STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555237	A. Building B. Wing	04/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Valley Medical Ctr D/P Snf	438 W. Las Tunas Drive San Gabriel, CA 91776

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 47362 Based on observation, interview, and record review the facility failed to promote respect and dignity for one (1) of 1 sampled resident (Residents 236) by not ensuring Resident 236's indwelling catheter (soft, plastic or rubber tube that is inserted into the bladder to drain the urine) urine collection bag was inside the dignity bag (a bag used to cover and hold the catheter drainage/collection bag, so it is not visible). This deficient practice had the potential for Resident 236 to experience loss of dignity and self-esteem. Findings: A review of Resident 236's Admission Record indicated the facility admitted Resident 236 on 4/1/2024 A review of Resident 236's History and Physical Examination, indicated Resident 236 was alert and oriented (it refers to a person's level of awareness of self, place, time, and situation). A review of Resident 236 's Minimum Data Set (MDS, standardized care and screening tool), dated 4/27/2024, indicated Resident 236 cognition was intact (processes of thinking and reasoning) skills for daily decision making. The MDS indicated Resident 236 was dependent (helper does all the effort) on eating, oral hygiene, toileting hygiene, shower bathe self, upper body dressing, lower body dressing. The MDS also indicated Resident 236 had indwelling catheter. The MDS also indicated Resident 236 had the following active diagnosis, dependence on respirator, quadriplegia (symptom of paralysis that affects all a person's limbs and body from the neck down), weakness, amyotrophic lateral sclerosis (ALS, causes loss of muscle control. The disease gets worse over time). During observation on 4/27/2024 at 8:24 AM, observed Resident 236's foley catheter bag was not inside the dignity bag. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2024
NAME OF PROVIDER OR SUPPLIER San Gabriel Valley Medical Ctr D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 438 W. Las Tunas Drive San Gabriel, CA 91776	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the concurrent observation and interview on 4/27/2024 at 4:51 PM with the License Vocational Nurse (LVN 5) stated Resident 236's foley catheter bag was not totally covered with the dignity bag, the urine was exposed. LVN 5 also stated the indwelling catheter bag, and the indwelling catheter tubing was touching the floor. LVN 5 stated the indwelling catheter bag should be inside the dignity bag to ensure the content (urine) was covered. LVN 5 further stated it was important to provide respect and dignity to Resident 236 and the resident might feel embarrassed. During interview on 4/27/2024 at 6:51 PM with the Minimum Data Set Coordinator (MDSC), the MDSC stated it is not allowed, foley (indwelling) catheter bag should be inside the dignity bag, fully covered and not touching the floor, for dignity and infection control. A record review of the facility's Policy and Procedure (P&P) titled Resident Privacy and Confidentiality, approved date 4/2022 indicated, to assure the resident's right to personal privacy and confidentiality. To assure the resident is treated with consideration and respect and full recognition of his/her dignity and individuality, including privacy in treatment and of care for personal needs, and confidentiality of his/her personal and clinical records. The nursing staff will use curtains to provide full visual privacy resident care, toileting, treatment and issues of dignity and other requested times.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to ensure three (3) of five sampled residents (Residents 3, 27, and 236) were provided necessary treatment and services to prevent formation of and promote healing of pressure injury (pressure ulcers- injury to the skin and underlying tissue resulting from prolonged pressure on the skin) in accordance with the facility's policy and procedure and physician's order by failing to: 1. Accurately monitor, assess, and document Resident 3's skin from 4/1/2024 to 4/26/2024. Facility also failed to measure and document assessment of Resident 3's newly developed stage 2 pressure injury (when the wound extends into the bottom layers of the skin) on the right shoulder. Facility also failed to measure Resident 3's stage 2 pressure injury (when the wound extends into the top two layers of the skin as well as the fatty tissue) on the left ischium (the large bone in the lower part of the hip) and stage 3 pressure injury on the right ischium. This deficient practice resulted in Resident 3 to develop a new stage 2 pressure injury on his right shoulder. The other deficient practices also had the potential to cause delayed healing and worsen Resident 3's pressure injuries. 2. Ensure Resident 27's low air loss mattress (LALM- an air mattress covered in tiny holes designed to let our air very slowly which helps keep the skin dry and [NAME] away any moisture) was set according to the resident's weight. Resident 27 was observed with the LALM set at 315 pounds ([lbs] unit of measurement) and Resident 27 weighed 117 lbs. This deficient practice placed Resident 27 at risk to develop pressure injury. 3. Ensure Resident 236's LALM was set according to the resident's weight to ensure effective worsening of pressure injuries. Resident 236 was observed with the LALM set at Zone 5 (210lbs.) Resident 236 weighed 165 lbs. This deficient practice placed Resident 236 at risk for progression of pressure injury. Findings: 1. A review of Resident 3's Admission Record indicated Resident 3 was admitted to the facility on [DATE]. A review of Resident 3's History and Physical Examination (H&P), dated 4/2/2024, indicated Resident 3 had a history of hypertension (high blood pressure), type 2 diabetes mellitus (a disease that occurs when the blood sugar is too high), ventilator dependent respiratory failure (a long term condition in which the blood does not have enough oxygen or has too much carbon dioxide and requires a machine to move air in and out of the lungs), tracheostomy (a surgically created hole in the windpipe that provides an alternate way of breathing). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 3's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/12/2024, indicated Resident 3 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making and was dependent (helper does all of the effort) with eating, oral hygiene, shower/bathe self, and upper/lower body dressing. A review of Resident 3's Fall and Braden Assessment for predicting pressure sore risk, dated 4/7/2024, indicated Resident 3 had a total score of 12 which indicated Resident 3 was at a very high risk for developing pressure sores. A review of Resident 3's Long Term Weekly Summary, dated 4/22/2024, indicated Resident 3 had a sacral (a large triangular bone at the bottom of the spine), bilateral ischial wounds, and a rash on the back of his head. During an interview with Family Member (FM 1), on 4/27/2024, at 6:44 PM, FM 1 stated Resident 3 has a developed a pressure injury on his right shoulder. FM 1 stated Resident 3 did not have a pressure injury on his right shoulder before his admission. During a concurrent interview and record review with the MDS Coordinator (MDSC) on 4/28/2024, at 10:20 AM, Resident 3's Admission Intake Assessment, dated 4/1/2024, was reviewed. MDSC stated Resident had a stage 2 pressure on his left ischium and a stage 3 pressure injury on his right ischium. MDSC stated there was no pressure ulcer on Resident 3's right shoulder. During the same concurrent interview and record review with the MDSC, on 4/28/2024, at 10:30 AM, Resident 3's Wound Care Assessment Progress Report, dated 4/2/2024, 4/16/2024, and 4/24/2024 was reviewed. MDSC stated the Wound Care Assessment Progress Report, dated 4/2/2024 indicated Resident 3 had a sacral IAD (incontinent associated dermatitis- skin damage associated with exposure to urine or feces), stage 2 left ischium pressure injury, stage 3 right pressure injury, left heel DTPI (deep tissue pressure injury- a persistent non-blanchable deep red, purple of maroon areas of intact skin or blood filled blister, right heel DTPI, left chest scab (a protective crust that forms over a wound during healing), right upper chest surgical incision (a surgical cut made on the skin), and an abdominal skin tear. MDSC stated the Wound Care Assessment Progress Reports on 4/2/2024 did not indicate the wound and pressure injury measurements. MDSC stated the Wound Care Progress Reports dated 4/16/2024 and 4/24/2024 did not indicate which wounds were assessed, the stage of the pressure injury wounds, the wound measurements, and the treatment specific to the wounds. MDSC stated it is important for wounds to be assessed and documented correctly to find out if the current treatment is appropriate and if the wound is healing. MDSC stated the wound needs to be measured to determine the healing status of the wound. During the same concurrent interview and record review with MDSC on 4/28/2024, at 10:30 AM, Resident 3's care plan titled, Skin Integrity, dated 4/1/2024 was reviewed. MDSC stated the care plan indicated an expected outcome/goal to decrease the size of the sacral and left/right ischium pressure injuries. MDSC stated Resident 3's care plan did not indicate to measure the size of the wounds. MDSC stated the standard practice for any wound assessment is to assess and measure the size of the wound. MDSC stated it is also in the facility's policy to measure the wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with MDSC on 4/28/2024, at 10:44 AM, MDSC stated Resident 3's Wound Assessment Progress Note, dated 4/27/2024, indicated Resident 3 had a stage 2 pressure injury on his right shoulder. MDSC stated Resident 3 did not have a skin assessment done on his shoulder before 4/27/2024. MDSC stated Resident 3 does not have a skin assessment for his right shoulder documented from 4/1/2024 to 4/26/2024. MDSC stated a skin assessment could have prevented Resident 3's pressure injury to be at stage 2. MDSC stated it is important for a complete body assessment to be performed for bed bound and vulnerable residents because they are at a higher risk for developing pressure injuries. During an interview with the Director of Nursing (DON), on 4/28/2024, at 2:33 PM, the DON stated all wounds need to be measured once a week and as needed. The DON stated Resident 3's wounds should have been measured and documented. The DON stated it is important to measure the wounds to monitor its progression or regression. The DON stated a proper skin assessment could have prevented Resident 3's right shoulder to become a stage 2 pressure ulcer. A review of the facility's Policy and Procedure (P&P), titled, Skin Care Policy, revised on 5/2023, indicated the following treatment for stage 2 pressure ulcers: a. Assess wound condition with each dressing change, review uploaded photos to evaluate status to determine if improved/worsened and report adverse changes to MD (physician) and Wound Care Nurse. b. Measure ulcer in centimeters ([cm]-unit of measurement), including length (ALWAYS head to toe), width) always hip to hip), and depth on admission, discharge, discovery and bi-weekly assessment with characteristics of ulcer bed, drainage amount, color, odor, and surrounding skin condition. The P&P indicated the following treatment for stage 3 pressure ulcers: a. Measure ulcer, including length (head to toe), width and depth on admission, discharge, and discovery twice a week. (Measurements done on weekly reassessment for Sub-Acute patients) b. Assess wound bed drainage amount; peri-wound (the area around the wound) skin, color and odor. The P&P indicated the following measures for prevention of pressure injury: complete Risk Assessment Tool-Braden Scale; inspect skin every shift- especially bony prominences (areas where bones are close to the surface). The P&P further indicated that the Registered Nurse/Licensed Vocational Nurse will obtain a picture of all pressure injuries and any other lesions/problem area(s) discovered. The Nurse will initiate twice weekly photographic documentation uploads and assessment. Measurements are ALWAYS to be recorded in centimeters with length by width by depth, length is always measured from head to toe direction, and width is always measured from hip to hip. 2. A review of Resident 27's Admission Record indicated Resident 27 was admitted to the facility on [DATE]. A review of Resident 27's H&P, dated 4/2/2024, indicated Resident 27 had a history of respiratory failure (a long term condition in which the blood does not have enough oxygen or has too much carbon dioxide), hypertension (high blood pressure), and hyperlipidemia (high levels of fat in the blood). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 27's MDS, dated [DATE], indicated Resident 27 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making and was dependent (helper does all of the effort) with eating, oral hygiene, shower/bathe self, and upper/lower body dressing. A review of Resident 27's 24 Hour Summary, dated 4/28/2024, indicated Resident 27 weighed 119 pounds ([lbs]- unit of measurement). A review of Resident 27's 24 Hour Summary, dated 4/28/2024, indicated a physician's order, with a start date of 6/2/2021, for low air loss mattress settings: Zone 1 based on patient's weight of 104 lbs. Increase to Zone 2 with 105 lbs, please use Max inflate to firm mattress for repositioning/ Do not change Zone to firm mattress. A review of Resident 27's Fall and Braden Assessment for predicting pressure sore risk, dated 4/26/27, indicated Resident 27 had a total score of 13 which indicated Resident 27 was at moderate risk for developing pressure sores. During an observation of Resident 27's room on 4/26/2024, at 8:23 PM, Resident 27 was observed in bed with the LALM set at 8 (315 lbs/145 kg ([kilograms] unit of measurement). During a concurrent observation in Resident 27's room and interview with Licensed Vocational Nurse 1 (LVN 1) and LVN 2, on 4/26/2024, at 9:31 PM, LVN 2 stated Resident 27 weighed 117 lbs. LVN 2 stated Resident 27's LALM was currently set at Zone 8 for 315 lbs. LVN 1 stated Resident 27's LALM was set at the wrong weight and should have been at Zone 2 (105lbs/55 kg). LVN 1 stated Resident 27's LALM setting needs to be at the right setting to prevent wounds from developing. LVN 1 stated Resident can get injured from getting more pressure than needed when he is on the bed. LVN 1 stated the LALM is used to redistribute air and relieve pressure for residents with skin breakdown or are at a high risk for skin breakdown. During an interview with the MDSC, on 4/27/2024, at 5:44 PM, MDSC stated the LALM is used to prevent residents from getting a pressure ulcer. MDSC stated Resident 27 has a history of a wound on his back and has an order to continue with the LALM. MDSC stated the LALM should be at the setting ordered by the physician which is based on the weight of the resident. MDSC stated Zone 8 is not the correct setting for Resident 27's LALM. MDSC stated Resident 27's LALM setting should be at Zone 1 or 2. MDSC stated if the setting is high then the bed is too hard for the resident which is uncomfortable, can cause harm, and cause a pressure ulcer to develop. A review of the facility's P&P, titled, Mattress, Alternating Air, approved on 4/2022, indicated the facility will provide stimulation and pressure relief to residents at risk for skin breakdown. To distribute body weight relieving areas of pressure. The P&P further indicated, It is the policy of this facility to use pressure-relieving mattresses as indicated by the resident's physical condition. 47362 3. A review of Resident 236's Admission Record indicated the facility admitted Resident 236 on 4/1/2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 236's History and Physical Examination, indicated Resident 236 was alert and oriented (it refers to a person's level of awareness of self, place, time, and situation). A review of Resident 236's Telephone Order, dated 4/12/2024, indicated may have LAL mattress. A review of Resident 236 's MDS, dated [DATE], indicated Resident 236 cognition was intact (processes of thinking and reasoning) skills for daily decision making. The MDS indicated Resident 236 was dependent (helper does all the effort) on eating, oral hygiene, toileting hygiene, shower bathe self, upper body dressing, lower body dressing. The MDS also indicated Resident 236 had the following active diagnosis, dependence on respirator, quadriplegia (symptom of paralysis that affects all a person's limbs and body from the neck down), weakness, amyotrophic lateral sclerosis (ALS, causes loss of muscle control. The disease gets worse over time). The MDS also indicated Resident 236 was at risk for developing pressure ulcer/ injuries. The MDS indicated Resident 236 has a pressure ulcer/injury, a scar over bony prominence. The MDS also indicated Resident 236 received skin and ulcer/ injury treatments, and pressure reducing device for bed. A review of the Braden Scale (developed to foster early identification of residents at risk for forming pressure injury), dated 4/27/2024 indicated a score of 10 to 12 (a score of 10-12 indicated high risk for pressure injury) During concurrent observation in Resident 236's room and interview on 4/27/2024 at 4:56 PM with the Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated Resident 236's LAL mattress was set at 5. LVN 5 also stated the most recent weight of Resident 236 was 165 pounds (lbs., a written abbreviation for pound, when it refers to weight). LVN 5 also stated the LAL mattress setting of 5 was wrong and the right setting was 4, because it should be depending on the resident's weight. LVN 5 further stated the reason for the LAL mattress use was for pressure injury prevention, if the LAL mattress setting was not on the right setting, it is not comfortable for the resident and the pressure injury might get worst. LVN 5 stated the LAL mattress should be on the right setting all the time. The facility policy and procedure (P&P) titled Skin Care Policy, revised date 5/2023, indicated principles of skin / wound care management reduce or alleviate causative factors such as pressure, shearing, friction and moisture. The P&P also indicated, to initiate pressure prevention device as indicated per skin care protocol. including therapy mattress: LAL use.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on observation, interview, and record review, the facility failed to follow its policy to check gastrostomy tube (G-tube, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) placement by auscultating the epigastric (upper central region of the abdomen) area while injecting a small amount of air for two (2) of two (2) sampled residents (Residents 14 and 24). This deficient practice had the potential for Resident 14 and 24 to aspirate (when something enters the airway or lungs by accident) which can lead to lung problems such as pneumonia (a lung infection). Findings: 1. A review of Resident 14's Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of anemia (a condition in which the body does not have enough healthy red blood cells [provide oxygen to body tissues]), coronary artery disease (caused by plaque buildup in the wall of the arteries that supply blood to the heart), and hypertension (high blood pressure) A review of Resident 14's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 2/26/2024, indicated Resident 14 had severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 14 was dependent (helper does all the effort) in eating, oral hygiene, toilet hygiene, shower/ bathe self, upper and lower body dressing, personal hygiene, and rolling in bed from left and right. During a concurrent observation in Resident 14's room and interview with Licensed Vocational Nurse 6 (LVN 6) on 4/27/2024 at 12:18 PM, Resident 14's head of the bed was elevated to 45 degrees. LVN 6 checked Resident 14's G-tube placement by aspirating stomach contents for residual but did not auscultate Resident 14's epigastric area while injecting a small amount of air. LVN 6 started to administer medications through gravity. Resident 14 started coughing and stomach content started backing up on the syringe. LVN 6 elevated the head of the bed to 60 degrees. LVN 6 stated she placed the feeding on hold because the Resident 14 was coughing. During an interview with LVN 6 on 4/27/2024 at 12:30 PM, LVN 6 stated, I should have auscultated the abdomen with the stethoscope before aspirating the contents to check the residual of the resident. I forgot that part. LVN added, It is important to check the placement to make sure the G-tube was in place. 2. A review of Resident 24's Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of anemia, coronary artery disease and hypertension. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 24's MDS, dated [DATE], indicated Resident 24 had severely impaired cognitive skills for daily decision making. The MDS also indicated Resident 24 was dependent in eating, oral hygiene, toilet hygiene, shower/ bathe self, upper and lower body dressing, personal hygiene, and rolling in bed from left and right. During a concurrent observation in Resident 24's Room and interview with Registered Nurse 1 (RNS 1) on 4/27/2024 at 5:46 PM, Resident 24's head of the bed was elevated to 30 degrees. Resident 24's G-tube feeding was observed turned on and running. RNS 1 was observed checking Resident 24's G-tube placement by aspirating the stomach contents with the syringe. RNS 1 did not auscultate Resident 24's epigastric area while injecting a small amount of air to check for G-tube placement. RNS 1 stated, The G-tube feeding should be turned off before administering the medications. RNS 1 stated, If there was a residual when G-tube placement was checked, the G-tube feeding will be stopped, but if there was no residual, the G-tube feeding will be kept running while administering medications. RNS 1 added, The head of the bed should be higher than 30 degrees. The higher the head of the bed the less of chance the resident would vomit. During an interview with RNS 1 on 4/27/2024 at 6:41 PM, RN 1 stated, I forgot to listen in to the abdomen before checking the residual. We should listen for abdominal sounds to make sure we are in the right area. If there is no sound, the G-tube might not be in the proper place, and it might be somewhere in the abdominal cavity. A review of the facility's Policy and Procedure (P&P) titled, Medication Administration Through a Feeding Tube, revised on 6/2017, indicated to put continuous tube feedings on hold. Check the residual and tube placement by aspirating stomach contents and auscultating the epigastric area while injecting a small amount of air.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for three (3) of three (3) sampled residents (Resident 4, 28, and 34) by failing to provide emergency equipment in the activity room for accidental decannulation (the process whereby tracheostomy [trach- a surgically created hole in the windpipe that provides an alternate way of breathing)]tube is removed) for a resident with a tracheostomy in the activity room. This deficient practice had the potential for Residents 4, 28, and 34 to have respiratory distress during accidental decannulation. Findings: 1. A review of Resident 4's Admission Record indicated Resident 4 was admitted to the facility on [DATE]. A review of Resident 4's History and Physical Examination (H&P), dated 8/27/2023, indicated Resident 4 had a history of seizure disorder (abnormal electrical activity in the brain that happens quickly), hypertension and chronic respiratory failure (a long term condition in which the blood doesn't have enough oxygen or has too much carbon dioxide) status post tracheostomy (a surgically created hole in the windpipe that provides an alternate way of breathing) and g-tube (gastrostomy tube-a flexible tube surgically inserted through the wall of the abdomen directly into the stomach for feeding, fluid, and medication administration). A review of Resident 4's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/28/2024, indicated Resident 4 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making and was dependent (helper does all of the effort) with eating, oral hygiene, and upper body dressing. During an observation of Resident 4 in the Activity Room, on 4/27/2024, at 11:54 AM, Resident 4 was sitting in her wheelchair watching television. Resident 4 had a tracheostomy in place. Observed Activities Assistant (AA 1) In the activity room and In addition, there was no Respiratory Therapist (RT- a certified medical professional trained to treat problems with the lungs and breathing. 2. A review of Resident 28's Admission Record indicated Resident 28 was admitted to the facility on [DATE]. A review of Resident 28's H&P, dated 10/11/2023, indicated Resident 28 had a history of acute (severe and sudden onset) respiratory failure status post tracheostomy, acute large left middle cerebral artery (MCA) infarct (a stroke that has resulted in damage to the left side of the brain), and right hemiplegia (paralysis that affects the right side of the body). A review of Resident 28's MDS, dated [DATE], indicated Resident 28 was assessed having severely impaired cognitive skills for daily decision making and was dependent with eating, oral hygiene, upper/lower body dressing, and personal hygiene. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of Resident 28 in the Activity Room, on 4/27/2024, at 11:54 AM, Resident 28 was sitting in her wheelchair watching television. Resident 28 have a tracheostomy tube in place. Observed AA 1 in the activity room and there was no RT present in the room. 3. A review of Resident 34's Admission record indicated Resident 34 was admitted to the facility on [DATE]. A review of Resident 34's H&P, dated 10/2/2023, indicated Resident 34 had a history of amniotic embolism (an unexpected birth complication that occurs when a mother suffers an allergic-like response to the fluid that surrounds the baby during pregnancy) resulting in anoxic encephalopathy (a complete lack of oxygen to the brain resulting in the death of brain cells), gastrostomy tube, chronic respiratory failure on tracheostomy. A review of Resident 34's MDS, dated [DATE], indicated Resident 34 was assessed having severely impaired cognitive skills for daily decision making and was dependent with eating, oral hygiene, upper/lower body dressing, and personal hygiene. During an observation of Resident 34 in the Activity Room, on 4/27/2024, at 11:54 AM, Resident 34 was sitting in her wheelchair watching television. Resident 28 have a tracheostomy. Observed AA 1 in the activity room and there was no RT present in the room. During an interview with AA 1, on 04/27/2024, at 12 noon, AA 1 stated all residents in the facility have tracheostomy. AA 1 stated residents do not have their trach kit (an emergency kit that contains necessary supplies in case the trach tube comes out accidentally or becomes blocked), inner cannula (an inner tube inserted within the main outer cannula of the tracheostomy), and obturators (a curved rod that provides a smooth surface to guide the tube into the airway without damaging the internal lining of the trachea) with them when they go to the Activity Room. During an interview with Registered Nurse Supervisor 1 (RNS 1) on 4/27/2024, at 12:15 PM, RNS 1 stated all residents with tracheostomy have trach kits at the bedside. RNS 1 stated the trach kit is used in case the trach gets accidentally pulled out. RNS 1 stated it is important for the trach to be replaced right away when it gets pulled out. RNS 1 stated something bad can happen to the resident if the trach does not get replaced right away. RNS 1 stated when the residents go to the Activity Room they do not bring the trach kits with them. RNS 1 stated there is no extra trach kit in the Activity Room. RNS 1 stated the Respiratory Therapist is responsible for putting the trach back in. During an interview with RT, on 4/27/2024, at 4:06 PM, RT 2 stated each resident has a [NAME] bag by the bedside that is used for in case the trach accidentally gets pulled out. RT 2 stated the [NAME] bag has the resident's spare trach which is specific to the resident, Ambu bag (artificial manual breathing unit- a device used to provide respiratory support to residents in emergency and non-emergency situations), and lubricant inside. RT 2 stated residents who have a tracheostomy need to have a spare trach and an Ambu bag with them everywhere they go in the facility. RT 2 stated he was unsure what the policy indicated regarding having a spare trach or trach kit when the residents go to the Activity Room. RT 2 stated not having a spare trach will cause the resident to not have a patent airway. RT 2 stated potential harm can happen to the resident because oxygen is taken away from the resident and the resident will not get proper gas exchange. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the MDS Coordinator (MDSC) and the Director of Nursing (DON), on 4/27/24, at 4:27 PM, the MDSC and the DON stated residents do not need to bring the trach kit or an extra inner cannula and obturator with them when they go to the Activity Room. During a follow up interview with AA 1 on 4/27/2024, at 4:17 PM, AA 1 stated she did not know what an Ambu bag was. AA 1 stated there was no Ambu bag in the Activity Room. During a concurrent interview with the DON and record review, on 4/28/2024, at 2:35 PM, the policy and procedure (P&P), titled, Resident Activities, revised on 2/2023 was reviewed. The DON confirmed that the policy indicated: a. There must be two staff members present at all times. I. One staff member must be a Respiratory Therapist II. The second staff member should be a clinical staff (example: RN, LVN, CNA), or activities personnel) III. An Ambu bag, oxygen, and a spare trach must always accompany the resident at all times.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 45099 Based on observation, interview, and record review, the facility failed to ensure the Nurse Staffing Information posted was complete by failing to reflect the total and actual number of hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift. This deficient practice had the potential for the Nurse Staffing Information not to be available to the residents and visitors at any given time. Findings: During an observation on 4/27/2024 at 11:11 AM, the Daily Posted Nurse Staffing (Nurse Staffing Information), dated 4/27/2024, located at the nurse's station for 7 am to 3pm shift indicated a census of 38. It also indicated six (6) and a half (0.5) Licensed Nurses and five (5) Certified Nurse Assistants (CNAs). The Daily Posted Staffing did not indicate the total and actual number of hours worked for both licensed and unlicensed nursing staff. During a concurrent record review of the Daily Posted Nurse Staffing, dated 4/26/2024 and interview with the Unit Secretary 1 (US 1) on 4/27/2024 at 11:11 AM, US 1 stated the US scheduled each day was assigned to complete and post the staffing. US 1 stated the posting on 4/26/2024 indicated the following worked for each shift: A. For the 7 am to 3pm shift, a census of 38, two (2) Registered Nurses, five (5) Licensed Vocational Nurses and 5 CNAs. B. For the 3pm to 11 pm shift, a census of 38, four (4) RNs, six (6) LVNs and 2 CNAs. C. For the 11 pm to 7 am shift, a census of 38, 4 RNs, three (3) LVNs and 3 CNAs. During a concurrent record review of the Daily Posted Nurse Staffing from 4/21/2024 to 4/26/2024 and interview with the Director of Nursing (DON) on 4/27/2024 at 3:50 PM, the DON stated that the Daily Posted Nurse Staffing included the census and the total number of RNs, LVNs, and CNAs but did not include the total and actual worked hours per shift for licensed and unlicensed nursing staff on the following dates: 1. April 21, 2024 2. April 22, 2024 3. April 23, 2024 4. April 24, 2024 5. April 25, 2024 6. April 26, 2024 (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 4/27/2024 at 4:15 PM, the DON stated the facility did not and should have a policy for Daily Posted Nurse Staffing to be compliant with the regulation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 Based on observation, interview, and record review, the facility failed to ensure safe provision of pharmaceutical services as indicated on the facility policy by failing to: 1. Dispose expired medication found in Medication cart 1 drawer. This deficient practice had the potential for adverse reaction in the event that expired medication was administered to the residents. 2. Ensure Resident 4's Primidone (Mysoline, a medication used to treat convulsions) was stored and not found on the floor by Resident 4's doorway. 3. Ensure medications were kept locked at all times to prevent unauthorized access of the medications in the facility. These deficient practices have the potential to result in unauthorized access to medications by visitors and staff and predisposing them to possible medication overdose (taking a toxic or poisonous amount of a drug or medicine), unauthorized use of medications, adverse reactions (any unexpected or dangerous reaction to a drug), and drug-to-drug interactions (a reaction between two or more drugs or between a drug, and a food, beverage, or supplement). Findings: 1. During a concurrent observation of Medication Cart 1 and interview with the Registered Nurse Supervisor 2 (RNS 2) on [DATE] at 10:18 AM, observed a Desitin diaper rash paste, with expiration date of [DATE], inside the drawer. Medication Cart 1 drawers were also observed dusty. RNS 2 stated it was important to discard expired medication because it may cause infection to the resident. RNS 2 added, It is important to clean the medication cart drawers to make sure it's not going to attract germs and cause infection to the residents. A review of facility's Policy and Procedure (P&P) titled Medication Management: General revised on , d+[DATE], Policy indicated to assure that storage, administration, and documentation of medications is managed to maintain patient safety. 46919 2. A review of Resident 4's Admission Record indicated Resident 4 was admitted to the facility on [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 4's History and Physical Examination (H&P), dated [DATE], indicated Resident 4 had a history of seizure disorder (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness), hypertension (chronic elevated blood pressure), chronic respiratory failure (a condition in which the blood doesn't have enough oxygen or has too much carbon dioxide) status post tracheostomy (a surgically created hole in the windpipe that provides an alternate way of breathing) and gastrostomy tube (Gtube, a flexible tube surgically inserted through the wall of the abdomen directly into the stomach for feeding, fluid, and medication administration). A review of Resident 4's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated [DATE], indicated Resident 4 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making and was dependent (helper does all of the effort) with eating, oral hygiene, and upper body dressing. A review of Resident 4's 24 hour Summary form, dated [DATE], indicated a current medication, with a start date of [DATE], for Primidone 50 mg (milligram, unit of measurement) three times daily. During an observation of Resident 4's room on [DATE], at 8:19 PM, a medication blister packet (a form of tamper-evident packaging where an individual pushes individually sealed tablets through the foil in order to take medication) was observed by Resident 4's doorway. A round white tablet was noted in the blister packet and the blister packet was labeled Primidone Tablet, USP, 50 mg had a white round tablet on the other side. During a concurrent observation and interview with the Director of Nursing (DON) on [DATE], at 8:22 PM, the DON stated the medication should not have been on the floor. During an interview with Licensed Vocational Nurse (LVN 8) on [DATE] at 8:27 PM, LVN 8 stated she administered Resident 4's Primidone medication at around 5 pm. LVN 8 stated the Primidone blister packet was not on the floor when she entered Resident 4's room to administer her medications. LVN 8 stated Resident 4's medication should not have been on the floor. LVN 8 stated if facility staff see any medication on the floor, they should pick it up to prevent it from possibly getting in the hands of someone who it does not belong to. 3. During an observation on [DATE], at 8:53 PM, different licensed staff were observed getting medications from Medication Cart 1 (Med Cart 1), located on the left front side of the Nurse's Station, without entering a code or using a key or security card. Med Cart 1 was observed unattended and the first and second drawers were unlocked. During an interview with LVN 3 on [DATE], at 8:57 PM, LVN 3 stated Med Cart 1 was unlocked because LVN 4 was currently administering medications. LVN 4 was observed donning (putting on) PPE (Personal Protective Equipment- gowns, gloves, N95 masks, and face shields worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) and proceeded to enter a resident's room. LVN 3 stated medication carts should always be locked. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview with LVN 4, on [DATE], at 9:15 PM, facility staff were observed getting medications from Med Cart 2, located on the right front side of the Nurse's Station, without entering a code or using a key or security card. Med Cart 2 was observed unattended and the three drawers were unlocked. LVN 4 stated it was important to lock Med Cart 1 and Med Cart 2 to prevent medications from getting stolen by anyone who passes by. LVN 4 stated Med Carts 1 and 2 should always be locked because they have routine medications, supplements, pain medications inside. LVN 4 stated residents can get harmed if they ingest unprescribed medications. LVN 4 stated Med Cart 1 and Med Cart 2 need to be locked after the facility staff gets the medications. LVN 4 stated Med Carts 1 and 2 usually lock automatically. LVN 4 stated licensed staff can also use their identification cards (ID) or enter a code to unlock and unlock the med carts. LVN 4 stated licensed staff should always lock and make sure the med carts are locked before walking away. During an interview with the Director of Pharmacy (DOP) on [DATE], at 3:31 PM, the DOP stated the facility's policy is to keep the medication carts locked at all times. The DOP stated the medication carts are unlocked with the licensed nurse's badge and relocked by pressing the lock button on the top part of the medication cart. The DOP stated the licensed nurses have to lock the medication carts before walking away because non nursing personnel or visitors walk down the hallway and have access to the medications if the medication carts are left unlocked. The DOP stated theft and tampering of medications can occur if medication carts are left unlocked. The DOP stated potential harm can happen if a resident, visitor, or staff takes the medication not prescribed to them. A review of the facility's policy and procedure (P&P), titled, Medication Management: General, revised on , d+[DATE], indicated the following: a. The purpose of the policy is to assure that storage, administration and documentation of medications is managed to maintain resident safety; to assure that access to medications is only available to appropriate licensed staff per regulatory requirements and accreditation standards. b. Medications are stored securely until preparation for administration. c. All non-controlled medications, including refrigerated medications, will be single locked when unattended. All controlled medications, including refrigerated medications, will be locked when unattended. Medications are NEVER to be left exposed and unattended on the Medication Cart, or elsewhere.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456 47362 Based on observation, interview, and record review, the facility failed to follow proper food handling practices in accordance with its policy and procedure by failing to: 1. Label food in the kitchen with item name, date opened, and expiration date. 2. Ensure kitchen surfaces were clean. 3. Ensure there were no personal belongings stored in the kitchen storage. These deficient practices had the potential to result in pathogen (germ) exposure to residents, which could place the residents at risk for developing foodborne illness (food poisoning with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever) which could lead to other serious medical complications and hospitalization . Findings: 1. During concurrent observation of the facility's kitchen storage area and interview on 4/26/2024 at 6:26 PM with the Dietary Staff 4 (DS 4), DS4 stated the rice, flour, oyster sauce, and salsa containers were not and should have been properly closed. During concurrent observation of the facility's Freezer 1 and interview on 4/26/2024 at 6:30 PM, DS 4 stated the frozen chicken did not and should have a label to indicate open and expiration dates. During a concurrent observation of Freezer 1 and interview with the DTD on 4/27/2024 at 10:10 AM, the unopened box of sherbet had no expiration date labeled on the box or on the individual cups. DTD stated, The delivery date should be labeled on the box or on the ice cream containers. Dietary staff should label the box, so they know when the date was delivered. It is important to label it to make sure the food is good, and it is not in bad condition. During a concurrent observation of Refrigerator 1 and interview with the DTD on 4/27/2024 at 10:33 AM, there were four (4) one (1) gallon containers of ranch dressing that have no delivery and expiration dates. DTD stated the dietary staff should have put a label on the containers to include the delivery dates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During concurrent interview and record review of the facility policy on food storage on 4/27/2024 at 4:22 PM with the Dietary Supervisor (DTS), DTS stated all containers are supposed to be closed fully because of dust and food contamination (the presence of unwanted materials or substances in food that may harm the residents). DTS stated all food items needs to have open and expiration dates to indicate when the food gets spoiled. DTS also stated, We cannot serve that to the residents, they might get sick. DTS also stated the facility Policy and Procedure titled, Food storage Leftovers, Refrigerator Stocks Item, Thawing and Meat Storage, revised on 2/2022, indicated its purpose was to ensure that food are properly covered, refrigerated, and stored appropriately to ensure safe for consumption. DTS stated, according to the policy, all food are to be covered, labeled and refrigerated, and items are dated, and a clear identification is placed on the container. DTS added, expiration dates are to be adhered to. 2. During a concurrent observation in the kitchen and interview with the Dietary Director (DTD) on 4/27/2024 at 9:58AM, the shelves on the side of the tray line table and the windowsill (a window ledge, the shelf-like, flat piece of the window trim found at the base of the window) were full of dust. DTD stated, It is important to keep the surfaces clean because the dust might fly on the food, and it might cause food contamination. During a concurrent observation and interview with the DTD on 4/27/2024 at 10:02AM, there was a pool of water on the surfaces of the tray line table. DTD stated they should keep the surfaces clean and dry to prevent food contamination. 3. During a concurrent observation in the Storage room [ROOM NUMBER] and interview with the DTD on 4/27/2024 at 10:15 AM, There were two (2) personal items (2 hooded jackets) found hanging inside the storage room. DTD stated, The personal item should not be left hanging in the storage room because it can cause food contamination. A review of the facility's Policy and Procedure (P&P) titled, Food Storage: leftover, Refrigerator Stock Items, Thawing and Meat Storage, revised on 2/2022, indicated all food are to be covered, labeled, and refrigerated. Items are dated and a clear identification (product label or written label) is placed on container. Expiration dates to be adhered to and items should be discarded if expiration date is reached, and item has not been used.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 45456 Based on observation, interview, and record review the facility failed to properly dispose garbage in the kitchen by failing to have a lid on the garbage containers in accordance with the facility's policy and procedure. This deficient practice had the potential to attract pests and rodents contributing to an unsanitary kitchen. Findings: During a concurrent observation and interview with Dietary Director (DTD) on 4/27/2024 at 9:54 AM, there were multiple uncovered garbage cans observed in the kitchen. DTD stated, It is okay not to have covers so we are not touching the lid every time we have to throw trash inside the garbage can. During a concurrent observation and interview with DTD on 4/27/2024 at 10:23 AM, the garbage can in the dirty dishwashing area was full and did not have a cover. During a concurrent record review of the facility's policy titled, Infection Control - Food and Nutrition Services, revised 2/2022 and interview with the DTD on 4/27/2024 at 3:52 PM, DTD stated, We need to have a fitting lid on the garbage cans per policy. We also need to change gloves every time we open the lids. It is important to put lids on the garbage cans to avoid the high risk of food contamination because residents might get sick. A review of the facility's Policy and Procedure (P&P) , Infection Control - Food and Nutrition Services, revised on 2/2022, indicated kitchen Wastes are disposed in heavy duty plastic garbage cans which are lined with disposable plastic bags. All containers should have fitting

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46919 Based on observation, interview, and record review, the facility failed to ensure one (1) of three (3) sampled residents (Resident 3) was provided a homelike environment in accordance with the facility's policy and procedure by: 1. Using Resident 3's room to store 3 hospital computers workstations (used to store resident medication records and for documentation) and one tablet stand (used by facility staff, residents, and families to translate or for video calls). 2. Not replacing the window screen in Resident 3's room and leaving it propped against the wall. 3. Leaving a used disposable plastic cup on the floor next to the trash in Resident 3's room. This deficient practice had the potential for an unsanitary and unkempt resident environment and had the potential to negatively impact the resident's quality of life. Findings: A review of Resident 3's Admission Record indicated Resident 3 was admitted to the facility on [DATE]. A review of Resident 3's History and Physical Examination (H&P), dated 4/2/2024, indicated Resident 3 had a history of hypertension (high blood pressure), type 2 diabetes mellitus (a disease that occurs when the blood sugar is too high), ventilator dependent respiratory failure (a long term condition in which the blood does not have enough oxygen or has too much carbon dioxide and requires a machine to move air in and out of the lungs), and tracheostomy (a surgically created hole in the windpipe that provides an alternate way of breathing). A review of Resident 3's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/12/2024, indicated Resident 3 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making and was dependent (helper does all of the effort) with eating, oral hygiene, shower/bathe self, and upper/lower body dressing. During an observation in Resident 3's room on 4/27/2024, at 8:18 AM, Resident 3's room was observed to have 3 computer tables and a tablet attached to a metal stand on the left side of Resident 3's bed. Resident 3's wall had a rectangular window screen leaning against it and a plastic disposable cup on the floor next to the trash. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2024
NAME OF PROVIDER OR SUPPLIER San Gabriel Valley Medical Ctr D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 438 W. Las Tunas Drive San Gabriel, CA 91776	

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the MDS Coordinator (MDSC), on 4/27/2024, at 6:07 PM, MDSC stated Resident 3's room needs to be like his home. MDSC stated the 3 computer workstations, and the tablet stand should not have been stored in Resident 3's room. MDSC stated it was wrong to leave and store facility equipment in any of the resident's rooms. MDSC stated Resident 3's room should not have items in his room that does not belong to him. MDSC stated the window screen should not have been left in Resident 3's room. MDSC stated facility staff should have reported to the charge nurse that the window screen was broken so it can get fixed right away instead of leaving it in Resident 3's room. MDSC stated facility staff needs to ensure disposable plastic cups are placed inside the trash can. MDSC stated Resident 3's right to have a room that is homelike should be respected. During an interview with the Director of Nursing (DON), on 4/28/2024, at 2:28 PM, the DON stated Resident 3's room should not be used a storage for facility equipment. The DON stated Resident 3 should only have his belongings in his room. The DON stated Resident 3's room should resemble his home. The DON stated the window screen should not have been left in Resident 3's room. The DON stated facility staff was responsible for notifying the Maintenance Department as soon as they observed the window screen was broken. The DON stated the window screen should have been replaced right away. A review of the facility's Policy and Procedure (P&P) titled, Resident Activities Program and Home life Environment, revised 2/2023, indicated, Creating a home like atmosphere in elderly care facilities is crucial for improving the quality of life for residents. As people age and require additional support and assistance, it is important that their living environment is comfortable, familiar, and promotes feelings of safety and security. By implementing strategies to create a homelike atmosphere, elderly care facilities can enhance the physical, emotional, and social well-being of their residents.