

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER El Encanto Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 555 South El Encanto Road City of Industry, CA 91745	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>37198</p> <p>Based on interview and record review, the facility failed to ensure staff did not give medications to one of three sampled residents (Resident 1) without a current physician's order as indicated in the facility's policy and procedure (P&P) titled, Medication Administration.</p> <p>This deficient practice had the potential to result in the unnecessary use of medication, medication errors, and adverse side effects for Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 10/19/2020, with diagnoses that included non-displaced intertrochanteric fracture of right femur (a type of fracture that occurs in the upper part of the thigh bone), dementia (a group of symptoms affecting memory, thinking and social abilities), and difficulty in walking.</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/26/2025, the MDS indicated Resident 1 was usually understood by others and had the ability to usually understand others. The MDS indicated Resident 1 was dependent (helper does all of the effort) on staff for toileting hygiene, showering/bathing self, lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>During a review of Resident 1's Order Summary Report (OSR), dated 2/22/2025, the OSR indicated there was no current physician's order for any medication as needed for nausea and vomiting.</p> <p>During a review of Resident 1's Licensed Nurses Progress Notes (PN), dated 3/10/2025 and timed at 11:30 pm, the PN indicated Licensed Vocational Nurse (LVN) 1 documented that Resident 1 had small amount of emesis (vomit), brown in color, liquid, similar to nighttime medications with chocolate pudding. The PN indicated Resident 1 had no further nausea or vomiting. The PN indicated Resident 1's vital signs were stable, and call light was within reach.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/26/2025 at 3:22 pm with LVN 1, LVN 1 stated Resident 1 had some Zofran (a medication that prevents nausea and vomiting) 4 milligrams (mg) tablets available in the medication cart, labeled with Resident 1's name on it. LVN 1 stated LVN 1 gave Zofran 4 mg (one tablet) to Resident 1 at 11:30 pm or 11:45 pm. LVN 1 stated LVN 1 did not review Resident 1's Medication Administration Record (MAR) and verify if there was a physician's order for Zofran before giving the Zofran to Resident 1. LVN 1 stated LVN 1 administered the Zofran to Resident 1 first then tried to document the medication administration in Resident 1's MAR but did not see an active order for the Zofran. LVN 1 stated before giving any resident a medication, LVN 1 needed to look at the MAR before administering any medications. LVN 1 stated LVN 1 did not look at the MAR and just obtained the Zofran 4 mg from the medication cart.</p> <p>During an interview on 3/26/2025 at 4 pm with the Assistant Director of Nursing (ADON), the ADON stated before staff administered any medication, staff needed to check the MAR and check the physician's order. The ADON stated if there was no physician's order, staff needed to contact the physician and inform the physician because administering a medication without a physician's order was considered a medication error.</p> <p>During an interview on 3/26/2025 at 4:55 pm with the Director of Nursing (DON), the DON stated when administering a medication, staff needed to check the process. The DON stated staff needed to check the physician's orders against the medication card and follow the order.</p> <p>During a review of the facility's P&P titled, Medication Administration, revised on 6/12/2023, the P&P indicated Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so, Personnel authorized to administer medications do so only after they familiarized with the medication. The P&P indicated, Medications are administered in accordance with written orders of the attending physician.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>37198</p> <p>Based on interview and record review, the facility failed to follow the facility ' s policy and procedure (P&P) titled, Charting and Documentation, by failing to document a complete assessment (the process of evaluating a patient's condition) for one of three sampled residents ' condition (Resident 1).</p> <p>This deficient practice had the potential to not provide complete information regarding Resident 1 ' s condition.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 10/19/2020 with diagnoses that included non-displaced intertrochanteric fracture of right femur (a type of fracture that occurs in the upper part of the thigh bone), dementia (a group of symptoms affecting memory, thinking and social abilities), and difficulty in walking.</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 1/26/2025, the MDS indicated Resident 1 was usually understood by others and had the ability to usually understand others. The MDS indicated Resident 1 was dependent (helper does all of the effort) on staff for toileting hygiene, showering/bathing self, lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>During a review of Resident 1 ' s Licensed Nurses Progress Notes (PN), dated on 3/10/2025 and timed at 11:30 pm, the PN indicated Licensed Vocational Nurse (LVN) 1 documented that Resident 1 had small amount of emesis (vomit), brown in color, liquid, similar to nighttime medications with chocolate pudding. The PN indicated Resident 1 had no further nausea or vomiting. The PN indicated Resident 1 ' s vital signs were stable, and call light was within reach.</p> <p>During a review of the Facility ' s Investigation Report (IR), dated 3/11/2025, the IR indicated during an interview with Certified Nursing Assistant (CNA) 1, CNA 1 had noticed Resident 1 was moaning on 3/10/2025 at 11:30 pm and Resident 1 suddenly screamed when CNA 1 repositioned Resident 1 to Resident 1 ' s right side. The IR indicated the Registered Nurse (RN) and LVN 1 checked on Resident 1. The IR indicated at 2:30 am, CNA 1 noticed that Resident 1 had an episode of moaning each time CNA 1 repositioned Resident 1.</p> <p>During a review of Resident 1 ' s SBAR (Situation, Background, Appearance, Review and Notify) Communication Form and Progress Notes (SBAR), dated 3/11/2025 at 11:30 am, the SBAR indicated CNA (unknown) reported that Resident 1 was moaning and grimacing of pain when moving Resident 1 ' s right leg. The SBAR indicated Resident 1 was noted with swelling on the right knee.</p> <p>During a review of Resident 1 ' s Radiology Report (RR) of the right knee, dated 3/11/2025, and timed at 2:58 pm, the RR indicated findings suggestive of a fracture of the proximal lateral tibia (a fracture, or break, in the shinbone just below the knee).</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the IR, dated 3/12/2025, the IR indicated during an interview with LVN 1, LVN 1 stated CNA 1 was changing Resident 1 on 3/10/2025 at 11:30 pm. The IR indicated LVN 1 and RN heard moaning from Resident 1 ' s room. The IR indicated LVN 1 and RN both went into Resident 1 ' s room to ask Resident 1 if Resident 1 had any pain. The IR indicated Resident 1 did not know if there was any pain. The IR indicated LVN 1 did not evaluate Resident 1 ' s bilateral lower extremities (both legs). The IR indicated LVN 1 could not state if Resident 1 had any knee or leg swelling because LVN 1 did not see Resident 1 ' s bilateral lower extremities and that no swelling was reported to LVN 1.</p> <p>During an interview on 3/26/2025 at 2:48 pm, with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 3/10/2025, during 11 pm - 7 am shift, Resident 1 had episodes of moaning whenever CNA 1 provided care to Resident 1. CNA 1 stated Resident 1 only moaned when CNA 1 touched and repositioned Resident 1. CNA 1 stated Resident 1 did not usually moan when touched and had never done that before. CNA 1 stated CNA 1 informed LVN 1 that maybe Resident 1 was in pain.</p> <p>During an interview on 3/26/2025 at 3:22 pm, with LVN 1, LVN 1 stated LVN 1 was supposed to document anything abnormal, changes in condition or on the body, and anything that needed to be reported to the physician about a resident.</p> <p>During an interview on 3/26/2025 at 4 pm, with the Assistant Director of Nursing (ADON), the ADON stated staff was supposed to have complete documentation of what occurred and paint a picture of what happened to the resident, for continuity of care.</p> <p>During a review of the facility ' s P&P titled, Charting and Documentation, revised in July 2017, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident ' s medical, physical, functional or psychosocial condition, shall be documented in the resident ' s medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident ' s condition and response to care. The following information is to be documented in the resident medical record: objective observations, medications administered, treatments or services performed, changes in the resident ' s condition, events, incidents or accidents involving the resident and progress toward or changes in the care plan goals and objectives.</p>