions were taken after she spoke to RP 1.</p> <p>During an interview on 12/18/2024 at 11:34 a.m., with the DSD, the DSD stated an abuse allegation needed to be reported within two hours and an internal investigation by the Administrator (ADM) would begin. The DSD stated she was consulted whether CNA 2 was assigned to Resident 88 during the alleged time frame. The DSD stated after they confirmed CNA 2 was not assigned to Resident 88, no further investigation took place. The DSD stated for a thorough investigation to occur, the alleged perpetrator, if an employee, would be suspended until the investigation was concluded. The DSD stated CNA 2 was not suspended after the alleged incident and continued to work in the facility until CNA 2 took a leave of absence. The DSD stated without a thorough investigation and suspending CNA 2, other residents could have been subject to potential abuse.</p> <p>b. During a review of Resident 259's Admission Record (Face Sheet), the Face Sheet indicated Resident 259 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses the included UTI, sepsis (a life-threatening blood infection), and type two diabetes mellitus.</p> <p>During a review of Resident 259's MDS, dated [DATE], the MDS indicated Resident 259's cognition was moderately impaired. The MDS indicated Resident 259 required supervision with eating and oral hygiene and required substantial assistance (helper does more than half the effort) with dressing and personal hygiene.</p> <p>During a review of Resident 259's H&amp;P, dated 12/13/2024, the H&amp;P indicated Resident 259 had the capacity to understand and make decisions.</p> <p>During an interview on 12/18/2024 at 9:05 a.m., with CNA 3, CNA 3 stated Resident 259 refused to have CNA 2 assigned to him and stated Resident 259 stated he (Resident 259) did not want to see CNA 2 and to get CNA 2 out of his room. CNA 3 stated she informed LVN 3 and the DSD.</p> <p>During an interview on 12/18/2024 at 10 a.m., with Resident 259, Resident 259 stated he felt uncomfortable with CNA 2 when CNA 2 gave him a bath. Resident 259 stated [CNA 2] touched me inappropriately, it felt like [CNA 2] was masturbating (stimulating genitals for sexual pleasure) me. Resident 259 stated he recalled telling another nurse of the incident.</p> <p>During an interview on 12/18/2024 at 10:26 a.m., with LVN 3, LVN 3 stated Resident 259 had an issue with CNA 2 and that Resident 259 stated, get [CNA 2] out of my room. LVN 3 stated the alleged incident occurred on Resident 259's shower day and Resident 259 preferred a bed bath than going to the shower room. LVN 3 stated when she went to Resident 259's room, Resident 259 told her that he did not want CNA 2 touching him down there and that [CNA 2] is jacking me off (stimulating genitals for sexual pleasure). LVN 3 stated due to Resident 259 being uncomfortable with the care CNA 2 provided to him, LVN 3 informed the DSD and switched the CNA assignment. LVN 3 stated she because she informed the DSD, she assumed the DSD would inform the superiors such as the DON and ADM.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/18/2024 at 11:48 a.m., with the DSD, the DSD stated she and LVN 3 decided to change CNA 2's assignment so Resident 259 would be more comfortable. The DS stated after she and LVN 3 changed the CNA assignment for Resident 259, Resident 259 no longer had any concerns regarding his care. The DSD stated Resident 259's allegations were not reported. The DSD stated a thorough investigation was not completed regarding Resident 259's allegation because they fixed the problem and Resident 259 was happy with the assignment change. The DSD stated CNA 2 was not suspended after the alleged incident but should have been to protect other residents from the same treatment.</p> <p>During an interview on 12/18/2024 at 3:14 p.m., with the DON, the DON stated if a staff member were to have knowledge of any kind of abuse allegation, they were responsible for informing the ADM, who was the abuse coordinator for the facility. The DON stated immediate reporting would ensure a thorough investigation was initiated. The DON stated an abuse allegation investigation included interviewing all the staff members who had knowledge of the alleged incident, interview the resident involved, and review any pertinent documents. The DON stated if an abuse allegation involved an employee of the facility, the employee would immediately be suspended pending the conclusion of the investigation. The DON stated suspending the employee was necessary to prevent potential further abuse on the involved resident and to the other residents in the facility. The DON stated a thorough investigation was not done regarding CNA 2's alleged incidents with Residents 88 and 259. The DON stated CNA 2 was not suspended after the alleged incidents and there were no disciplinary actions towards CNA 2.</p> <p>During an interview on 12/18/2024 at 3:41 p.m., the ADM stated once a staff member had knowledge of an abuse allegation, they were expected to report it to him. The ADM stated an allegation could be true or false, however, the allegation needed to be reported so a thorough investigation could be conducted. The ADM stated the facility did not tolerate any kind of abuse and the proper steps should have been taken. The ADM stated CNA 2 should have been suspended while an investigation took place, however, the staff members who had knowledge of the alleged incidents failed to go up the chain of command. The ADM stated the process of reporting and investigating abuse allegations was to protect all residents in the facility.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Abuse- Reporting &amp; Investigations, revised 3/2018, the P&amp;P indicated when the Administrator received a report of an incident or suspected incident of resident abuse, an investigation would be initiated immediately. The P&amp;P indicated, If the suspected perpetrator is an employee, remove the employee immediately from the care of the resident(s) and immediately suspend the employee pending the outcome of the investigation in accordance with facilities policies.</p>		

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<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**</b> 47679</p> <p>Based on interview and record review, the facility failed to develop a person-centered care plan (document that helps nurses and other team care members organize aspects of resident care) with interventions (actions a nurse takes to implement a care plan, intend to improve the resident's comfort and health) for two of 24 sampled residents (Residents 88 and 259) by failing to:</p> <ol style="list-style-type: none"> <li>1. Develop a care plan for Resident 88 after Responsible Party (RP) 1 informed Registered Nurse (RN) 1 that Certified Nursing Assistant (CNA) 2 said hurtful things to Resident 88.</li> <li>2. Develop a care plan for Resident 259 after Resident 259 informed Licensed Vocational Nurse (LVN) 3 that CNA 2 had made him feel uncomfortable during a bed bath.</li> </ol> <p>These deficient practices had the potential to negatively affect Residents 88 and 259's physical, mental, and psychosocial well-being and had the potential to delay the delivery of necessary care and services.</p> <p>Findings:</p> <p>a. During a review of Resident 88's Admission Record (Face Sheet), the Face Sheet indicated Resident 88 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 88's diagnoses included urinary tract infection (UTI, an infection in the bladder/urinary tract), type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder (a mood disorder that causes persistent feeling of sadness and loss of interest).</p> <p>During a review of Resident 88's Minimum Data Set ([MDS], a resident assessment tool), dated 10/13/2024, the MDS indicated Resident 88's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 88 was dependent on staff's assistance with eating, oral hygiene, toileting, bathing, and dressing.</p> <p>During a review of Resident 88's History and Physical Examination (H&amp;P), dated 10/8/2024, the H&amp;P indicated Resident 88 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 88's Progress Notes, dated 9/3/2024 and timed at 5:31 p.m., the Progress Note indicated, At 5:30 p.m., [RP 1] called the facility to report that her mother was confused and claimed that [CNA 2] was saying hurtful things to her, which made her upset and affected her eating. A supervisor and nurse went to [Resident 88]'s room to speak with her, and [Resident 88] repeated the same concerns. The Director of Staff Development (DSD) was consulted, and it was confirmed that [CNA 2] was not assigned to [Resident 88] for over a month. The Progress Note indicated Resident 88's physician was informed, and RP 1 was informed of the situation.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/16/2024 at 11:10 a.m., with RP 1, RP 1 stated Resident 88 had a CNA that did not treat the resident well. RP 1 stated she called the facility to inquire if that specific CNA was still taking care of Resident 88. RP 1 stated she spoke to someone at the facility and was informed that an investigation was initiated and the CNA described did not care of Resident 88 for some time.</p> <p>During an interview on 12/18/2024 at 9:41 a.m., with Registered Nurse (RN) 1, RN 1 stated RP 1 was at the facility during dinner time on 9/3/2024. RN 1 stated RP 1 told her that Resident 88 stated CNA 2 was saying hurtful things to her a few days prior. RN 1 stated Resident 88 told her and another nurse the same story. RN 1 stated RP 1 raised the concern and wanted to know if the allegation was true. RN 1 stated she initiated the investigation of the allegation by speaking to the DSD to find out that CNA 2 was not assigned to Resident 88 for a month. RN 1 stated she called RP 1 and explained that CNA 2 was not assigned to Resident 88, therefore probably did not interact with Resident 88.</p> <p>During a concurrent interview and record review on 12/18/2024 at 2:11 p.m., with RN 2, Resident 88's Care Plans were reviewed. The Care Plans did not indicate there was an abuse allegation involving Resident 88. RN 2 stated a care plan should have been developed for Resident 88 after RP 1 made the allegation against CNA 2. RN 2 stated a care plan included the problem, a goal, and interventions that needed to be implemented. RN 2 stated due to the abuse allegation, interventions would include monitoring Resident 88 for any psychosocial issues and/or orders from the physician.</p> <p>b. During a review of Resident 259's Admission Record (Face Sheet), the Face Sheet indicated Resident 259 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses the included UTI, sepsis (a life-threatening blood infection), and type two diabetes mellitus.</p> <p>During a review of Resident 259's MDS, dated [DATE], the MDS indicated Resident 259's cognition was moderately impaired. The MDS indicated Resident 259 required supervision with eating and oral hygiene and required substantial assistance (helper does more than half the effort) with dressing and personal hygiene.</p> <p>During a review of Resident 259's H&amp;P, dated 12/13/2024, the H&amp;P indicated Resident 259 had the capacity to understand and make decisions.</p> <p>During an interview on 12/18/2024 at 10 a.m., with Resident 259, Resident 259 stated he felt uncomfortable with CNA 2 when CNA 2 gave him a bath. Resident 259 stated [CNA 2] touched me inappropriately, it felt like [CNA 2] was masturbating (stimulating genitals for sexual pleasure) me. Resident 259 stated he recalled telling another nurse of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/18/2024 at 1:28 p.m., with LVN 3, LVN 3 stated Resident 259 felt uncomfortable with the way CNA 2 gave him (Resident 259) a bed bath. LVN 3 stated when she went to Resident 259's room, Resident 259 told her that he did not want CNA 2 touching him down there and that [CNA 2] is jacking me off (stimulating genitals for sexual pleasure). LVN 3 stated she took the initiative to reassign CNA 2 to another resident and for a different CNA to be assigned to Resident 259. LVN 3 stated care plans were developed when a resident has a problem or was at risk for a problem to occur. LVN 3 stated care plans were developed when there was a change of condition, and the physician was notified. LVN 3 stated, I do not know if they do care plans for that kind of things pertaining to abuse allegations. LVN 3 stated Resident 259 no longer had any other concerns after CNA 2 was removed from his care. LVN 3 stated the alleged incident was not a continuous problem and a care plan was not needed.</p> <p>During an interview on 12/18/2024 at 3:14 p.m., with the Director of Nursing (DON), the DON stated for any abuse allegation, a care plan needed to be developed. The DON stated the care plan would outline the care Residents 88 and 259 would need to receive based on the problem and specific alleged incident they experienced.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Comprehensive Person-Centered Care Planning, revised 8/24/2023, the P&amp;P indicated, Additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident.</p>

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48131</p> <p>Based on observation, interview, and record review, the facility failed to provide a communication device at the bedside for one of six residents (Resident 17) who had aphasia (a disorder that makes it difficult to speak).</p> <p>This deficient practice prevented Resident 17 from communicating effectively and had the potential to delay appropriate care and treatment the resident needed.</p> <p>Findings:</p> <p>During a review of Resident 17's Admission Record, dated 12/18/2024, the admission record indicated Resident 17 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 17's diagnoses included end stage renal disease (ESDR - irreversible kidney failure), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), schizophrenia (a mental illness that is characterized by disturbances in thought), paraplegia (loss of movement and/or sensation, to some degree, of the legs), dysphasia (difficulty swallowing) and aphasia.</p> <p>During a review of Resident 17's History and Physical (H&amp;P), dated 8/21/2024, the H&amp;P indicated Resident 17 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool), dated 8/27/2024, the MDS indicated Resident 17's cognition (ability to think, remember, and reason) was intact. The MDS indicated Resident 17 had unclear speech and mumbled words. The MDS indicated Resident 17 required moderate assistance (helper does half of the effort) with eating and was dependent (helper does all of the effort) for toileting and bathing.</p> <p>During a review of Resident 17's Care Plan titled Impaired verbal communication related to Speech Difficult to Understand, initiated on 8/20/2024, the care plan indicated Resident 17's speech difficulty was related to her aphasia. The care plan indicated Resident 17 would have improved ability to communicate within the next three months. The care plan interventions included to allow Resident 17 enough time to talk, use the communication board much as possible and give a pencil and paper to the resident for better communication.</p> <p>During an observation on 12/16/2024 at 10:04 a.m., in Resident 17's room, Resident 17 was observed sitting in her wheelchair applying make-up. Resident 17 was alert and oriented but was unable to orally communicate. Resident 17 did not have a communication board or communication device at the bedside to assist with communication.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Maywood Skilled Nursing & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE  6025 Pine Ave Maywood, CA 90270	
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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 12/17/2024 at 1:17 p.m., with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 17 did not have a communication board in her room because she wrote down what she wanted. CNA 4 stated Resident 17 pointed to her nose to for yes and pointed to her forehead for no. CNA 4 asked Resident 17 to demonstrate how she gestured to answer yes or no and how she was able to write things down to communicate. Resident 17 slowly raised her arm to point to her forehead. Resident 17 then proceeded to pick up a pencil and slowly write on a piece of paper. Resident 17's handwriting was not legible (clear enough to read). CNA 4 stated since Resident 17 moved very slowly, there should have been a sign posted to inform visitors that Resident 17 communicated by writing things down or the resident should have had a communication board at the bedside.</p> <p>During an interview on 12/17/2024 at 1:29 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated not everyone was aware that Resident 17 could write things down or touch her nose or forehead to answer yes or no. LVN 2 stated it was important to have a communication device at Resident 17's bedside so that her needs could be communicated. LVN 2 stated that even though the nurses were aware of how Resident 17 communicated, some things could be miscommunicated without a communication board. LVN 2 stated Resident 17 not having a way to communicate effectively could affect her mentally and socially if she was unable to make her needs known.</p> <p>During an interview on 12/19/2024 at 10:51 a.m., with the Director of Nursing (DON), the DON stated he would notify social services to place a communication board at Resident 17's bedside and on the resident's wheelchair. The DON stated not all people know how to communicate with Resident 17 and she may have visitors that did not know the resident could write.</p> <p>During a review of the facility's policy and procedure (P&amp;P), titled, Accommodation of Residents' Communication Needs, dated March 2017, the P&amp;P indicated, the staff would observe the residents' interactions with others in different settings (group activity, one-on-one) and in different circumstances. The P&amp;P indicated staff would provide adaptive devices as needed to enable the resident to communicate as effectively as possible. The P&amp;P indicated a communication board/chart was an example of adaptive devices that staff could provide the resident.</p>		

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<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** 49900</b></p> <p>Based on observation, interview, and record review, the facility failed to implement interventions to prevent the formation and/ or worsening of pressure ulcers/ injuries (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) for three of three residents (Resident 15, 36, and 94) when the follow occurred:</p> <ol style="list-style-type: none"> <li>1. Resident 15'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 resident's weight on 12/16/2024.</li> <li>2. Resident 36's LALM did not reflect resident's weight on 12/16/2024.</li> <li>3. Resident 94's LALM did not reflect resident's weight on 12/16/2024.</li> </ol> <p>These deficient practices placed Resident 15, 36, and 94 at risk for worsening 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 12/16/2024 at 9:30 a.m., in Resident 15's room, Resident 15 was observed lying on a LALM. The LALM was set for weight of 300 pounds (lbs., a unit of measuring mass).</li> </ol> <p>During a review of Resident 15's Admission Record, the admission record indicated Resident 15 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnosis of chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), generalized muscle weakness, Stage III pressure ulcer (full-thickness loss of skin, dead and black tissue might be visible), and schizophrenia (a mental illness that was characterized by disturbances in thought).</p> <p>During a review of Resident 15's History and Physical (H&amp;P), dated 10/24/2024, the H&amp;P indicated Resident 15 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool), dated 10/29/2024, the MDS indicated Resident 15's cognitive (ability to think, remember, and reason) skills for daily decision making was severely impaired. The MDS indicated Resident 15 was dependent (helper did all the effort) for self-care (eating, oral hygiene, toileting hygiene, and shower/ bathe self). The MDS indicated Resident 15 was at risk of developing pressure injuries and had a pressure reducing device for the bed.</p> <p>During a review of Resident 15's Order Summary Report as of 10/22/2024, the report indicated to provide a LALM for skin maintenance and wound management. The orders indicated to monitor the settings and verify functioning every shift.</p> <p>During a review of Resident 15's care plan titled, Risk for development of pressure injury, initiated on 10/22/2024, the care plan indicated the goal was for Resident 15 to not develop pressure injury or any skin condition.</p> <p>(continued on next page)</p>

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<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 15's Weight Summary Report, dated 12/18/2024, the report indicated Resident 15 weighed 170 lbs. on 12/11/2024.</p> <p>During a concurrent interview and picture review on 12/17/2024 at 1:27 p.m. with Treatment Nurse (TN) 1, the picture taken on 12/16/2024 at 9:33 a.m. was reviewed, the picture indicated the LALM was set up for a weight of 300 lbs. TN 1 stated the LALM was not set properly for Resident 15 because the resident weighted 170 lbs. TN 1 stated Resident 15's LALM was for skin maintenance and Resident 15 had a resolved Stage III pressure ulcer.</p> <p>2. During an observation on 12/16/2024 at 9:48 a.m., in Resident 94's room, Resident 94 was observed lying on a LALM. The LALM was set for 200 lbs.</p> <p>During a review of Resident 94's Admission Record, the record indicated Resident 94 was admitted to the facility on [DATE] with diagnosis of COPD, malnutrition (a serious condition that occurred when the body did not get enough nutrients or calories, or the right balance of nutrients), generalized muscle weakness, diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and anemia (a condition where the body did not have enough healthy red blood cells).</p> <p>During a review of Resident 94's H&amp;P, dated 6/8/2024, the H&amp;P indicated Resident 94 had the capacity to understand and make decisions.</p> <p>During a review of Resident 94's MDS, dated [DATE], the MDS indicated Resident 94's cognitive skills for daily decision making was intact. The MDS indicated Resident 94 required partial assistance (helper did less than half the effort) to shower/ bathe and supervision for eating, oral hygiene, toileting hygiene, and personal hygiene The MDS indicated Resident 94 was at risk of developing pressure injuries and had surgical wounds. The MDS indicated Resident 94 had a pressure reducing device for the bed.</p> <p>During a review of Resident 94's physician order on 6/13/2024, the order indicated to provide a LALM for wound management and to monitor and verify functioning every shift.</p> <p>During a review of Resident 94's Weight Summary Report, dated 12/19/2024, the report indicated Resident 94 weighed 147.8 lbs. on 12/12/2024.</p> <p>During a concurrent interview and picture review on 12/17/2024 at 1:29 p.m. with TN 1, the picture taken on 12/16/2024 at 9:56 a.m. was reviewed, the picture indicated the LALM was set for 200 lbs. TN 1 stated the LALM was not inflated properly for Resident 94 because the resident weighed 147.8 lbs. TN 1 stated Resident 94 had a big surgical wound on the lower back which extended to the buttock and thighs. TN 1 stated lower back, buttocks and thighs were pressure points and would benefit from the use of a LALM.</p> <p>3. During an observation on 12/16/2024 at 11:31 a.m., in Resident 36's room, Resident 36 was observed lying on a LALM. The LALM was set for 550 lbs.</p> <p>(continued on next page)</p>		

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<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 36's Admission Record, the record indicated Resident 36 was originally admitted to the facility on [DATE] and readmitted on [DATE], with Stage II (partial-thickness loss of skin, presenting as a shallow open sore or wound) pressure ulcer, generalized muscle weakness, COPD, and obesity (a chronic disease that occurred when a person had too much body fat, or more than was considered healthy for their heights).</p> <p>During a review of Resident 36's H&amp;P, dated 5/25/2024, the H&amp;P indicated Resident 36 had the capacity to understand and make decisions.</p> <p>During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 36 required partial assistance with eating and oral hygiene; and substantial assistance (helper did more than half the effort) for toileting hygiene and shower/ bathe self. The MDS indicated Resident 36 was at risk of developing pressure injuries and had one Stage II pressure ulcer. The MDS further indicated Resident 36 had a pressure reducing device for the bed and chair.</p> <p>During a review of Resident 36's physician order on 11/5/2024, the order indicated to verify functioning of the LALM every shift.</p> <p>During a review of Resident 36's care plan titled, Risk for development of pressure injury, initiated on 5/25/2024, the care plan indicated the goal was for Resident 36 to not develop a pressure injury or any skin condition.</p> <p>During a review of Resident 36's Weight Summary Report, dated 12/18/2024, the report indicated Resident 36 weighed 190.2 lbs. on 12/11/2024.</p> <p>During a concurrent interview and picture review on 12/17/2024 at 1:25 p.m. with Licensed Vocational Nurse (LVN) 1, the picture taken on 12/16/2024 at 11:34 a.m. was reviewed, the picture indicated the LALM was set for 550 lbs. LVN 1 stated the LALM was not a correct setting for Resident 36 and the LALM should indicate Resident 36's accurate weight. LVN 1 stated the license nurse and/ or treatment nurse should check the LALM setting every shift, when passing medication, and when providing treatment to make sure the right setting of the LALM matched the resident's weight. LVN 1 stated it was important to have the proper LALM setting that matched the resident's weight for wound healing, prevention, and management purposes. LVN 1 stated an incorrect LALM setting would delay the wound healing process.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P), titled Mattresses, revised on 1/1/2012, the P&amp;P indicated staff were to make sure the air mattress was inflating properly and to check the air mattress routinely to ensure that it was working properly.</p>

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<p>F 0690</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858</b></p> <p>Based on observation, interview, and record review, the facility failed to:</p> <p>1. Provide services to prevent the development of septic shock for one out of six sampled residents (Resident 259), who had long-term usage of an indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) by failing to ensure the following:</p> <p>1a. Ensure Resident 259's the urinary drainage was monitored for the presence of sediment (a buildup of particles within the catheter tubing, often caused by factors like dehydration, urinary tract infection [UTI- an infection in the bladder/urinary tract], improper catheter care, or the presence of certain bacteria that promote crystal formation), abnormal color, and foul odor, per the facility's P&amp;P and Resident 259's care plan, for a total of six months.</p> <p>1b. Ensure a urine culture (a lab test that checks for bacteria in a urine sample) was performed after Resident 259's urine analysis (a lab test that provides information about the appearance, chemical composition, and microscopic contents of a urine sample) results indicated Resident 259 had a urinary tract infection on 10/7/2024.</p> <p>These deficient practices led to the delay in UTI identification, delayed treatment, and a three-day admission to the intensive care unit for a diagnosis of septic shock secondary to a UTI for Resident 259.</p> <p>2. Provide adequate nephrostomy (a tube that lets urine drain from the kidney through an opening in the skin on the back) care for one of six sampled residents (Resident 95) when:</p> <p>2a. The nephrostomy bags (a bag that collects urine that drains from a nephrostomy tube) were not placed to gravity (where the urine flows downhill from the nephrostomy tube [inserted in the kidneys] and into the nephrostomy bag and must be positioned below the resident's bladder to allow urine to drain properly) by nursing staff.</p> <p>2b. Sediment (crystals, bacteria, or blood exited through the urine) was present in the right nephrostomy tubing was not documented by the licensed nurses and the physician was not notified of the sediment as ordered.</p> <p>This failure had the potential to cause avoidable urinary tract infections (UTI - an infection in the bladder/urinary tract) and delay in treatment for Resident 95.</p> <p>Findings:</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>1. During a review of Resident 259's Admission Record, the Admission Record indicated Resident 259 was originally admitted to the facility on [DATE]. Resident 259's diagnoses included UTI, sepsis, extended spectrum beta lactamase resistance ([ESBL]- a bacterial infection that can occur in the blood, skin and other parts of the body, which can cause frequent urination, burning when urinating, and reddened skin) , hydronephrosis (kidney swelling) with ureteropelvic junction (the area where the ureter [urine tube] connects to the renal pelvis [inner curve of the kidney]) obstruction (a blockage preventing urine from draining properly and causing the kidney to enlarge), renal and ureteral calculus obstruction (a condition where the kidneys swell due to a blockage in the urinary tract caused by kidney stones and ureteral stones), and neuromuscular dysfunction of the bladder (lack of bladder control).</p> <p>During a review of Resident 259's Minimum Data Set ([MDS], a resident assessment tool), dated 9/26/2024, the MDS indicated Resident 259's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was moderately impaired. The MDS indicated Resident 259 was entirely dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a review of Resident 259's care plan titled, Urinary Catheter Care Plan, initiated 6/4/2024, the Care Plan indicated the facility was to monitor Resident 259's urine for color, sediments, amount, and hematuria (blood in the urine), and order laboratory tests, if indicated.</p> <p>During a review of Resident 259's Situation, Background, Assessment, Recommendation (SBAR -a communication tool used by healthcare workers when there is a change of condition among the residents), dated 12/4/2024, the SBAR indicated Resident 259 exhibited generalized weakness, an elevated heart rate of 147 beats per minutes (bpm, normal range 60 -100 bpm), and rapid breathing with the use of accessory muscles (additional muscles used when a resident exhibits difficulty breathing). The SBAR indicated an unspecified licensed nurse elevated Resident 259's head of the bed and administered oxygen via nasal cannula (tubing used to deliver oxygen) at three liters per minute (LPM). The SBAR indicated Resident 259's oxygen saturation (the percentage of oxygen in a person's blood) increased from 88 percent (%) to 98%, (normal range 93-100%). The SBAR indicated Resident 259 was provided cooling measures and administered acetaminophen (fever-reducing medication). The SBAR indicated Resident 259's indwelling urinary catheter drainage bag had large amounts of sediments present. The SBAR indicated Resident 259's physician was notified and the resident was transferred to the general acute care hospital (GACH). The SBAR indicated Resident 259 had the following vital signs (measurements of the body's most basic functions):</p> <ol style="list-style-type: none"> <li>1. Respiratory (breathing) Rate of 25 breaths per minute (RR, normal RR 12 to 20 breaths per minute).</li> <li>2. Blood Pressure was 100/64 millimeters of mercury ([MM HG]- unit of measurement that describes the amount of force blood uses to get through the vessels of the body [normal range of 120-129 [top number] and 80-84 [bottom number]).</li> <li>3. Temperature of 101.1 Fahrenheit (normal range 97 to 99 degrees Fahrenheit [a unit of measurement]).</li> </ol> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 259's Urine Analysis (UA), dated 10/7/2024, the UA indicated Resident 259's urine appearance was cloudy, positive for nitrites (byproducts found in urine when bacteria like Escherichia coli [[E. Coli] - a type of bacteria] are present), and positive for the presence of leukocytes (white blood cells that help your body fight an infection). The UA also indicated Resident 259's physician did not order a urine culture.</p> <p>During a review of Resident 259's GACH Emergency Department (ED) Medical Doctor (MD) Progress Notes, dated 12/4/2024, the notes indicated Resident 259 was brought into the emergency department, on 12/4/2024 at 10:54 a.m. with the following vital signs: blood pressure of 78/54 MM HG, temperature of 102.4 F, heart rate of 145 bpm, respiratory rate of 42 (RR, breaths per minute), and oxygen saturation of 84 percent (%) and was placed on 15 liters per minute via non-rebreather mask (oxygen mask that delivers high concentrations of oxygen). The notes indicated Resident 259 was disoriented and repeatedly asked about the reason for his visit. The notes indicated Resident 259's computed tomography ([CT]- a noninvasive imaging procedure that uses X-rays to create cross-sectional images of the body) scan indicated Resident 259 had a 2.5 centimeter ([CM]- a unit of measurement) left ureter stone (a crystal-like hard stone that gets lodged into ureter [the tube that connects your kidneys to your bladder]) with hydronephrosis and perinephric stranding (a sign of inflammation or obstruction in the kidney or collecting system). The notes indicated Resident 259 was given intravenous (IV, through the veins) fluid, placed on a Levophed (a medication used to maintain blood pressure) and Amiodarone (a medication used to stabilize and control the heart rate) drip, and admitted to the Intensive Care Unit (ICU, a specialized hospital ward that provides critical care and life support to patients who are very ill or injured), on 12/4/2024, for stabilization. The note indicated Resident 259 was diagnosed with sepsis (a life-threatening medical emergency that occurs when the body's immune system has an extreme response to an infection or injury) due to UTI with hypotension (low blood pressure).</p> <p>During a review of Resident 259's GACH UA Laboratory Results, dated 12/4/2024, the results indicated Resident 259's urine appearance was turbid (not clear or transparent because of stirred-up sediment).</p> <p>During a review of Resident 259's GACH Blood Laboratory Results, dated 12/4/2024, the results indicated Resident 259's lactic acid level (a blood test that is used to help diagnose sepsis) was critically high at a value of 4.1 (normal: 0.7-1.9) millimoles per liter ([MMOL/L]- a unit of measurement). The results indicated Resident 259's white blood cell count ([WBC]-a blood test used to indicate the presence of inflammation or an infection) was abnormally high at a value of 15.5 (normal WBC count: 4.5 and 11.0 microliters) microliter ([X10<sup>3</sup>/UI]- a unit of measurement used to report WBC counts).</p> <p>During a review of Resident 259's GACH Urine Culture Laboratory Results, dated 12/4/2024, the results indicated Resident 259 had greater than 100,000 colony forming units per milliliter ([CFU/ML]- a unit of measurement) of E. Coli and Proteus Mirabilis (a type of bacteria).</p> <p>During a review of Resident 259's GACH Progress Notes, dated 12/5/2024, the notes indicated Resident 259 was treated with a Levophed drip 4 milligram (mg, unit of measurement) per 250 milliliters (ML)- a unit of measurement, Amiodarone drip 900 MG /18 ML, and Ceftriaxone (an antibiotic) 1 gram ([GM]- a unit of measurement) IV every 24 hours.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 259's GACH MD Progress Notes, dated 12/10/2024, the notes indicated Resident 259 was downgraded from the ICU to the telemetry unit (a unit that enables continuous tracking of the resident's heartbeat).</p> <p>During a review of Resident 259's GACH Discharge Summary Note, dated 12/11/2024, the note indicated Resident 259 was diagnosed with septic shock secondary to pyelonephritis (kidney infection) and bacteremia (bacteria in the blood) with ESBL E. coli.</p> <p>During an interview on 12/18/2024, at 9:35 a.m., with the facility's Treatment Nurse (TXN) 1, TXN 1 stated she was familiar with Resident 259 and noticed Resident 259's indwelling urinary catheter always had sediments since his initial admission into the facility. TXN 1 stated she did not notify the charge nurse or Resident 259's physician because Resident 259 always had sediments in his urine.</p> <p>During a concurrent record review and interview, on 12/18/2024, at 10:30 a.m., with Registered Nurse (RN) 2, Resident 259's Physician Orders, dated 6/2024 to 12/4/2024, and Medication Administration Record (MAR), dated 6/2024 to 12/4/2024, were reviewed. RN 2 stated the Physician Orders indicated Resident 259 was ordered to have an indwelling urinary catheter from 6/3/2024 to 12/4/2024. RN 2 stated the Physician Orders did not indicate any orders to monitor Resident 259's urine output appearance (presence of sediment, color, foul odor) from 6/3/2024 to 12/4/2024. RN 2 stated the MAR indicated Resident 259's urine output appearance was not documented from 6/3/2024 to 12/4/2024. RN 2 stated it was important for the licensed nursing staff to monitor the appearance of Resident 259's urine output to prevent Resident 259 from developing an infection and sepsis. RN 2 stated the order to monitor the indwelling urinary catheter's urine output was missed, and all licensed nurses were responsible with ensuring the order was inputted and carried out. RN 2 stated the facility may have delayed the treatment of Resident 259's UTI because the licensed nurses did not effectively monitor Resident 259's urine output appearance.</p> <p>During a concurrent record review and interview, on 12/18/2024 2:00 p.m., with RN 2, Resident 259's UA, dated 10/7/2024, was reviewed. RN 2 stated it was important to order a urine culture if a UA was positive so the resident could receive the proper antibiotics for treatment of the UTI. RN 2 stated MD 1 was made aware of the positive UA. RN 2 stated MD 1 did not order a urine culture because MD 1 was conservative when it came to prescribing antibiotics for Resident 259. RN 2 stated because Resident 259 did not present with any other signs and symptoms of a UTI antibiotics were not prescribed.</p> <p>During an interview, on 12/18/2024, at 3:31 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 259's urine output appeared foggy at various times (CNA 1 could not recall the dates). CNA 1 stated she did not notify the charge nurses because she believed the charge nurses already knew Resident 259's urine output normally appeared that way.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Maywood Skilled Nursing & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE  6025 Pine Ave Maywood, CA 90270	
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<p>F 0690</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 12/19/2024, at 10:06 a.m., with Physician 1, Physician 1 stated that he was Resident 259's attending physician, a urologist (a medical doctor who specializes in the diagnosis and treatment of diseases and conditions of the urinary tract system) and the facility's Medical Director. Physician 1 stated that the expectation of the licensed nurses regarding the care of a resident with an indwelling urinary catheter was to monitor for the signs and symptoms of an infection. Physician 1 stated that it was important to monitor the urine output appearance to identify the signs of an active urinary infection and to avoid sepsis. Physician 1 stated that the order to assess the qualities of the urine output was a part of the order set for all residents who had an indwelling foley catheter. Physician 1 stated that he met with the nursing staff to educate them on the importance of monitoring the appearance of the urine output and always reminded the staff not to underestimate the presence of precipitate (a buildup of particles), and cloudiness of the urine. Physician 1 expected that he would have been notified of these kinds of changes for Resident 259.</p> <p>During an interview, on 12/19/2024, at 11:53 a.m., with the Director of Nursing (DON), the DON stated it was important that the licensed nurses assessed the qualities and characteristics of a resident's urine output for cloudiness, presence of sediment and odor every shift so that the care of the resident was not delayed and to decrease the potential for sepsis. The DON stated Resident 259's order to assess the urine output was missed and there was no documentation of a baseline assessment to verify that Resident 259's urinary output improved or worsened over time. The DON stated a urine culture should have been ordered so that Resident 259 could have received treatment in a timely manner even if Resident 259 was asymptomatic (exhibiting no signs and symptoms of a medical condition). The DON stated the lack of assessment of Resident 259's urinary output and advocacy for a urine culture led to a delay in treatment, diagnosis of septic shock, and harm for Resident 259.</p> <p>48131</p> <p>2. During a review of Resident 95's Admission Record, dated 12/18/2024, the admission record indicated Resident 95 was admitted on [DATE] and readmitted on [DATE] with the following diagnoses which included chronic kidney disease (CKD - a longstanding disease in which the kidneys are damaged and cannot filter blood as well as they should leading to renal failure), acute kidney failure (the sudden and rapid loss of the kidney's ability to filter waste and balance fluid in blood), hydronephrosis (a condition where one or both kidneys swell due to a buildup of urine), malignant neoplasm of the bladder (bladder cancer), and retention of urine definition (a condition that makes it difficult to empty the bladder).</p> <p>During a review of Resident 95's History and Physical (H&amp;P), dated 8/9/2024, the H&amp;P indicated Resident 95 had the capacity to understand and make decisions.</p> <p>During a review of Resident 95's MDS, dated [DATE], the MDS indicated Resident 95's cognition was intact. The MDS indicated Resident 95 had an indwelling catheter and required supervision with eating, toileting and personal hygiene, and toileting.</p> <p>During a review of Resident 95's Order Summary Report, dated 10/10/2024, the order summary report indicated and active order to monitor Resident 95's nephrostomy bag for signs and symptoms of infection, noting cloudiness, sediment, blood, and odor and notify if any signs and symptoms were present every shift.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 95's MAR, dated 12/1/2024 through 12/16/2024. The MAR indicated to monitor Resident 95's nephrostomy bag for signs and symptoms of infection, noting cloudiness, sediment, blood, and odor and notify if any signs and symptoms were present every shift. The MAR indicated there were no signs of cloudiness, sediment, blood, or odor from 12/1/2024 through 12/16/2024 for all shifts.</p> <p>During a review of Resident 95's Care Plan titled Nephrostomy Placement Bilateral (both sides) Surgery, initiated on 10/10/2024 and revised on 11/13/2024, the care plan indicated Resident 95's bladder would be adequately emptied without complication as evidenced by no bladder distention, pain/discomfort and no signs and symptoms UTI The care plan interventions indicated to monitor nephrostomy bag for signs and symptoms of infection and notify physician if an signs and symptoms present and provide nephrostomy care per protocol daily and as needed.</p> <p>During a review of Resident 95's Care Plan titled UTI, initiated on 12/8/2024, the care plan indicated Resident 95's would have no complaints of pain or bladder discomfort and would resolve after treatment interventions. The care plan indicated interventions to monitor urine for sediment, cloudiness, odor, blood tinge and amount and report any signs and symptoms to the physician. m bladder would be adequately emptied without complication as evidenced by no bladder distention, pain/discomfort and no signs and symptoms of UTI. The care plan interventions indicated to monitor nephrostomy bag for signs and symptoms of infection and notify physician if an signs and symptoms present and provide nephrostomy care per protocol daily and as needed.</p> <p>During a review of Resident 95's Nursing Progress Notes, dated 2/9/2024, the progress note indicated Resident 95 was started on Rocephin (a medication to treat infections) until 12/15/2024 due to UTI.</p> <p>During an observation on 12/16/2024 at 2:44 p.m., in Resident 95's room, Resident 95 was sitting in a wheelchair with both left and right nephrostomy bags lying on his bed which was positioned higher than his wheelchair. The right nephrostomy tubing contained an off-white, thick milky sediment.</p> <p>During an observation on 12/17/2024 at 1:44 p.m., in Resident 95's room, Resident 95 was sitting in his wheelchair with both left and right nephrostomy bags rolled up into his pants pocket. Resident 95's pocket on the right side was wet from urine leaking from the nephrostomy bag. Resident 95's nephrostomy tubing on the right side showed an off-white, thick, milky sediment.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation, interview, and record review on 12/17/2024 at 1:47 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 observed Resident 95's nephrostomy bag and nephrostomy tubing. LVN 2 also reviewed Resident 95's monitoring log on the MAR, and the nursing progress notes. LVN 2 noted that there was sediment in Resident 95's nephrostomy tubing on the right side and the nephrostomy bags on the left and right side were rolled up and placed inside of Resident 95's pants pockets as he sat in his wheelchair. LVN 2 also noted Resident 95's right pants pocket was saturated with urine leaking from the right nephrostomy bag. LVN 2 stated Resident 95 was recently treated for a UTI and the sediment in the tubing was due to the recent UTI. LVN 2 stated it was her responsibility to monitor the tubing for signs of infection, which included cloudiness, sediment, or blood and document the findings on Resident 95's nephrostomy monitoring log and nursing progress notes during her shift. LVN 2 admitted she had not monitored Resident 95's nephrostomy for sediment in the tubing on 12/16/2024 and this observation was her first time seeing the sedimentation in the right tubing. LVN 2 stated she would notify the doctor immediately since she had been made aware of the sedimentation. LVN 2 reviewed Resident 95's nephrostomy monitoring log. LVN 2 acknowledged that she had been marking N for no sedimentation on Resident 95's nephrostomy monitoring log even though she had not been checking it daily. LVN 2 acknowledged she placed an N for no sediment on Resident 95's nephrostomy monitoring log on 12/16/2024 although she had not checked for sedimentation on that day. LVN 2 stated it was important to monitor Resident 95's nephrostomy tubing and urine output every shift and to call the doctor if sediment was observed in the tubing so that the doctor would be aware of Resident 95's status and write orders if needed. LVN 2 stated it was also important to document the finding in the nursing progress notes and the nephrostomy monitoring log. LVN 2 acknowledged she had not made any notes regarding Resident 95's nephrostomy bags or tubing in the nursing progress notes. LVN 2 also admitted it was inappropriate for Resident 95 to keep his nephrostomy bags and tubing rolled up inside of his pockets. LVN 2 stated the nephrostomy bags should have been positioned to gravity so the urine in the tubing could flow freely into the bags and not back flow into the kidneys. LVN 2 stated if urine flowed backwards into the kidneys, it could lead to further urinary tract infections.</p> <p>During a concurrent interview and record review with LVN 1, Resident 95's nursing progress notes and nephrostomy care plan were reviewed for the month of November and December. LVN 1 stated that Resident 95's primary care physician informed the nurses that it was normal for Resident 95 to have sediment in the tubing because he had bladder cancer. LVN 1 viewed the nursing progress notes and stated he could not find the notes regarding sediment in the nephrostomy tubing to be normal for Resident 95. LVN 1 reviewed Resident 95's nephrostomy care plan and acknowledged the care plan indicated to notify the physician if there was sedimentation in the nephrostomy tubing. LVN 1 stated the physician should have been notified if sedimentation was present in the tubing.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 12/17/2024 at 3:09 p.m., with TXN 1, Resident 95's nursing care plan and nephrostomy monitoring log on the MAR was reviewed. TXN 1 stated she was responsible for Resident 95's daily nephrostomy dressings change. TXN 1 stated she had observed sedimentation in Resident 95's tubing every day for the month of December 2024 when performing nephrostomy dressing changes. TXN 1 stated she did not document the sedimentation or call the physician because she had heard from nurses that it was okay for Resident 95 to have sedimentation in his nephrostomy tubing. TXN 1 acknowledged there was no documentation in the nursing progress notes to indicate it was okay for resident to have sedimentation in his tubing. TXN 1 stated Resident 95's nephrostomy instructions should have been documented in the nursing progress notes when the resident returned from his nephrology appointment so that the nursing staff would have something to follow regarding the nephrostomy tubing. TXN 1 reviewed Resident 95's nephrostomy care plan and stated she was not following the care plan interventions for monitoring the nephrostomy bags for signs and symptoms of infection, including monitoring for sediment as indicated because Resident 95 was already on antibiotics for a UTI. TXN 1 admitted she should have followed Resident 95's nephrostomy care plan to ensure Resident 95 did not continue to develop UTIs.</p> <p>During a concurrent observation and interview on 12/19/2024 at 8:04 a.m., with TXN 1 and Resident 95, the nephrostomy dressing changes were observed by TXN 1. Resident 95 was sitting on the edge of his bed with both nephrostomy bags lying on his bed. TXN 1 stated she put Resident 95's nephrostomy bags on the bed to prepare for his nephrostomy dressing changes. Resident 95 stated wanted his nephrostomy bags lying out on the bed or in his pockets because it was easier to get to the bags when he needed to urinate. TXN 1 stated Resident 95 needed more education regarding the care of his nephrostomy bags because he should not have to bother the bags when he needed to urinate. TXN 1 stated, since Resident 95 could also urinate from his penis, he only needed to use the bedside urinal when he had the urge to urinate. TXN 1 stated there was a urinal at his bedside. TXN 1 proceeded to educate Resident 95 in Spanish regarding the care of his nephrostomy bags. TXN 1 stated that she educated Resident 95 that he should not touch the nephrostomy bags when he had an urge to urinate. TXN 1 stated she also explained to Resident 95 the importance of keeping the bags to gravity and not in his pocket to prevent infection. TXN 1 explained that the dignity bag was for his protection and privacy. TXN 1 showed the dignity bag to Resident 95 and how they were to be placed inside of the dignity bag. Resident 95 shook his head in agreement and did not refuse the dignity bags.</p> <p>During a telephone interview on 12/19/2024 at 10:17 a.m., with Physician 1, Physician 1 stated that the white slimy sedimentation noted in Resident 95's nephrostomy tubing was normal for Resident 95, however the sedimentation should have been documented and monitored by the nurse to ensure any changes could be noted for comparisons. Physician 1 stated he would educate the nurses on the proper care of Resident 95's nephrostomies because the nurses are not familiar with the caring for nephrostomies. Physician 1 state he would also educate the nurses on Resident 95's nephrostomy baseline (an initial measurement of a resident's condition and used for comparison over time to look for changes) and inform the nurses that the baseline should be documented. Physician 1 stated the nurses must then notify him (Physician 1) if there were any changes from the baseline.</p> <p>During an interview on 12/19/2024 at 10:42 a.m. with the DON, the DON stated it was important to ensure Resident 95's nephrostomy tubing was at gravity level and not rolled up in his pockets to prevent back flow to the kidneys which would cause an infection. The DON stated Resident 95 was preparing for surgery and could not afford to keep getting UTIs. The DON stated once Resident 95's immune system was compromised, and frequent infections would delay his radiation treatments and upcoming surgery.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During review of the facility's policy and procedure (P&amp;P) titled, Catheter - Care of, revised on 6/10/2021, the P&amp;P indicated the purpose of the policy was to prevent catheter associated urinary tract infections while ensuring that residents are not given indwelling catheters unless medically necessary. The P&amp;P also indicated the following:</p> <ol style="list-style-type: none"> <li>1. Nursing staff would assess urinary drainage for signs and symptoms of infection, noting cloudiness, color, sediment, blood, odor, and amount of urine.</li> <li>2. Licensed nurse would notify the attending physician of any signs and symptoms of infection for clinical interventions.</li> <li>3. Anyone manipulating the catheter site or apparatus must wash their hands thoroughly immediately before and after touching the site or apparatus.</li> <li>4. The catheter and collecting tube would be kept free from kinking and the collection bag would be kept below the level of the bladder.</li> <li>5. The catheter will be anchored to prevent excessive tension on the catheter.</li> <li>6. Documentation of catheter care will be maintained in the resident's medical record.</li> <li>7. The resident's privacy and dignity will be protected by placing a cover over the drainage bag when the resident is out of bed.</li> </ol>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48131</p> <p>Based on observation, interview, and record review, the facility failed to check the gastrostomy tube (GT, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) placement and gastric residual volume (GRV - the amount of liquid remaining in the stomach after an enteral feeding [method of feeding that uses the gastrointestinal [GI - stomach and intestines tract to deliver nutrition and calories]) for one of six residents (Resident 12).</p> <p>This deficient practice had the potential to cause aspiration (feeding entering the lungs), stomach irritation, vomiting, and malnutrition for Resident 12 .</p> <p>Findings:</p> <p>During a review of Resident 12's Admission Record, dated 12/18/2024, the admission record indicated Resident 12 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 12's diagnoses included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic kidney disease (CKD - a longstanding disease in which the kidneys are damaged and cannot filter blood as well as they should leading to renal failure), dysphagia (difficulty swallowing), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 12's History and Physical (H&amp;P), dated 4/2/2024, the H&amp;P indicated Resident 12 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool), dated 12/3/2024, the MDS indicated Resident 12's cognition (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 12 required substantial assistance (helper does more than half the effort) with eating and toileting and was dependent (helper does all of the effort) on staff with bathing and personal hygiene.</p> <p>During a review of Resident 12's Order Summary Report, dated 6/2/2024, the order summary report indicated to check Resident 12's residuals every shift and hold tube feeding if the residual was above 100 milliliters (ml - a metric unit of measurement, used for liquid/fluids).</p> <p>During a review of Resident 12's Care Plan titled Needs GT Tube feeding initiated on 6/2/2024 and revised on 9/4/2024, the care plan indicated Resident 12 would have no signs and symptoms of aspiration or infection at the GT site for three months. The care plan interventions included to check placement and patency of GT every shift, check residual prior to restarting feeding and hold if residual is above 100 ml. The care plan indicated to monitor for tolerance of the prescribed GT feeding and monitor for complications of non-tolerance of feeding such as nausea, vomiting, abdominal distention, pain diarrhea and constipation.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 12/18/2024 at 12:06 p.m., with Licensed Vocational Nurse (LVN) 5, in Resident 12's room, observed LVN 5 connect Resident 12's tube feeding and start the feeding pump at 75 ml per hour. LVN 5 did not check for residuals or the placement of the g-tube before starting the tube feeding. LVN 5 acknowledged Resident 12's residual and g-tube placement should have been checked before starting the tube feeding. LVN 5 stated it was important to know if Resident 12 was digesting the food properly. LVN 5 stated if Resident 12's residual was more than 100 mls, she should stop the tube feeding and call the doctor. LVN 5 stated Resident 12 could have started vomiting or have abdominal discomfort if the tube feeding was given with a residual greater than 100 mls.</p> <p>During an interview on 12/19/2024 at 10:55 a.m., with the Director of Nursing (DON), the DON stated it was important to check Resident 12's g-tube placement because the g-tube may not have been properly placed in the stoma (a surgically created opening in the body that connects an internal organ to the outside of the body). The DON stated if the g-tube was not in the stoma, the tube feeding would go inside the lining of the stomach and could cause peritonitis (inflammation of the peritoneum, the tissue that lines the abdominal wall and covers most of the abdominal organs).</p> <p>During a review of the facility's policy and procedure (P&amp;P), titled, Enteral Tube Management: Gastrostomy Tube - Jejunostomy Tube, revised 9/28/2023, the P&amp;P indicated:</p> <p>Enteral tubes should be verified for placement and patency prior to intermittent feeding, at every shift, and prior to administering medications, hydration, and nutrition via enteral feeding tubes. The P&amp;P indicated to check for correct placement of gastrostomy feeding tube by using the following method:</p> <ol style="list-style-type: none"> <li>1. Connect the syringe to the end of tube.</li> <li>2. Slowly pull back the syringe to aspirate contents.</li> <li>3. Note the characteristics of syringe contents: amount, color, and texture</li> <li>4. Return aspirate contents to the stomach.</li> <li>5. If correct placement is not completely assured, do not administer feeding or medication. Contact physician for further instruction.</li> </ol>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>49900</p> <p>Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved temperatures when the lunch tray line food temperatures were as follows:</p> <ol style="list-style-type: none"> <li>1. Quesadillas temperature measurement indicated 120 degrees Fahrenheit ( F, a degree of temperature).</li> <li>2. Lasagna temperature measurement indicated 126 F .</li> </ol> <p>This deficient practice had the potential to place 112 of 115 facility residents who received food from the kitchen at risk of unplanned weight loss, a consequence of poor food intake from food in the kitchen. Cross reference to F812.</p> <p>Findings:</p> <p>During an observation on 12/17/2024 at 11:50 a.m., the dietary staff were observed starting the tray line service for lunch.</p> <p>During a concurrent observation and interview on 12/17/2024 at 12:05 p.m., in the kitchen, with [NAME] 1, a tray of quesadillas and lasagna was observed placed on the shelf away from the stove and steam table (a large metal table or container with openings that held smaller metal pans of food over hot water or steam). [NAME] 1 was observed taking the temperature of the food items using the facility's food thermometer. The food item temperatures were as follows:</p> <ol style="list-style-type: none"> <li>1. Quesadillas - 120 F.</li> <li>2. Lasagna - 126 F.</li> </ol> <p>Cook 1 stated the quesadillas were for the alternative menu and the lasagna was for residents receiving a liquid diet. [NAME] 1 stated he placed the quesadillas and lasagna on the shelf because there was no more space on the stove or the steam table.</p> <p>During a concurrent interview and record review on 12/17/2024 at 12:40 p.m. with the Dietary Supervisor (DS), the facility's Policy and Procedure (P&amp;P) titled, Food temperatures, revised on 7/1/2024, was reviewed. The P&amp;P indicated the required temperature for hot food was greater than 140 F. The DS stated the temperature for hot food should be above 140 F. The DS a temperature of 120 F for quesadillas and 126 F for lasagna were unacceptable. The DS stated the quesadillas could be provided to residents with regular and mechanical soft diet (a diet of soft foods that were easy to chew and swallow), and the lasagna was provided to residents who were unable to tolerate a pureed diet (a texture-modified eating plan where all foods were blended, mixed, or processed into a smooth, pudding-like consistency). The DS stated the food would not be palatable for resident because it was cold, and it could potentially increase the risk of poor food intake and unplanned weight lost.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Maywood Skilled Nursing & Wellness Centre		STREET ADDRESS, CITY, STATE, ZIP CODE  6025 Pine Ave Maywood, CA 90270	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 12/18/24 at 2:30 p.m. with the DS, the DS stated there was no policy for food palatability or menu planning, and the facility should have a policy addressing the food palatability if there was a concern.</p>

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<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>49900</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when food temperatures were out of range as follows:</p> <ol style="list-style-type: none"> <li>1. Quesadillas measurement indicated 120 degrees Fahrenheit ( F, a degree of temperature).</li> <li>2. Lasagna measurement indicated 126 F.</li> </ol> <p>This deficient practice had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (transfer of bacteria from one object to another) in 112 of 115 medically compromised residents who received food from the kitchen. Cross reference to F804.</p> <p>Findings:</p> <p>During an observation on 12/17/2024 at 11:50 a.m., the dietary staff were observed starting the tray line service for lunch.</p> <p>During a concurrent observation and interview on 12/17/2024 at 12:05 p.m., in the kitchen, with [NAME] 1, a tray of quesadillas and lasagna was observed placed on the shelf away from the stove and steam table (a large metal table or container with openings that held smaller metal pans of food over hot water or steam). [NAME] 1 was observed taking the temperature of the food items using the facility's food thermometer. The food item temperatures were as follows:</p> <ol style="list-style-type: none"> <li>1. Quesadillas - 120 F.</li> <li>2. Lasagna - 126 F.</li> </ol> <p>Cook 1 stated the quesadillas were for the alternative menu and the lasagna was for residents receiving a liquid diet. [NAME] 1 stated he placed the quesadillas and lasagna on the shelf because there was no more space on the stove or the steam table.</p> <p>During a concurrent interview and record review on 12/17/2024 at 12:40 p.m. with the Dietary Supervisor (DS), the facility's Policy and Procedure (P&amp;P) titled, Food temperatures, revised on 7/1/2024, was reviewed. The P&amp;P indicated the required temperature for hot food was greater than 140 F. The DS stated the temperature for hot food should be above 140 F, and 120 F for quesadillas and 126 F for lasagna were unacceptable. The DS stated the quesadillas could be provided to residents with regular and mechanical soft diet (a diet of soft foods that were easy to chew and swallow), and the liquid lasagna was provided to residents who were unable to tolerate a pureed diet.</p> <p>(continued on next page)</p>

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F 0812  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Many	During an interview on 12/19/2024 at 11:30 a.m. with the Infection Preventionist Nurse (IPN), the IPN stated hot food cold have bacteria growth if it was less than 140 F. The IPN stated residents might become sick and develop stomach issues from eating hot food outside of the appropriate temperature range.		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>49900</p> <p>Based on observation, interview, and record review, the facility failed to ensure the garbage storage area was maintained in a sanitary manner to prevent the harborage and feeding of pests when the outside trash dumpster lids were not closed.</p> <p>This deficient practice had the potential to result in creating harborage and feeding of pests which could lead to diseases and increase the morbidity (the amount of disease in a population) and mortality (the state of being subject to death) among facility residents.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 12/17/2024 at 9:58 a.m., of the outdoor garbage storage area, with the Dietary Supervisor (DS), two trash dumpster lids were observed not closed completely. The DS stated the trash dumpster lids should be closed completely to keep flies away. The DS stated flies transported bacteria and residents might catch bacteria and get sick.</p> <p>During an interview on 12/17/2024 at 1:40 p.m. with the Infection Preventionist Nurse (IPN), the IPN stated the outside trash dumpster lids should be closed completely for infection control prevention.</p> <p>During an interview on 12/18/2024 at 10:40 a.m. with the Administrator (ADM), the ADM stated the facility did not have a policy that specified the outside trash dumpster lids needed to be closed completely, but would formulate one.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Garbage and trash can use and cleaning, revised on 10/1/2014, the P&amp;P indicated Food waste will be placed in covered garbage and trash cans.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</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 implement infection control practices for two of two resident (Resident 52 and 310) when the following occurred:</p> <ol style="list-style-type: none"> <li>1. Resident 52's nebulizer mask (a plastic cup that fit over the mouth and nose to deliver liquid medication as a mist into the lungs) was unlabeled.</li> <li>2. Resident 310's nebulizer mask was unlabeled.</li> </ol> <p>These deficient practices placed Resident 52 and Resident 310 at risk for infection which could increase the morbidity (the amount of disease in a population) and mortality (the state of being subject to death) among residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During an observation on 12/16/2024 at 10:37 a.m., in Resident 52's room, observed an opened, unlabeled nebulizer mask at the bedside. The mask did not indicate the resident's name or date.</li> </ol> <p>During an observation on 12/16/2024 at 3:58 p.m., in Resident 52's room, observed an opened, unlabeled nebulizer mask at the bedside. The mask did not indicate the resident's name or date.</p> <p>During a review of Resident 52's Admission Record, the admission record indicated Resident 52 was admitted to the facility on [DATE]. Resident 52's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), generalized muscle weakness, schizophrenia (a mental illness that was characterized by disturbances in thought), and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 52's History and Physical (H&amp;P), dated 12/15/2024, the H&amp;P indicated Resident 52 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 52's Minimum Data Set (MDS - a resident assessment tool), dated 7/5/2024, the MDS indicated Resident 52's cognition (ability to think, remember, and reason) was intact. The MDS indicated Resident 52 required supervision with eating and oral hygiene; and partial assistance (helper did less than half the effort) with toileting hygiene, showering, bathing, and personal hygiene.</p> <p>During a review of Resident 52's Oder Summary Report, dated 12/14/2024, the order summary report indicated an order, dated 12/14/2024, to administer albuterol sulfate (a liquid medicine, typically used with a nebulizer machine [a small, electrically-powered machine that turned liquid medication into a mist for inhalation] that helped people with lung conditions to breathe easier) 0.63 milligram (mg, a unit of mass or weight) via nebulizer at bedtime.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and picture review on 12/17/2024 at 1:19 p.m. with Licensed Vocational Nurse (LVN) 1, the picture taken on 12/16/2024 at 10:37 a.m. was reviewed. The picture indicated an opened, unlabeled nebulizer mask without the resident's name or date. LVN 1 stated the nebulizer mask should have the resident's name or date labeled.</p> <p>2. During an observation on 12/16/2024 at 10:53 a.m., in Resident 310's room, observed an opened, unlabeled nebulizer mask at the bedside. The mask did not indicate the resident's name or date.</p> <p>During an observation on 12/16/2024 at 3:59 p.m., in Resident 310's room, observed an opened, unlabeled nebulizer mask at the bedside. The mask did not indicate the resident's name or date.</p> <p>During a review of Resident 310's Admission Record, the admission record indicated Resident 310 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 310's diagnoses included COPD, generalized muscle weakness, schizophrenia, and dementia.</p> <p>During a review of Resident 310's H&amp;P, dated 12/14/2024, the H&amp;P indicated Resident 310 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 310's MDS, dated [DATE], the MDS indicated Resident 310's cognition was severely impaired. The MDS indicated Resident 310 required setup or clean-up assistance (helper set up or cleaned up; resident completed activity) with eating; partial assistance with oral and toileting hygiene; and substantial assistance (helper did more than half the effort) with showering and bathing.</p> <p>During a review of Resident 310's Oder Summary Report, dated 12/13/2024, the order summary report indicated an order, dated 12/13/2024, to administer albuterol sulfate 0.63 mg via nebulizer at bedtime.</p> <p>During a concurrent of interview and picture review on 12/17/2024 at 1:15 p.m. with LVN 1, a picture of Resident 310's bedside taken on 12/16/2024 at 10:53 a.m. was reviewed. The picture indicated an opened, unlabeled nebulizer mask. The mask did not indicated the resident's name or date. LVN 1 stated the nebulizer mask was for breathing treatments (a medical procedure that delivered medication directly into the lungs to help people with respiratory conditions breathe more easily) and needed to be dated by the nurse who opened it. LVN 1 stated the nebulizer mask should have a date, so staff knew when it was opened. LVN 1 stated it could potentially cause infections for the resident. LVN 1 stated staff should change the nebulizer mask every week, every 7 days, and/or as needed.</p> <p>During a concurrent interview and picture review on 12/19/2024 at 11:27 a.m. with the Infection Preventionist Nurse (IPN), a picture taken on 12/16/2024 at 3:59 p.m. was reviewed. The picture indicated an opened , unlabeled nebulizer mask. The mask did not indicate the resident's name or date. The IPN stated the nebulizer mask did not have indicated the resident's name or date. The IPN stated when the nebulizer mask became old, it would have dust and debris that caused germs and make residents sick.</p> <p>(continued on next page)</p>		

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<p>F 0880</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 12/19/2024 at 11:29 a.m. with the IPN, the facility's Policy and Procedure (P&amp;P) titled Oxygen therapy, revised on 11/2017, was reviewed. The P&amp;P indicated Oxygen tubing, mask, and cannulas will be changed no more than every seven days and as needed. The supplies will be dated each time they are changed. The IPN stated the facility utilized the Oxygen therapy P&amp;P for nebulizer masks, and staff should change the nebulizer mask every seven days and label it with the resident's name and date once opened.</p> <p>During a review of the facility's P&amp;P titled, Nebulizer (small volume), revised on 10/15/2020, the P&amp;P indicated, If new, label the set-up bag with the resident's name and date.</p>