

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 03/28/2025
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456</p> <p>Based on observation, interview, and record review, the facility failed to promote dignity and respect for two (2) of 2 residents (Residents 12 and 24) by failing to ensure:</p> <ol style="list-style-type: none"> 1. Licensed Vocational Nurse 1 (LVN 1) address Resident 12 with the resident's name instead of using a label prior to medication administration. 2. The curtain in Resident 24's room was fully drawn and/or the resident's door was closed while Certified Nurse Assistant 1 (CNA1) was providing incontinent care to Resident 24. <p>This deficient practice had the potential to affect Resident 12 and 24's emotional and mental well-being.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 12's Admission Record, the admission record indicated Resident 12 was admitted to the facility on [DATE]. Resident 12's diagnoses included metabolic encephalopathy (ME, occurs when problems with your metabolism cause brain dysfunction), diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels), and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). <p>During a review of Resident 12's Minimum Data Set (MDS, resident assessment tool), dated 1/29/2025, the MDS indicated Resident 12 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 12 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, and personal hygiene.</p> <p>During a review of Resident 12's Care Plan (CP) for Activities of Daily Living (ADLs, are activities related to personal care including bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating), dated 4/9/2024, the CP indicated staff interventions/approaches included to maintain dignity / privacy.</p> <p>During an observation on 3/26/2025 at 1:30 PM inside Resident 12's room, LVN 1 stated, Sorry to wake you up honey! before administering the eye drops to Resident 12.</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 - Some</p>	<p>During an interview on 3/26/2025 at 1:52 PM, with LVN 1, LVN 1 stated, It is not okay to call the residents Honey. We have to call them with their last name and that is how we should address the Residents, to show respect.</p> <p>During an interview on 3/26/2025 at 2:43 PM with the Director of Staff Development (DSD), the DSD stated, We do not call the residents 'Honey. We have to call the residents with their first or last name for respect.</p> <p>During an interview on 3/28/2025 at 2:53 PM, with the Director of Nursing (DON), DON stated, It is not okay to call the residents 'Honey.' The staff should be calling the residents with their last name, with Mister, Miss or Mrs (title used before a married woman's name) or title to promote respect and dignity.</p> <p>44018</p> <p>2. During a review of Resident 24's Admission Record, the Admission Record indicated Resident 24 was originally admitted to the facility on [DATE].</p> <p>During a review of Resident 24's History and Physical Examination (H&P) dated 8/23/2024, the H&P indicated Resident 24's diagnoses included chronic (long-term) subdural hematoma (a type of bleeding near the brain that can happen after a head injury), respiratory failure (lung cannot properly exchange gases, causing abnormal levels of oxygen and carbon dioxide in the blood), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe).</p> <p>During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24 was severely impaired with cognitive skills for daily decision making. The MDS indicated Resident 24 was dependent with toileting hygiene, oral hygiene, and upper/lower body dressing.</p> <p>During a review of Resident 24's CP initiated on 8/23/2024, the CP indicated resident had an alteration in bowel elimination (a change or disruption in the normal process of bowel movement) related to immobility, and incontinence. Staff interventions included providing diaper/pad change and providing privacy during bowel movement.</p> <p>During observation in Resident 24's room on 3/25/2025 at 10:45 AM, Resident 24's room door was wide opened, and the curtain was not entirely drawn while CNA 1 was providing incontinent care to Resident 24.</p> <p>During an interview on 3/25/2025 at 11:03 AM with CNA 1, CNA 1 stated the curtain was not closed all the way and the door was opened when she changed Resident 24. CNA 1 stated she should at least close the curtain while providing care to residents. CNA further stated it was important to provide respect, dignity, and privacy to residents. CNA 1 stated Resident 24 might feel embarrassed if not given privacy.</p> <p>During an interview on 3/27/2025 at 5:23 PM, with Director of Staff Development (DSD), DSD stated CNAs should closed the door and/or curtain during a personal care procedure like changing a resident, to avoid exposing the resident to unnecessary observation and violating the resident's dignity and privacy.</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 - Some</p>	<p>During a record review of facility's policy and procedure (P&P) titled, Patient Rights, revised 11/2021, the P&P indicated the hospital promotes the preservation of patient rights based on a concern for personal dignity and awareness of human relationships. Recognize and respect the individuality and dignity of each patient.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456</p> <p>Based on observation, interview, and record review, the facility failed to secure the confidential medical records for one (1) of three (3) residents (Residents 4) as indicated on the facility's policy.</p> <p>This deficient practice had the potential to violate the resident's right to confidentiality (safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent of the resident and/or the resident's representative) and privacy and misuse of Resident 4's Protected Health Information (PHI, any information that relates to an individual's health status, medical history, or treatment).</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record, the admission record indicated Resident 4 was admitted to the facility on [DATE]. Resident 4's diagnoses included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and seizure (a sudden, uncontrolled burst of electrical activity in the brain)</p> <p>During a review of Resident 4's Minimum Data Set (MDS, resident assessment tool), dated 1/10/2025, the MDS indicated Resident 4 has severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 4 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and roll left and right.</p> <p>During an observation on 3/27/2025 at 4:56 PM in the hallway with Licensed Vocational Nurse 2 (LVN 2), the monitor screen displaying the Resident 4's medication list and information such as resident's date of birth, was left turned on and unattended. The monitor screen was on top of the medication cart, parked in the hallway, in front of Resident 4's door.</p> <p>During an interview on 3/27/2025 at 5:04 PM, with LVN 2, LVN 2 stated, The computer monitor should be turned off when you step away from the computer to comply with HIPAA (Health Insurance Portability and Accountability Act) privacy and security rules, and to protect the resident's information.</p> <p>During an interview on 3/28/2025 at 8:03AM with the Director of Staff Development (DSD), DSD stated, We always have to turn off the computer screens for privacy because of HIPAA. It is important to turn off the monitors and it is the staff responsibility to follow HIPAA because not everyone is allowed to see the resident's information.</p> <p>During an interview on 3/28/2025 at 3:08 PM, with the Director of Nursing (DON), DON stated, The staff should not leave the computer monitor unattended especially if the resident information was displayed on the screen exposing the resident's information. The staff should always follow HIPAA regulations.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review of facility's Policy and Procedure (P&P) titled, Resident Privacy and Confidentiality, dated 4/2022, the P&P indicated the facility will maintain personal and clinical records in a confidential manner, including all types of records the facility might keep on a resident, whether they are medical, social, fund accounts, automated or other. All staff using a computer must not leave the workstation or terminal unattended without first logging-off or blanking the screen, using a screen, using a screen saver.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456</p> <p>Based on observation, interview, and record review, the facility failed to implement a comprehensive person-centered care plan for the use of Apixaban (Eliquis, a prescription medicine used to treat blood clots in the veins of the legs or lungs) by not having a documented evidence to monitor the side effects and effectiveness of the medication for one (1) of 5 sampled residents (Resident 26) as indicated on the facility's policy.</p> <p>This deficient practice had the potential for Resident 26 not to receive the care and treatment if the medication is ineffective and resident suffers from the side effects of Eliquis such as bleeding, which may result in injury and harm.</p> <p>Findings:</p> <p>During a review of Resident 26's Admission Record, the admission record indicated Resident 26 was admitted to the facility on [DATE]. Resident 26's diagnoses included respiratory failure (a serious condition that makes it difficult to breathe on your respiratory system [organs/ structures in the body that allows you to breath such as lungs]), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), and atrial fibrillation (Afib, is an irregular and often very rapid heartbeat).</p> <p>During a review of Resident 26's Minimum Data Set (MDS, a resident assessment tool), dated 3/21/2025, the MDS indicated Resident 26 has severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 26 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and roll left and right.</p> <p>During a review of Resident 26's Physician's Order, dated 10/15/2024, the physician's order indicated Apixaban five (5) milligrams (mg, unit of measure) tablet, give 5 mg twice a day (BID) via gastrostomy (surgical procedure creating an opening through the abdomen wall into the stomach, allowing for the insertion of gastrostomy tube [G-tube] used for nutrition and medication administration) tube.</p> <p>During a review of Resident 26's Care Plan (CP) for bleeding due to anticoagulant therapy on Eliquis due to atrial fibrillation, dated 3/19/2025, the CP interventions indicated the following:</p> <p>Monitor for bruising or bleeding.</p> <p>Monitor effectiveness/ side effects of medications.</p> <p>During a concurrent interview and record review on 3/27/2025 at 11:31 AM with MDS Coordinator (MDSC), Resident 26's Physician's order dated 10/15/2024 was reviewed. The physician's order indicated Apixaban give 5 mg BID via G-tube.</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 a concurrent interview and record review on 3/27/2025 at 11:33 AM with MDSC, Resident 26's Nurses' Progress Notes dated 3/1/2025 to 3/27/2025 were reviewed. MDSC stated the Nurses' Progress Notes did not and should have a documentation that the nursing staff monitored the side effects, such as bleeding and effectiveness of Resident 26's anticoagulant therapy. MDSC stated, Since there was no documentation it means the staff were not checking the resident (Resident 26) for bleeding while using Eliquis.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Assessment and Care Planning, revised on 5/2014, the P&P indicated to identify resident needs and to provide a data base to be used in planning the comprehensive nursing care to meet the resident's individual needs and to assist the resident in reaching the highest level of independence as possible.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018</p> <p>Based on observation, interview, and record review, the facility failed to ensure one (1) of 1 sampled resident (Resident 24), who was dependent on the staff, was provided with appropriate care for activities of daily living (ADLs, activities related to personal care including bathing or showering, dressing, personal hygiene, using the toilet, and eating). Resident 24's fingernails on both contracted hands (a condition where the fingers or palm of the hand become permanently bent or curled) were observed long and untrimmed.</p> <p>This deficient practice had the potential for Resident 24 to develop infection, skin breakdown, and injury, which could negatively affect resident's overall wellbeing.</p> <p>Findings:</p> <p>During a review of Resident 24's Admission Record, the Admission Record indicated Resident 24 was originally admitted to the facility on [DATE].</p> <p>During a review of Resident 24's History and Physical Examination (H&P) dated 8/23/2024, the H&P indicated Resident 24's diagnoses included chronic (long-term) subdural hematoma (a type of bleeding near the brain that can happen after a head injury), respiratory failure (lung cannot properly exchange gases, causing abnormal levels of oxygen and carbon dioxide in the blood), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe).</p> <p>During a review of Resident 24's Minimum Data Set (MDS, resident assessment tool), dated 12/25/2024, the MDS indicated Resident 24 was severely impaired with cognitive skills (ability to think, understand, and reason) for daily decision making. The MDS indicated Resident 24 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on toileting hygiene, oral hygiene, and upper/lower body dressing.</p> <p>During an observation on 3/25/2025 at 11:44 AM in Resident 24's room, Resident 24 was laying on his bed. Both of Resident 24's hands were positioned across the resident's chest, which exposed the resident's long and untrimmed nails.</p> <p>During an observation in Resident 24's room and interview with Certified Nursing Assistant 1 (CNA 1) on 3/25/2025 at 12:10 PM, CNA 1 confirmed Resident 24's fingernails were long, untrimmed, and touching resident's skin. CNA 1 stated fingernails care was part of daily grooming. CNA 1 stated long fingernails could harbor bacteria and could potentially lead to infection. CNA 1 stated Resident 24's fingernails touching his skin could cause skin tear.</p> <p>During an interview with Director of Staff Development (DSD) on 3/27/2025 at 4:11 PM, DSD stated CNA should provide appropriate grooming care to Resident 24 who was ADL dependent. DSD stated grooming care including bathing, dressing, nails care, and oral care.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's Policy and Procedure (P&P) titled, Grooming and Hair Care Activities, revised 5/2015, the P&P indicated grooming activities would be scheduled based on resident's need. Grooming activities may include nail care, makeup application, hair washing, and hair trimming. CNAs would provide nail care as needed for resident hygiene and safety. If a resident diabetic, licensed staff would provide fingernail trimming.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456</p> <p>Based on interview and record review, the facility failed to ensure two (2) of 13 sampled residents (Resident 19 and Resident 24) received treatment and care by failing to administer sequential compression device (SCD, a medical device that uses inflatable sleeves to apply pressure to the legs to help blood flow and prevent clots) as ordered by the physician.</p> <p>This deficient practice had the potential to result in Resident 19 and Resident 24 to develop deep vein thrombosis (DVT, occurred when a blood clot develops in one of the deep veins in the body) which could lead to hospitalization and death.</p> <p>Findings:</p> <p>1. During a review of Resident 19's Admission Record, the Admission Record indicated Resident 19 was originally admitted to the facility on [DATE]. Resident 19's diagnoses included chronic respiratory failure (lung cannot properly exchange gases, causing abnormal levels of oxygen and carbon dioxide in the blood), encephalopathy (a decrease in blood flow or oxygen to the brain), and quadriplegia (paralysis [loss of voluntary movement {motor function}] from the neck down, including legs, and arms, usually due to a spinal cord injury).</p> <p>During a review of Resident 19's Minimum Data Set (MDS, resident assessment tool), dated 1/21/2025, the MDS indicated Resident 19 was severely impaired with cognitive skills (ability to think, understand, and reason) for daily decision making. The MDS indicated Resident 19 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and roll left and right.</p> <p>During a review of Resident 19's Venous Thromboembolism Assessment and Prophylaxis (VTEAP- to identify patients at high risk for blood clots and implement measures to prevent them) Order, dated 3/31/2022, the VTEAP indicated Resident 19 had a score of nine (9), which indicated Resident 19 was at high risk for developing venous thromboembolism (VTE, medical condition where a blood clot forms in a vein.). The VTEAP recommended to use SCD for prevent development of VTE.</p> <p>During a review of Resident 19's Physician's Order Summary, dated 12/23/2023, the Physician's Order Summary indicated an order for SCD.</p> <p>During an observation on 3/25/2025 at 9:53 AM in Resident 19's room, Resident 19 was awake and laying on his bed. Resident 19's SCD leg sleeves were on the foot of the bed and were not applied on Resident 19's bilateral lower legs. The SCD machine was turned off.</p> <p>During an observation on 3/27/2025 at 9:26 AM in Resident 19's room, Resident 19 was awake and laying on his bed. Resident 19's SCD leg sleeves were applied on Resident 19's bilateral lower legs but the SCD machine was turned off.</p> <p>(continued on next page)</p>		

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<p>F 0684</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 3/27/2025 at 9:43 AM with Registered Nurse 1 (RN1) in Resident 19's room, Resident 19's SCD machine was turned off. RN 1 stated, SCD machine was turned off. It should always be turned on. SCD is used to prevent DVT. If it was turned off, we are not following MD order, and it will not serve the purpose to promote blood circulation for Resident 19.</p> <p>44018</p> <p>2. During a review of Resident 24's Admission Record, the Admission Record indicated Resident 24 was originally admitted to the facility on [DATE].</p> <p>During a review of Resident 24's History and Physical Examination (H&P), dated 8/23/2024, the H&P indicated Resident 24's diagnoses included chronic (long-term) subdural hematoma (a type of bleeding near the brain that can happen after a head injury), respiratory failure (lung cannot properly exchange gases, causing abnormal levels of oxygen and carbon dioxide in the blood), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe).</p> <p>During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24 was severely impaired with cognitive skills [ability to think, understand, and reason] for daily decision making. The MDS indicated Resident 24 was dependent on staff for toileting hygiene, oral hygiene, and upper/lower body dressing.</p> <p>During a review of Resident 24's VTEAP Order, dated 8/23/2024, the VTEAP indicated Resident 24 had a score of 6 which indicated Resident 24 was at high risk for developing venous thromboembolism. The VTEAP recommended to use SCD for prevent development of VTE.</p> <p>During a review of Resident 24's Physician's Order Summary, dated of 8/23/2024, the Physician's Order Summary indicated an order for SCD.</p> <p>During a concurrent observation on 3/26/2025 at 10:12 AM in Resident 24's room and interview with Licensed Vocational Nurse 1 (LVN 1), Resident 24 was observed lying in bed. There was an SCD machine hanging on the end of the bed which was turned off, and the SCD sleeves were on top of the SCD machine. LVN 1 stated the SCD was not applied on the Resident 24's lower legs. LVN 1 stated the SCD sleeves should have been applied on Resident 24's lower legs to help prevent DVT and to improve blood flow.</p> <p>During an interview on 3/26/2025 at 4:08 PM with Registered Nurse 1 (RN1), RN 1 stated the licensed nurse should apply SCD around the Resident 24's legs while resident is in bed. RN stated it was important to use the SCD as ordered to prevent blood clot specially when Resident 24 was in prolonged bed rest.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Prevention of Venous Thromboembolism, dated 3/2022, the P&P indicated that all patients will be screened for risk for development of venous thromboembolism and appropriate measures will be put in place to prevent development of venous thromboembolism based on the level of risk.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018</p> <p>Based on observation, interview, and record review, the facility failed to implement treatment for the prevention of pressure ulcer (painful wound caused as a result of pressure or friction) by failing to ensure that the low air loss mattress (LALM, mattress used for residents who are at risk for developing pressure ulcer or already have a pressure ulcer, designed to circulate a constant flow of air) was on the correct settings for three (3) of four (4) sampled residents (Residents 14, 21, and 136) in accordance with the facility's policy and procedure and physician's order.</p> <p>This deficient practice had the potential for Resident 14 and 136 to develop a pressure ulcer and for Resident 21's stage 4 pressure ulcer (full-thickness skin loss in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole [rolled wound edges] are often present) to worsen.</p> <p>Findings:</p> <p>1. During a review of Resident 14's Admission Record, the Admission record indicated Resident 14 was admitted to the facility on [DATE].</p> <p>During a review of Resident 14's History and Physical Examination (H&P), dated 5/3/2024, the H&P indicated Resident 14 had a history of cerebrovascular accident (CVA - occurs when blood flow to a part of the brain is stopped either by a blockage or the rupture of a blood vessel) with right sided hemiplegia (severe or complete loss of strength on one side of the body), tracheostomy (a surgically created hole in the windpipe that provides an alternate way of breathing), and hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood).</p> <p>During a review of Resident 14's Minimum Data Set (MDS, resident assessment tool), dated 2/11/2025, the MDS indicated Resident 14 was moderately impaired with cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision-making) The MDS indicated Resident 14 was dependent (helper does all of the effort) with eating, oral hygiene, toileting hygiene, and personal hygiene. The MDS also indicated Resident 14 was at risk of developing pressure ulcers/injuries and had a pressure reducing device for bed.</p> <p>During a review of Resident 14's Care Plan (CP) revised 2/16/2025, the CP indicated Resident 14 had a potential risk for developing pressure ulcer on his sacral and mid back. Staff interventions included were to use low air loss mattress and to position Resident 14 to avoid pressure to affected areas.</p> <p>During a review of Resident 14's Braden Scale (BS, used for predicting pressure sore risk) with an effective date from 3/25/2025 to 4/1/2025, the BS indicated Resident 14 had a score of 13, which indicated Resident 14 was at moderate risk for developing pressure sore.</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 - Some</p>	<p>During a review of Resident 14's physician order (PO), dated 5/1/2024, the PO indicated physician's order of low air loss mattress for Resident 14 who had a history of multiple, at least stage 3 pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin.), resident being underweight, low body mass index (BMI, it was a measure that calculated a person's weight in relation to their height.) and high risk for breakdown.</p> <p>During an observation on 3/25/2025 at 9:24 AM in Resident 14's room, Resident 14 was observed in bed with the LALM set at Zone 1 (70 lbs. 40 kg [kilogram-unit of measurement])</p> <p>During a review of facility 's Low Air Mattress Utilization List - Zone Setting Based on Weight, dated 3/27/2025, indicated Resident 14 weighed 137 lbs. and on Zone 2 setting (105lbs/55kg).</p> <p>During a concurrent observation on 3/26/2025 at 9:32 AM in Resident 14's room and interview with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated Resident 14 weighed 137 lbs. as of 3/22/2025 at 6:17 AM. LVN 3 stated Resident 14's LALM was currently set at level 1 for 70 lbs. LVN 3 stated LALM was set incorrectly and should have been set at Zone 2. LVN 3 stated if the LAL mattress was on a wrong setting, the LALM could worsen Resident 14's pressure ulcer.</p> <p>During a concurrent observation on 3/26/2025 at 9:40 AM in Resident 14's room and interview with Registered Nurse 1 (RN 1), RN 1 stated Resident 14 weighed 137 lbs. and the LALM was set at zone 1, which was too soft for resident's weight. RN 1 stated the LALM setting was too soft, which could exacerbate or worsen the resident's exiting pressure injuries.</p> <p>45456</p> <p>2. During a review of Resident 21's Admission Record, the admission record indicated Resident was admitted to the facility on [DATE].</p> <p>During a review of Resident 21's History and Physical (H&P) dated 8/3/2024. The H&P included Resident 21's diagnoses of Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), and Stage 3 Pressure Ulcer (Full-thickness loss of skin. Dead and black tissue may be visible) of the sacral region (a triangular-shaped bone at the base of the spine just superior to the coccyx [tailbone]).</p> <p>During a review of Resident 21's MDS, dated [DATE], the MDS indicated Resident 21 was severely impaired with cognitive skills for daily decision making. The MDS indicated Resident 21 was dependent with eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and rolling in bed from left and right. The MDS also indicated Resident 21 has two Stage 1 pressure ulcer (intact skin with a localized area of redness and/or changes in sensation, temperature, or firmness) and one Stage 4 pressure ulcer upon admission. It also indicated Resident 21 was on a pressure reducing device for bed.</p> <p>During a review of Resident 21's Care Plan (CP) for skin integrity, dated on 7/11/2024, the CP indicated Resident 21 has potential risk for developing pressure ulcer on the sacral area and left fifth toe. Staff interventions included were to use low air loss mattress and to position Resident 21 to avoid pressure to affected areas.</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 - Some</p>	<p>During a review of Resident 21's physician's order, dated 7/11/2024, the physician's order indicated support surface: low air loss mattress.</p> <p>During a review of Resident 21's Braden Scale with an effective date from 3/25/2025 to 3/26/2025, the BS indicated Resident 21 had a score of 12, which indicated Resident 21 was at high risk for developing pressure ulcer.</p> <p>During an observation on 3/25/2025 at 9:17AM inside Resident 21's room, Resident 21 was observed in bed with the LALM set at Zone 1 (70 lbs. 40 kg [kilogram-unit of measurement])</p> <p>During an observation on 3/27/2025 at 9:20AM inside Resident 21's room, Resident 21's was observed in bed with the LALM set at Zone 1.</p> <p>During a concurrent observation and interview on 3/27/2025 at 9:50 AM with Registered Nurse 1 (RN 1), Resident 21's LALM was observed set at Zone 1. RN 1 stated, LALM was set at Zone 1. The resident (Resident 21)'s weight dated 3/17/2025 was 98 lbs. The LALM should be set at Zone 2 (105 lbs) based on her weight. The resident (Resident 21) has a wound on the sacral area. LALM was used for the resident (Resident 21)'s wound management. If the LALM was set incorrectly, it will not be effective for wound healing.</p> <p>During an interview on 3/28/2025 at 2:01 PM with the Director of Staff Development (DSD), the DSD stated, LALM should be based on resident's weight, or the therapeutic effect will not be effective if the resident has a wound, which might become worse.</p> <p>During an interview on 3/28/2025 at 3:01 PM with the Interim Director of Nursing (IDON), the IDON stated, LALM should be set at resident's weight. LALM should always be in the correct setting to prevent further complication if the resident has a skin damage.</p> <p>3. During a review of Resident 136's Admission Record, the admission record indicated Resident 136 was admitted to the facility on [DATE]. Resident 136's diagnoses included chronic respiratory failure, cerebrovascular accident, and hypertension.</p> <p>During a review of Resident 136's MDS, dated [DATE], the MDS indicated Resident 136 was severely impaired with cognitive skills for daily decision-making. The MDS indicated Resident 136 was dependent with eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and roll left and right.</p> <p>During a review of Resident 136's CP, revised 2/16/2025, the CP indicated Resident 136 had a potential risk for skin injury. Staff interventions included were to use low air loss mattress, check skin every shift, inform physician if there were any changes, and to observe and report signs of skin breakdown</p> <p>During a review of Resident 136's BS, with an effective date of 3/28/2025, the BS indicated Resident 136 had a score of 12, which indicated Resident 136 was a high risk for developing pressure sore.</p> <p>During a review of Resident 136's physician order, dated 5/27/2021, the physician's order indicated special therapy bed of low air loss mattress.</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 - Some</p>	<p>During an observation on 3/25/2025 at 9:50 AM inside Resident 136's room, Resident 136's was observed in bed with the LALM set at Zone 2 (105 lbs.)</p> <p>During an observation on 3/27/2025 at 9:25AM in Resident 136's room, Resident 136's was observed in bed with the LALM set at Zone 2 (105lbs).</p> <p>During a concurrent observation and interview on 3/27/2025 at 9:37 AM with RN 1, Resident 136's LALM was observed set at Zone 2 (105lbs). RN 1 stated, The resident (Resident 136)'s weight, dated 3/22/2025 was 133 lbs. The LALM should be set at Zone 3 (140 lbs) based on the resident's weight. The resident (Resident 136) does not have any skin breakdown. The LALM was used for resident (Resident 136)'s skin maintenance. If the LALM was set incorrectly, the therapeutic effect of maintaining his skin will not be effective.</p> <p>During a concurrent interview and record review on 3/27/2025 at 3:24 PM, with MDS Coordinator (MDSC), Resident 136's Skin assessment dated [DATE] was reviewed. MDSC stated, The resident (Resident 136) has unstageable pressure ulcer on the back prior to admission on 5/2021. The pressure ulcer on his back was healed. The LALM was used for his skin maintenance. If the LALM was in the wrong setting, the resident (Resident 136) can possibly develop a pressure ulcer.</p> <p>During an interview on 3/27/2025 at 3:02 PM with IDON, IDON stated, LAL should be set based on resident's weight. If there's no skin issue, the incorrect setting of LALM can create friction and more problems to the resident's skin.</p> <p>During a review of facility's policy and procedure (P&P) titled, Mattress, Alternating Air, revised 5/2024, the P&P indicated for the facility to use pressure-relieving mattresses as indicated by the resident's physical condition. Setting of the mattress must be appropriate to patient's weight. The policy indicated to provide stimulation and pressure relief to residents at risk for skin breakdown. To distribute weight relieving areas of pressure.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456</p> <p>Based on observation, interview, and record review, the facility failed to provide appropriate care to prevent complications of enteral feeding (nutrition taken through the mouth or through a tube that goes directly to the stomach or small intestine) for two (2) of 2 sampled residents (Resident 12 and 4) in accordance with the facility's policy and procedure by failing to:</p> <ol style="list-style-type: none"> 1. Turn off the enteral feeding pump before and during medication administration via gastrostomy tube (G-tube, surgical procedure wherein a tube is inserted through the abdomen wall and into the stomach used for nutrition and medication administration) for Resident 12. 2. Ensure medications were administered by gentle instillation or gravity via syringe into Resident 4's G- tube. <p>This deficient practice had the potential for drug-nutrient interaction, G-tube clogging, less medication absorption and efficacy which could affect Residents 12 and 4's overall wellbeing.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 12's Admission Record, the admission record indicated Resident 12 was admitted to the facility on [DATE]. <p>During a review of Resident 12's History and Physical (H&P), dated 3/17/2024, the H& P indicated diagnoses included chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), aspiration pneumonia (a lung infection that occurs when food, liquid, or other foreign substances are inhaled into the lungs), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool) dated 1/29/2025, the MDS indicated Resident 12 has severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 12 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and roll left and right.</p> <p>During a medication administration observation on 3/26/2025 at 1:27 PM inside of Resident 12's room with Licensed Vocational Nurse 1 (LVN 1), LVN 1 was observed checking Resident 12's G-tube placement by aspirating Resident 12's gastric residual volume (GRV, refers to the amount of fluid remaining in the stomach after a meal or during tube feeding). LVN 1 proceeded to administer Resident 12's medications via G-Tube while the G-tube feeding was running. LVN 1 did not turn off Resident 12's tube feeding machine before and while administering the resident's medications.</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 - Some</p>	<p>During an interview on 3/26/2025 at 1:31 PM with LVN 1, LVN 1 stated, I usually do not hold the feeding before I do my medication administration. We do not hold the tube feeding before the medication administration because it is only held for 2 hours a day, in the morning shift that starts from 8AM to 10AM.</p> <p>During an interview on 3/26/2025 at 1:34 PM, with LVN 1, LVN 1 stated, it was important to check G-tube placement. The tube feeding and medications are delivered to the stomach and not to the surrounding areas like the lungs.</p> <p>During an interview on 3/28/2025 at 2:54 PM with Interim Director of Nursing (IDON), IDON stated, During G-Tube medication administration, we always use the 5Ps of medication administration, identify the resident, and aspirate residual. We should check if the G-tube was in correct placement before starting medication administration.</p> <p>During an interview on 3/28/2025 at 2:57 PM with IDON, IDON stated, We should hold the tube feeding and turn off the tube feeding machine feeding prior and during medication administration via G-tube to avoid complicating with the feeding flow and spilling the feeding formula.</p> <p>During a review of the facility's P&P titled, Medication Administration Through a Feeding Tube, revised on 6/2017, the P&P indicated, Put continuous tube feedings on hold. Check the residual and tube placement by aspirating stomach contents and auscultating the epigastric (upper middle area of the abdomen, just below the ribs and above the belly button) area while injecting a small amount of air.</p> <p>2. During a review of Resident 4's Admission Record, the admission record indicated Resident 4 was admitted to the facility on [DATE]. Resident 4's diagnoses included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), diabetes mellitus, gastrostomy tube, and seizure (a sudden, uncontrolled burst of electrical activity in the brain).</p> <p>During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 has severely impaired cognitive skills for daily decision making. The MDS indicated Resident 4 has an abdominal percutaneous endoscopic gastrostomy (PEG tube, a feeding tube that is inserted into the stomach through the abdominal wall, used to provide nutrition, fluids, and medications to residents who cannot swallow or eat normally) and was dependent in eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and roll left and right.</p> <p>During a review of Resident 4's Physician's order, dated 7/1/2024, the physician's order indicated the following:</p> <ol style="list-style-type: none"> 1. Lactulose 20 gram (gm, unit of measurement) /30 milliliters (ml, unit of measurement of volume) twice a day via G-tube for constipation 2. Rivastigmine 1.5 milligrams (mg, unit of measurement) give 1.5mg capsule twice a day (BID) with meals via G-tube for Alzheimer's Disease. <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 - Some</p>	<p>During an observation on 3/27/2025 at 4:59 PM in front of Resident 4's room with LVN 2, LVN 2 mixed the 30 ml of Lactulose liquid and opened the capsule and poured the powder of Rivastigmine in a plastic cup with 50 ml of water during medication administration preparation.</p> <p>During an observation on 3/27/2025 at 5:01 PM in Resident 4's room with LVN 2, LVN 2 administered the first 50 ml of mixed medications with water within 2 seconds via Resident 4's G-tube with the use of the syringe plunger then administered another 30 ml of mixed medications in less than 2 seconds to Resident 4's G-tube.</p> <p>During an interview on 3/27/2025 at 5:06 PM with LVN 2, LVN 2 stated, It is okay to mix medications when administering via G-tube, because you can mix some medications.</p> <p>During an interview on 3/28/2025 at 2:56 PM with Interim Director of Nursing (IDON), IDON stated, Medications should be given one at a time, given by gravity and should not be pushed in the G-tube. We should be careful with the G-tube balloon because it might burst and possibly get dislodged.</p> <p>During an interview on 3/28/2025 at 3:09 PM with IDON, IDON stated, We should not mix medications. There could be complications, risk of clogging the G-Tube, and risk of drug interaction.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Management: Administration of Medication by Nursing, revised on 9/2013, the P&P indicated, the nurse shall read and follow precautionary or additional instruction available on the prescription label/package (i.e. shake well, give on empty stomach). Do not mix incompatible medications. Allow medication to infuse via gravity not bolus (a single large dose of a drug given all at once push). Never force medications/fluids through tubing.</p> <p>During a review of the facility's P&P titled, Medication Administration Through a Feeding Tube, revised on 6/2017, the P&P indicated, Administer medications via gentle instillation or gravity via syringe into the resident's feeding tube, flushing with a minimum of 10-15 ml sterile water between each medication.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456</p> <p>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures to ensure the safe administration of drugs meet the needs of one (1) of five sampled residents (Resident 4) in accordance with the facility's policy and procedure (P&P) by failing to ensure Licensed Vocational Nurse 2 (LVN 2) did not mix Lactulose (used to treat constipation) and Rivastigmine (used to treat dementia [a progressive state of decline in mental abilities] in people with Alzheimer's disease [a disease characterized by a progressive decline in mental abilities]) and administer to Resident 4 on 3/27/2025.</p> <p>This deficient practice had the potential for medication interaction, affect the efficacy of the medications, cause clogging in Resident 4's gastrostomy tube (G-tube, surgical procedure wherein a tube is inserted through the abdomen wall and into the stomach used for nutrition and medication administration) and result in adverse reactions such as gastrointestinal (GI) complications which includes abdominal pain, nausea, vomiting, or diarrhea.</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record, the admission record indicated Resident 4 was admitted to the facility on [DATE]. Resident 4's diagnoses included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), diabetes mellitus, gastrostomy tube, and Alzheimer's disease.</p> <p>During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 1/10/2025, the MDS indicated Resident 4 has severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 4 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and roll left and right.</p> <p>During a review of Resident 4's Physician's order, dated 7/1/2024, the physician's order indicated the following:</p> <ol style="list-style-type: none"> 1. Lactulose 20 gram (gm, unit of measurement) /30 milliliters (ml, unit of measurement of volume) twice a day via G-tube for constipation 2. Rivastigmine 1.5 milligrams (mg, unit of measurement) give 1.5mg capsule twice a day (BID) with meals via G-tube for Alzheimer's Disease. <p>During an observation on 3/27/2025 at 4:59 PM in front of Resident 4's room with LVN 2, LVN 2 was observed preparing the medications for Resident 4. LVN 2 opened the capsule of Rivastigmine, poured its powder into a plastic cup and mixed it with 30 ml of Lactulose liquid and 50 ml of water.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 3/27/2025 at 5:01 PM in Resident 4's room with LVN 2, LVN 2 was observed pouring the cup with Rivastigmine, Lactulose, and water into a syringe. LVN 2 administered the first 50 ml of mixed medications with water within 2 seconds by pushing the syringe plunger attached to the Resident 4's G-tube. LVN 2 administered the remaining 30 ml of mixed medications with water in less than 2 seconds by pushing the syringe plunger attached to the Resident 4's G-tube.</p> <p>During an interview on 3/27/2025 at 5:06 PM with LVN 2, LVN 2 stated, It is okay to mix medications when administering via G-tube, because you can mix some medications.</p> <p>During an interview on 3/28/2025 at 3:09 PM with Interim Director of Nursing (IDON), IDON stated, We should not mix medications. It should be administered one at a time. There could be complications, risk of clogging the G-Tube, and risk of drug interaction.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Management: Administration of Medication by Nursing, revised on 9/2013, the P&P indicated, the nurse shall read and follow precautionary or additional instruction available on the prescription label/package (i.e. shake well, give on empty stomach). Do not mix incompatible medications. Allow medication to infuse via gravity not bolus (a single large dose of a drug given all at once push). Never force medications/fluids through tubing.</p> <p>During a review of the facility's P&P titled, Medication Administration Through a Feeding Tube, revised on 6/2017, the P&P indicated, Administer medications via gentle instillation or gravity via syringe into the resident's feeding tube, flushing with a minimum of 10-15 ml sterile water between each medication.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45456</p> <p>Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five (5) percent (%). Two (2) medication errors (the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order/ manufacturer's specifications / accepted professional standards and principles) out of 25 opportunities (observed administered medications) for error which yielded a facility medication rate of 8% for one (1) of 5 sampled residents (Resident 4) observed during medication administration (med pass).</p> <p>Licensed Vocational Nurse 2 (LVN 2) did not mix Lactulose (used to treat constipation) and Rivastigmine (used to treat dementia [a progressive state of decline in mental abilities] in people with Alzheimer's disease [a disease characterized by a progressive decline in mental abilities]) and administer to Resident 4 on 3/27/2025.</p> <p>This deficient practice had the potential to result in gastrointestinal (GI) complications which includes abdominal pain, nausea, vomiting, or diarrhea, which could result in harm to Resident 4.</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record, the admission record indicated Resident 4 was admitted to the facility on [DATE]. Resident 4's diagnoses included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), diabetes mellitus, gastrostomy tube, and Alzheimer's disease.</p> <p>During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool) dated 1/10/2025, the MDS indicated Resident 4 has severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 4 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and roll left and right.</p> <p>During a review of Resident 4's Physician's order, dated 7/1/2024, the physician's order indicated the following:</p> <ol style="list-style-type: none"> 1. Lactulose 20 gram (gm, unit of measurement) /30 milliliters (ml, unit of measurement of volume) twice a day via G-tube for constipation 2. Rivastigmine 1.5 milligrams (mg, unit of measurement) give 1.5mg capsule twice a day (BID) with meals via G-tube for Alzheimer's Disease. <p>During an observation on 3/27/2025 at 4:59 PM in front of Resident 4's room with LVN 2, LVN 2 was observed preparing the medications for Resident 4. LVN 2 opened the capsule of Rivastigmine, poured its powder into a plastic cup and mixed it with 30 ml of Lactulose liquid and 50 ml of water.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 3/27/2025 at 5:01 PM in Resident 4's room with LVN 2, LVN 2 was observed pouring the cup with Rivastigmine, Lactulose, and water into a syringe. LVN 2 administered the first 50 ml of mixed medications with water within 2 seconds by pushing the syringe plunger attached to the Resident 4's G-tube. LVN 2 administered the remaining 30 ml of mixed medications with water in less than 2 seconds by pushing the syringe plunger attached to the Resident 4's G-tube.</p> <p>During an interview on 3/27/2025 at 5:06 PM with LVN 2, LVN 2 stated, It is okay to mix medications when administering via G-tube, because you can mix some medications.</p> <p>During an interview on 3/28/2025 at 3:09 PM with Interim Director of Nursing (IDON), IDON stated, We should not mix medications. It should be administered one at a time. There could be complications, risk of clogging the G-Tube, and risk of drug interaction.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Management: Administration of Medication by Nursing, revised on 9/2013, the P&P indicated, the nurse shall read and follow precautionary or additional instruction available on the prescription label/package (i.e. shake well, give on empty stomach). Do not mix incompatible medications. Allow medication to infuse via gravity not</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018</p> <p>Based on observation and interview, the facility failed to store and prepare food items served to facility residents by failing to ensure:</p> <ol style="list-style-type: none"> 1. Refrigerated opened food items were properly labeled with used by date 2. Unopened food items were removed from the original boxes were labeled with used by date <p>This deficient practice had the potential to result in food borne illness (any sickness that is caused by the consumption of food or beverages that are contaminated with certain infectious or noninfectious agents) to all residents who consume food by mouth and served by the facility kitchen.</p> <p>Findings:</p> <p>During a concurrent observation the walk-in refrigerator and interview with the Dietary Supervisor 1 (DS 1) on [DATE] at 9:45 AM, DS 1 stated one (1) opened container with peeled garlic did not have a label to indicate opened date and used by date. DS 1 also stated several unopened food items which were removed from their original boxes did not have a label to indicate the name of the item, expired date, opened date, and used by date.</p> <ol style="list-style-type: none"> 1. Four (4) unopened 1 Gallon (gal., a measure unit) containers of Asian Sesame dressing 2. Three (3) unopened 1 gal. containers of Ranch dressing 3. 4 unopened 1 gal. containers of Creamy Caesar dressing <p>DS 1 stated any food items that were removed from their original packaging must be clearly labeled with the name of the item, expired date, opened date, and used by date to ensure food safety.</p> <p>During an interview with Food Service Director (FSD) on [DATE] at 11:30 AM, FSD stated that proper labeling and storage practices were important for maintaining food safety and preventing foodborne illness such as upset stomach, nausea, vomiting, diarrhea, and/or fever. FSD further stated foodborne illness could lead to serious medical complication and hospitalization .</p> <p>During a review of facility's policy and procedure (P&P) titled, Standards for Storing Food and Supplies, revised dated ,d+[DATE], the P&P indicated food which is prepared and not served shall be clearly labeled and dated. Items not in original containers shall be labeled and dated.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018</p> <p>45456</p> <p>Based on observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were followed for five (5) of 13 sampled resident (Resident 26, 12, 4, 32, and 10) in accordance with the facility's policy and procedure when:</p> <ol style="list-style-type: none"> 1. Resident 26's foley catheter drainage bag (a urine collection bag) was observed touching the floor on 3/25/2025. 2. Licensed Vocational Nurse 1 (LVN 1) failed to change gloves and perform hand hygiene in between tasks during medication administration to Resident 12. 3. LVN 2 failed to change gloves and perform hand hygiene in between task during Resident 32's gastrostomy tube (G-tube, is a tube inserted through the belly that brings nutrition directly to the stomach) dressing change 4. LVN 2 failed to change gloves and perform hand hygiene in between task during medication administration to Resident 4. 5. Facility failed to clean and disinfect Resident 10's feeding pump (a device that delivers liquid nutrition and/or medications to a patient's digestive tract via a feeding tube) which was observed with brown/yellow stain on it. <p>These deficient practices have a potential to contaminate clean items and can place the residents at risk for infection</p> <p>Findings</p> <ol style="list-style-type: none"> 1. During a review of Resident 26's Admission Record, the admission record indicated Resident 26 was admitted to the facility on [DATE]. Resident 26's diagnoses included respiratory failure (a serious condition that makes it difficult to breathe on your respiratory system [organs/ structures in the body that allows you to breath such as lungs]), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), atrial fibrillation (Afib, is an irregular and often very rapid heartbeat), and urinary retention (a condition in which you cannot empty all the urine from the bladder) <p>During a review of Resident 26's Minimum Data Set (MDS, a resident assessment tool), dated 3/21/2025, the MDS indicated Resident 26 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 26 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and rolling from left and right while in bed.</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 - Some</p>	<p>During a review of Resident 26's Care Plan (CP) for urinary elimination related to the use of urinary catheter and urinary retention, dated 3/19/2025, the CP interventions indicated to keep urinary catheter bag or dignity bag off the floor.</p> <p>During an observation on 3/25/2025 at 9:45 AM in Resident 26's room, Resident 26's foley catheter drainage bag was on the floor and was not covered with a dignity bag.</p> <p>During an interview on 3/27/2025 at 9:46 AM with Registered Nurse 1 (RN 1), RN 1 stated, The foley catheter drainage bag should not be on the floor because of infection control. Resident 26 can acquire infection when the bag is left on the floor. The dignity bag should always cover the drainage bag to provide dignity and privacy and also for infection control.</p> <p>During an interview on 3/28/2025 at 2:59 PM with Interim Director of Nursing (IDON), IDON stated The foley catheter drainage bag should be hanging freely, and dignity bag covering the drainage bag should not be on the floor because of infection control.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Catheter, Indwelling: General & Irrigation, revised 7/2019, the P&P indicated to properly place the foley bag on bed.</p> <p>2. During a review of Resident 12's Admission Record, the admission record indicated Resident 12 was admitted to the facility on [DATE].</p> <p>During a review of Resident 12's History and Physical (H&P), dated 3/17/2024, the H& P indicated diagnoses included chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), aspiration pneumonia (a lung infection that occurs when food, liquid, or other foreign substances are inhaled into the lungs), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 12's MDS, dated [DATE], the MDS indicated Resident 12 was severely impaired with cognitive skills for daily decision making. The MDS indicated Resident 12 was dependent with eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and rolling from left and right while in bed.</p> <p>During a medication administration observation on 3/26/2025 at 1:23 PM in Resident 12's room with LVN 1, LVN 1 was observed picking up a medication bottle that fell and rolled on the floor with her gloved hands. LVN1 was then observed placing the medication on the medication tray with the other medications of Resident 12. LVN 1 did not change her gloves and continued preparing Resident 12's medications.</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 - Some</p>	<p>During a medication administration observation on 3/26/2025 at 1:25 PM in Resident 12's room with LVN 1, LVN 1 was observed with the same set of gloves, was poking the container lid of a medication using the bandage scissor hanging from her waist. LVN 1 poured the medication to a medicine cup. LVN 1 held the 3 medicine cups together by holding the inside part of the cups and put them on Resident 12's overbed table. LVN 1 pulled the curtains to provide privacy and touched Resident 12's linens. LVN 1 proceeded to check Resident 12's G-tube residual, then touched the towel that was on Resident 12's chest and proceeded to administer resident's medications via G-tube. LVN 1 then administered eye drops to Resident 12's both eyes using the same gloves all along.</p> <p>During an interview on 3/26/2025 at 1:38 PM with LVN 1, LVN 1 stated, I have not been told to change gloves when doing different tasks in a resident's room. It is okay to touch Resident 12's curtains and administer his medications without changing gloves because it is his germs anyway. I did not know if I have to change gloves in between tasks. I do think it is okay not to change gloves.</p> <p>During an interview on 3/26/2025 at 1:40 PM with LVN 1, LVN 1 stated, It is not okay that I did not change my gloves after picking up the medication that rolled on the floor because it is infection control. Resident 12 can get infection.</p> <p>During an interview on 3/26/2025 at 1:41 PM with LVN 1, LVN 1 stated, I did not notice that I was touching the inner part of the medicine cups when I picked up the 3 medicine cups. I am not paying attention. I should not have done that because of infection control.</p> <p>During a review of the facility's P&P titled, Infection Control Manual- Isolation Overview, revised on 10/2007, the P&P indicated, practicing good hygiene as promptly and thoroughly as possible between patient contacts and after contact of blood, body fluids, secretions, excretions and equipment or articles contaminated by them is an important component of component of infection control and isolation precautions. Gloves are worn to reduce the likelihood that hands of personnel contaminated with microorganisms to the patient. In these situations, hands must be washed after gloves are removed.</p> <p>During a review of the facility's P&P titled, Administration of Medication by Nursing, revised on 9/2013, the P&P indicated, when administering eye drops, eardrops, nasal sprays, orally inhaled medications, suppositories or topical medications such as patches, always wash hands prior to and immediately following administration. Hands must be washed with soap and water. Gloves may be utilized and recommended, but hands still must be washed.</p> <p>3. During a review of Resident 32's Admission Record, the admission record indicated Resident 32 was admitted to the facility on [DATE].</p> <p>During a review of Resident 32's History and Physical (H&P), dated 9/18/2024, the H& P indicated diagnoses included chronic respiratory failure, gastrostomy and diabetes.</p> <p>During a review of Resident 32's MDS dated [DATE], the MDS indicated Resident 32 has intact cognitive skills for daily decision making. The MDS indicated Resident 32 was dependent in eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and rolling from left and right while in bed. Resident 32 was assessed to has as an abdominal Percutaneous Endoscopic Gastrostomy (PEG tube, a feeding tube that's inserted into the stomach through the abdominal wall, used to provide nutrition, fluids, and medications to residents who cannot swallow or eat normally).</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 - Some</p>	<p>During an observation on 3/27/2025 at 4:44 PM in Resident 32's room with LVN 2, LVN 2 was wearing a Personal Protective Equipment (PPE, specialized clothing or equipment worn by an employee for protection against infectious materials, such as gowns, gloves, masks, and goggles) and observed touching Resident 32's clothes and opened the resident's abdominal binder (a wide belt that encircles your abdomen). LVN 2 proceeded to replace the Resident 32's dirty G-tube site dressing with a clean dressing then touched Resident 12's clothes while using the same set of gloves.</p> <p>During an interview on 3/27/2025 at 4:51 PM, LVN 2 stated, I forgot to change my gloves. I should have removed my dirty gloves when I removed the dirty dressing because there is a possibility that resident can have an infection.</p> <p>During a review of the facility's P&P titled, Infection Control Manual- Isolation Overview revised on 10/2007, the P&P indicated, gloves are worn to reduce the likelihood that microorganisms present on the hands of personnel will be transmitted to patients during invasive or other patient-care procedures that involve touching a patient's mucous membranes and non-intact skin.</p> <p>4. During a review of Resident 4's Admission Record, the admission record indicated Resident 4 was admitted to the facility on [DATE]. Resident 4's diagnoses included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), diabetes mellitus, gastrostomy tube, and Alzheimer's disease.</p> <p>During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 was severely impaired with cognitive skills for daily decision making. The MDS indicated Resident 4 was dependent with eating, oral hygiene, toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene and rolling from left and right while in bed.</p> <p>During an observation on 3/27/2025 at 4:59 PM in Resident 4's room with LVN 2, LVN 2 was observed touching and fixing his mask with his gloved hand and started to check Resident 4's Gtube placement by aspirating residual. LVN 2 proceeded to administer Resident 12's medications via G-tube using the same set of gloves.</p> <p>During an interview on 3/27/2025 at 5:03 PM in front of Resident 4's room with LVN 2, LVN 2 stated, I should have changed my gloves after touching my mask before administering medications to the resident (Resident 12) because I can contaminate the resident's medications.</p> <p>During a review of the facility's P&P titled Infection Control Manual- Isolation Overview, revised on 10/2007, the P&P indicated, practicing good hygiene as promptly and thoroughly as possible between patient contacts and after contact of blood, body fluids, secretions, excretions and equipment or articles contaminated by them is an important component of component of infection control and isolation precautions.</p> <p>5. During a review of Resident 10's Admission Record, the Admission Record indicated Resident 10 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 10's History and Physical Examination (H&P) dated 8/23/2024, the H&P indicated Resident 10's diagnoses included chronic (long-term) respiratory failure (lung cannot properly exchange gases, causing abnormal levels of oxygen and carbon dioxide in the blood), recurrent Pneumonia (infection of one or both of the lung caused by bacteria, viruses, or fungi.) and end stage Amyotrophic Lateral Sclerosis (ALS, a severe and progressive decline in physical and cognitive function.)</p> <p>During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10 was impaired with cognitive skills [ability to think, understand, and reason] for daily decision making. The MDS indicated Resident 10 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for toileting hygiene, oral hygiene, and upper/lower body dressing.</p> <p>During a concurrent observation and interview in Resident 10's room on 3/25/2025 at 9:10 AM with the present of Certified Nursing Assistant 1 (CNA 1), CNA 1 stated the base of the IV pole was visible dirty with brown/yellow substance stained. CNA 1 stated IV pole should be disinfected or cleaned every day.</p> <p>During an interview on 3/5/2025 at 11:12 AM with the Infection Preventive Nurse (IPN), the IPN stated daily cleaning of medical equipment/devices was essential for preventing infections and ensuring safety of the residents.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Cleaning Products and Equipment, revised date 11/2024, the P&P indicated to reduce the risk of transmission of infections and always ensure the cleanliness of patient care items and equipment. The P&P indicated that medical equipment that was used in a patient room or that came into contact with the patient, or his/her contaminated environment would be cleaned and disinfected before it could be used on any other patient. The P&P further indicated that IV pole in the patient rooms should be disinfected daily.</p>		