| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555199 | A. Building<br>B. Wing | 12/23/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Coast Care Convalescent Center | 14518 E. Los Angeles St.<br>Baldwin Park, CA 91706 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop specific and resident-centered care plans (CP) for three of three sampled residents (Residents 1, 2, and 3). These deficient practices had the potential for Residents 1, 2, and 3 to not receive appropriate care, treatment, and/or services related to their needs. Findings: a. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypertensive heart disease (high blood pressure [HTN] damaged the heart over time) and generalized muscle weakness. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 12/18/2025, the MDS indicated Resident 1 had moderate cognitive (ability to understand) impairment. The MDS indicated Resident 1 required supervision from staff with eating and oral hygiene. The MDS indicated Resident 1 required maximal assistance (helper did more than half the effort) from staff with toileting hygiene and toileting transferring. During a review of Resident 1's Order Summary Report (OSR), with active orders as of 12/22/2025, the OSR indicated a physician's order for licensed staff to administer losartan (medication to treat HTN) daily starting on 12/13/2025. The OSR indicated a diet order of no added salt (NAS) with mechanical soft texture (a diet that included foods softened by cooking, chopping, or mashing) and thin liquids consistency (a liquid consistency that flowed easily like water and did not require chewing), starting on 12/13/2025. During a concurrent record review and interview with the facility's Infection Preventionist Nurse (IPN) on 12/23/2025 at 12:56 PM, Resident 1's CP for hypertensive heart disease, revised on 12/22/2025 was reviewed. The CP indicated staff were to maintain optimum quality of life for Resident 1. The CP interventions indicated staff were to administer medication and diet as ordered. The IPN stated the CP was not specific and should have included the medication name. b. During a review of Resident 2's AR, the AR indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including pneumonia (an infection in the lungs), sepsis (a life-threatening blood infection), and gastroesophageal reflux disease (GERD, stomach acid goes back up ). During a review of Resident 2's History and Physical (H&P) dated 10/26/2025, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had intact cognition (ability to think and reason). The MDS indicated Resident 2 required supervision from staff for eating. The MDS indicated Resident 2 required partial assistance (helper did less than half the effort) from staff for oral hygiene, personal hygiene, toileting hygiene, showering, bed-to-chair transferring, and walking. During a review of Resident 2's OSR with active orders as of 12/22/2025, the OSR indicated a physician's order for licensed staff to administer famotidine (medication for GERD) 20 milligrams (mg- unit of measurement) daily for GERD starting on 10/25/2025. The OSR indicated a regular diet order with double portion and no added salt starting on 10/29/2025. The OSR did not indicate an order for antibiotic (medication to treat infection) medication. During a concurrent record review and interview with the facility's IPN on 12/23/2025 at 12:56 PM, Resident 2's CP for GERD revised on 11/3/2025 was reviewed. The CP intervention indicated staff were to provide diet as ordered and administer medication as ordered. The IPN stated the CP was not specific because the medication was not listed. During a concurrent record review and interview with the facility's IPN on 12/23/2025 at 12:56 PM, Resident 2's CP for sepsis related to pneumonia revised on 11/3/2025 was reviewed. The CP goal indicated that sepsis would be resolved after antibiotic therapy. The CP intervention indicated staff were to administer antibiotic medication as ordered. The IPN stated the CP was not specific. The IPN stated the CP was not updated and should have been discontinued because Resident 2 did not have active pneumonia nor ongoing antibiotic treatment at this time. The IPN stated the licensed nurse who administered the last dose of the antibiotic should have discontinued the CP. The IPN stated if a medication changed or was discontinued, the CP should have been updated. The IPN stated the risk of not updating CP included medication errors and negative effects on the residents' care. The IPN stated it was not acceptable to have a CP that was outdated, did not reflect changes based on the resident's current condition or did not meet the resident's needs. c. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including dyspepsia (discomfort or pain in the upper abdomen after eating) and muscle weakness. During a review of Resident 3's H&P dated 10/25/2025, the H&P indicated Resident 3 had fluctuating capacity to understand and make decisions. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 had |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the physician's order for one of three sampled residents (Resident 1) when the licensed nurse did not take Resident 1's heart rate prior to administration of losartan (medication for high blood pressure) as ordered, from 12/13/2025 to 12/22/2025. These violations had the potential to compromise Resident 1's health and safety.Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypertensive heart disease (high blood pressure [HTN] damaged the heart over time) and generalized muscle weakness. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 12/18/2025, the MDS indicated Resident 1 had moderate cognitive (ability to understand) impairment. The MDS indicated Resident 1 required supervision from staff with eating and oral hygiene. The MDS indicated Resident 1 required maximal assistance (helper did more than half the effort) from staff with toileting hygiene and toileting transferring. During a review of Resident 1's Order Summary Report (OSR) with active orders as of 12/22/2025, the OSR indicated a physician's order to hold losartan for heart rate less than 60 beats per minute-(BPM) daily, starting on 12/13/2025. During a review of Resident 1's Care Plan (CP) for hypertensive heart disease revised on 12/22/2025, the CP indicated staff were to maintain optimum quality of life for Resident 1. The CP interventions indicated staff were to obtain vital signs (measurements of temperature, heart rate, breathing rate, and blood pressure) and administer medication as ordered. During an interview with the Infection Preventionist Nurse (IPN) 1 on 12/23/2025 at 12:56 PM, the IPN stated it was important for the licensed nurse who received the physician order to carry out and transcribe to electronic MAR (EMAR). The IPN stated carrying out the physician order meant to do the action as ordered. The IPN stated that when the physician ordered to hold losartan for heart rate of less than 60 BPM, the licensed nurse should check the resident's heart rate prior to the medication administration and document the readings on the EMAR. During a concurrent interview and record review on 12/23/2025 at 12:56 PM. with the IPN, Resident 1's Medication Administration Record (MAR) dated 12/13/2025 to 12/22/2025 was reviewed. The MAR indicated Resident 1 received ten doses of losartan daily at 9 AM from 12/13/2025 to 12/22/2025. The IPN stated the MAR did not indicate heart rate readings were taken/documented prior to the administration of losartan daily at 9 AM from 12/13/2025 to 12/22/2025. The IPN stated it was important to monitor the heart rate as ordered. During a concurrent interview and record review on 12/23/2025 at 2:01 p.m., Resident 1's Vital Summary dated 12/13/2025 to 12/22/2025 was reviewed. The DON stated there were no heart rate readings documented on 12/13, 12/15, 12/16, 12/17, 12/18, 12/19, 12/20, and 12/22/2025 at 9 AM. The DON stated the licensed nurse did not carry out the physician order to check Resident 1's heart rate prior to the administration of losartan to Resident 1. The DON stated the licensed nurse should have followed the physician's order to check the resident's heart rate before administering losartan to Resident 1. During a review of the facility's undated Policy and Procedure (P&P) titled Physician Orders, the P&P indicated the facility should provide care and services to the resident in accordance with the physician's orders. During a review of the facility's undated P&P titled Documenting Physician Orders/ Notification, the P&P indicated the licensed nurse should implement and carry out the physician's orders within two hours upon receiving. During a review of the facility's P&P titled Vital Sign, revised 1/25/2024, the P&P indicated the vital signs would be taken as ordered by the physician and before giving medication when there were conditional parameters (limit that helped measure something) of administration. |