

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  06/13/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure call lights were within reach and were functioning properly for two of three sampled residents (Residents 30 and 18).</p> <p>This failure had the potential for Residents 30 and 18 not to receive necessary care or receive delayed services.</p> <p>Findings:</p> <p>a. During a review of Resident 30's admission Record (AR), the AR indicated Resident 30 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (paralysis [complete or partial loss of muscle function] on one side of the body), blindness on the left eye, and dementia (a group of conditions, decline in mental ability, that interfere with daily activities).</p> <p>During a review of Resident 30's Care Plans (CPs), dated 9/26/2024, the CPs indicated Resident 30 was at risk for decline in activity of daily living (ADL, term used in healthcare that refers to self-care activities)/range of motion (ROM, full movement potential of a joint), had impaired vision, and was at risk for injury from falls. The CP's interventions included keeping the call light within Resident 30's reach and answering the call light promptly.</p> <p>During a review of Resident 30's Minimum Data Set (MDS, a resident assessment tool), dated 3/29/2025, the MDS indicated Resident 30's cognition (ability to understand and process information) was severely impaired. The MDS indicated Resident 30 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with oral hygiene, toileting, showers, and personal hygiene.</p> <p>During a concurrent observation inside Resident 30's room and interview on 6/10/2025 at 8:39 am with Licensed Vocational Nurse 1 (LVN 1), Resident 30 was lying in bed, on Resident 30's back and the call light was located on top of Resident 30's rolling (bedside) table. The rolling table was located approximately three (3) feet (ft, unit of measurement) away from Resident 30's bed. LVN 1 stated Resident 30 could not reach the call light. LVN 1 stated the rolling table with the call light should be placed next to and close to Resident 30's bed for Resident 30 to call for help [when needed] and prevent injuries like falls.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/11/2025 at 1:44 pm with the Assistant Director of Nursing (ADON), the ADON stated the call light should be placed close to Resident 30's good arm and hand for Resident 30 to be able to use the call light and staff could address Resident 30's needs timely and promptly.</p> <p>b. During a review of Resident 18's AR, the AR indicated Resident 18 was admitted to the facility on [DATE] with diagnoses that included abnormalities of gait (a person's manner of walking) and mobility (the ability to move) and unspecified osteoarthritis (type of joint disease that results from breakdown of joint cartilage [connective tissue] and underlying bone).</p> <p>During a review of Resident 18's CP, dated 9/4/2015, the CP indicated Resident 18 was at risk for injury from falls as evidenced by unsteady gait and balance. The CP's interventions indicated for the nursing staff to have Resident 18's call light within reach and to answer promptly, and to remind Resident 18 to use the call light to call for help as needed.</p> <p>During a review of Resident 18's Fall Risk Assessment (FRA- method of assessing a patient's likelihood of falling), dated 3/17/2025, the FRA indicated Resident 18 was assessed as a high risk for falls due to history of falls in the past 3 months. The FRA indicated Resident 18's vision was impaired, had balance problems, and required assisting devices.</p> <p>During a review of Resident 18's MDS, dated [DATE], the MDS indicated, Resident 18 had intact cognition for daily decision making. The MDS indicated Resident 18 was dependent on staff for eating, oral hygiene, toileting hygiene, showers, upper/lower body dressing, putting on/taking off footwear, and for personal hygiene.</p> <p>During a concurrent observation and interview on 6/10/2025 at 8:30 am, Resident 18 was awake, sitting in Resident 18's bed, and pressing the call light button. Resident 18 stated Resident 18's call light was not working for two days and Resident 18 informed Licensed Vocational Nurse 2 (LVN 2) on 6/9/2025. Resident 18 stated no [staff] came [to check on the light]. Resident 18 stated Resident 18 pressed the call light and no [staff] came to Resident 18's room on 6/10/2025. Resident 18 stated, Resident 18 went out of Resident 18's room to look for the nurse when Resident 18 needed assistance because the call light was not working.</p> <p>During an interview on 6/10/2025 at 10 am with the facility's Assistant Director of Nursing (ADON), the facility's ADON stated, a resident [used the] call light to call for assistance from the staff to [the call light was important to] maintain residents' safety. The ADON stated, call lights needed to be answered by the facility staff within 15 minutes.</p> <p>During a review of the undated facility's Policy and Procedure (P&amp;P) titled, Call Lights, the P&amp;P indicated to instruct the resident to use the call button any time he/she needs to talk with a nurse or be assisted. The P&amp;P indicated for nursing staff to check to see that the system is functioning and if any malfunction, report immediately to [the] maintenance [department]. The P&amp;P indicated to answer all [call] lights promptly, regardless of whose resident it is to ascertain what resident's needs are. The P&amp;P indicated call lights need to be answered within three to five minutes.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility failed to ensure one of three sampled resident's (Resident 39) discharge destination was coded correctly in Resident 39's Minimum Data Set (MDS, a resident assessment tool). Resident 39 was discharge home but the MDS was coded as Resident 39 being discharged short term to the general hospital.</p> <p>This deficient practice resulted in reporting that was not accurate to the Centers of Medicare and Medicaid (CMS, a federal agency that administers the Medicare program and works with state governments to administer the Medicaid and health insurance portability standards) agency.</p> <p>Findings:</p> <p>During a review of Resident 39's admission Record (AR), the AR indicated Resident 39 was admitted to the facility 3/14/2025 with diagnoses that included hyperlipidemia (high levels of fats in the blood) and diabetes mellitus type 2 (a disease that results in elevated levels of glucose in the blood).</p> <p>During a review of Resident 39's Physicians Order (PO), dated 3/18/2025, the PO indicated to discharge Resident 39 home on 3/22/2025, per Resident 39's request.</p> <p>During a review of Resident 39's Discharge Summary, dated 3/18/2025, timed at 2:19 pm, the summary indicated Resident 39 was transferred home on 3/22/2025.</p> <p>During a review of Resident 39's MDS, dated [DATE], the MDS indicated Resident 39 was discharged to a short-term general hospital.</p> <p>During a concurrent interview and record review of Resident 39's MDS, with the MDS Coordinator (MDSC) on 6/11/2025 at 9:50 am, the MDSC stated Resident 39 was coded as discharged to a short-term general hospital. The MDSC stated, Resident 39 was discharged home on 3/22/2025 and not to the general hospital. The MDSC stated, Resident 39's MDS assessment needed to be coded as discharged home. The MDSC stated Resident 39's MDS assessment needed to be coded accurately, and CMS needed to be provided with accurate information.</p> <p>During a concurrent interview and record review of Resident 39's medical record (chart) with the Assistant Director of Nursing (ADON) on 6/12/2025, at 9:33 am, the ADON stated Resident 39 was discharged home on 3/22/2025 per Resident 39's request. The ADON stated, Resident 39 was discharged home after dialysis treatment. The ADON stated MDS assessments needed to be coded accurately.</p> <p>During a review of the facility's undated policy and procedure (P&amp;P) titled, MDS and Resident Assessment Instrument (RAI) Process, the P&amp;P indicated, all members of the Interdisciplinary Team (IDT, a team of health care professions who work together to establish plans of care for residents) shared responsibility for accurate completion of the RAI. The P&amp;P indicated RN MDS Coordinator reviewed all sections of the MDS and signed to indicate completion of the assessment.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 17) was provided adequate supervision during activities of daily living (ADL, activities such as bathing, dressing, and toileting a person performs daily) by using a two-person assist to prevent a fall occurrence.</p> <p>This failure resulted in a fall which had the potential to result in severe harm or injury to Resident 17.</p> <p>Findings:</p> <p>During a review of Resident 17's admission Record (Face Sheet), the admission Record indicated the facility admitted Resident 17 on 4/17/2025 with diagnoses including osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), morbid obesity (a disorder that involves having too much body fat), generalized muscle weakness (a decrease in muscle strength throughout the body), and lack of coordination (an inability to smoothly and precisely control body movements).</p> <p>During a review of Resident 17's Minimum Data Set (MDS, a resident assessment tool) dated 4/24/2025 , the MDS indicated Resident 17 was dependent (helper did all the effort, resident did none of the effort to complete the activity, the assistance of 2 or more helpers are required for the resident to complete the activity) with eating, oral hygiene, toileting, showering, upper/lower body dressing and personal hygiene. The MDS indicated Resident 17 was dependent on staff for rolling to the left and right side.</p> <p>During a review of Resident 17's MDS dated [DATE], the MDS indicated Resident 17 had moderately impaired cognition (ability to understand and process information).</p> <p>During a review of Resident 17's CT (Computed Tomography, a type of specialized x-ray) of the head with no contrast results indicated Resident 17 had no significant abnormality (findings are all normal).</p> <p>During a concurrent observation and interview with Resident 17 on 6/10/2025 at 10:59 a.m., Resident 17 was observed with dark colored areas on the left arm, Resident 17 stated about two weeks ago a lady (resident was unable to identify the staff) turned me to right side, and I slid and fell while the staff was changing my diaper. Resident 17 stated she slid and fell off the bed on her right side. Resident 17 stated she was taken to the emergency room, and had no broken bones.</p> <p>During an interview on 6/11/2025 at 3:23 p.m. with Certified Nursing Assistant 4 (CNA 4). CNA 4 stated Resident 17 needed 2-person assistance for all ADLs and bed mobility such as turning, repositioning, changing, and cleaning. CNA 4 stated she was providing ADL care to Resident 17 when the resident slid very slowly from the bed. CNA 4 stated she was alone providing care at that time. CNA 4 stated she was holding Resident 17's shoulders but the resident was a heavy person and could not prevent the fall. CNA 4 stated she called for assistance and the charge nurse came into the room, while another CNA brought the Hoyer lift (mechanical equipment used to transfer a person support the body from one place to another) to transfer the resident back into bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/11/2025 at 3:32 p.m. with Licensed Vocational Nurse (LVN 3), LVN 3 stated Resident 17 should be cleaned and provided ADL with 2-person assistance for the safety of the resident and to prevent fall.</p> <p>During a concurrent interview and record review on 6/11/2025 at 3:46 p.m. with the Assistant Director of Nursing (ADON), Resident 17's nurses' notes dated 6/1/2025 and care plans dated 4/21/2025 were reviewed. The ADON stated based on the documentation, Resident 17 was provided care by only one CNA. The ADON stated Resident 17's ADL should be performed by two CNAs, one to hold the weight of Resident 17 on the other side of the bed to prevent a fall.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Activities of Daily Living (ADL) Supporting, revised on 3/2018, the P&amp;P indicated, Appropriate care and services will be provided for residents who are unable to carry out ADL's independently .including appropriate support and assistance with .hygiene (bathing, dressing, grooming and oral care).</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure a Foley catheter (FC, a thin, flexible, rubber or plastic tube used to drain urine from the bladder [hollow muscular organ that acts as a reservoir for urine]) was secured on the resident's thigh for one of two sampled residents (Resident 141).</p> <p>This failure had the potential to result in catheter-related complications like tissue trauma and a physical decline to Resident 141.</p> <p>Findings:</p> <p>During a review of Resident 141's admission Record (AR), the AR indicated Resident 141 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease (CKD, a progressive condition where the kidneys gradually lose their ability to filter waste and excess fluid from the blood), urine retention (inability to fully or partially empty the bladder) and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 141's Care Plan (CP), dated 6/3/2025, the CP indicated Resident 141 had alteration in urinary elimination and required the use of a Foley catheter. The CP's approaches included to secure catheter tubing to Resident 141's leg to avoid pulling or trauma.</p> <p>During a review of Resident 141's History and Physical (H&amp;P), dated 6/4/2025, the H&amp;P indicated Resident 141 had urinary retention and used an indwelling Foley catheter. The H&amp;P indicated Resident 141 appeared confused</p> <p>During a review of Resident 141's Minimum Data Set (MDS, a resident assessment tool), dated 6/9/2025, the MDS indicated, Resident 141 had an indwelling catheter (Foley catheter).</p> <p>During a concurrent observation inside Resident 141's room and interview on 6/10/2025 at 8:54 am with Licensed Vocational Nurse 1 (LVN 1), Resident 141 was sitting on the wheelchair and had a Foley catheter. LVN 1 stated the Foley catheter tubing was not secured on Resident 141's thigh. LVN 1 stated the Foley catheter's tubing should be secured properly to prevent pulling during movement that could cause trauma and bleeding.</p> <p>During an interview on 6/11/2025 at 1:29 pm with the Assistant Director of Nursing (ADON), the ADON stated, all indwelling catheters should be secured properly on the resident's (in general) thigh to hold the catheter in place and to prevent pulling and injury to the residents during movements and transfers.</p> <p>During a review of the facility's undated Policy and Procedure (P&amp;P) titled, Catheter Care, General, the P&amp;P indicated, Use leg straps to attached catheter tubing to residents' leg to avoid tension on catheter. Be sure [the] strap is attached comfortably and is not too tight.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to label the nasal cannula (NC, a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen [colorless, odorless gas]) tubing for one of one sampled resident (Resident 140).</p> <p>This failure had the potential for Resident 140 to result in infection.</p> <p>Findings:</p> <p>During a review of Resident 140's admission Record (AR), the AR indicated Resident 140 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure (CHF, long term condition that happens when the heart cannot pump blood well enough to give the body a normal supply sometimes resulting in leg swelling), cirrhosis of liver (a condition where the liver is permanently scarred or damaged), and obstructive sleep apnea (a sleep disorder characterized by repeated episodes of upper airway obstruction during sleep).</p> <p>During a review of Resident 140's Physician Order (PO), dated 6/9/2025, the PO indicated, Resident 140 had an order for oxygen at 2 liters (L, unit of measurement) via NC as needed.</p> <p>During a review of Resident 140's History and Physical (H&amp;P), dated 6/10/2025, the H&amp;P indicated, Resident 140 had limited decision-making capacity.</p> <p>During a concurrent observation inside Resident 140's room and interview on 6/10/2025 at 8:31 am, with Certified Nurse Assistant 1 (CNA 1), Resident 140 was lying in bed on his back with oxygen running at 2L via NC. CNA 1 stated the NC tubing was not labeled with a date to indicate when the tubing was last changed.</p> <p>During an interview on 6/11/2025 at 1:28 pm with the Assistant Director of Nursing (ADON), the ADON stated NCs, and other respiratory tubing should be labeled with the date to indicate when [the oxygen] was started or the tubing was changed and for infection control [purposes].</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Oxygen Administration, revised 9/2014, the P&amp;P indicated, Label and date nasal cannula tubing and change every 7 days by Licensed Nurses.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure a physician's order, and an informed consent was obtained before the installation of bilateral (both sides) one-fourth (1/4) siderails/bedrails (adjustable metal or plastic bars attached to the bed) for one of three sampled residents (Resident 1).</p> <p>This failure placed Resident 1 at risk for entrapment (an event in which resident was caught, trapped, or entangled in the tight spaced around the bed) and injury from the use of siderails/bedrails.</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (paralysis [complete or partial loss of muscle function] on one side of the body), hemiparesis (characterized by weakness on one side of the body), and diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 3/11/2025, the MDS indicated Resident 1 was severely impaired in cognition (ability to understand and process information). The MDS indicated Resident 1 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with oral hygiene, toileting, showers, upper and lower body dressing, and personal hygiene.</p> <p>During an observation inside Resident 1's room on 6/10/2025 at 9:24 am Resident 1 was in bed, on her left side with <math>\frac{1}{4}</math> siderails/bedrails up on both sides of the bed.</p> <p>During a concurrent interview and record review on 6/10/2025 at 9:24 am with the Minimum Data Set Coordinator (MDSC), Resident 1's medical record (chart) was reviewed. The MDSC stated Resident 1 did not have a physician's order and an informed consent was not obtained before the installation of bilateral <math>\frac{1}{4}</math> siderails/bedrails. The MDSC stated a physician's order, and a signed informed consent should be obtained before the installation of siderails/bedrails to make sure that Resident 1 and/or the representative understood the risks and benefits for the use of siderails/bedrails to prevent potential entrapment and injury.</p> <p>During an interview on 6/10/2025 at 9:27 am with the Assistant Director of Nursing (ADON), the ADON stated, Resident 1 should have a physician's order for the use of <math>\frac{1}{4}</math> siderails, and an informed consent obtained and signed before the installation of the siderails [this was important] for resident's safety and to prevent potential entrapment and injury.</p> <p>During a review of the facility's undated Policy and Procedure (P&amp;P) titled, Siderails, the P&amp;P indicated, Prior to placing a siderail on the bed, informed consent will be obtained when siderail meets the definition of a physical restraint even when it can also be used as an enabler.</p> <p>(continued on next page)</p>		

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<p>F 0700</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 undated P&amp;P titled, Physician Orders, the P&amp;P indicated, Restraint orders specify the type, reason, frequency of check and release, duration of use, and purpose of restraint.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>Based on observation, interview, and record review, the facility failed to post accurate nurse staffing information of actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift daily for 6/10/25, 6/11/25, and 6/12/25 in accordance with the facility's policy and procedure titled Posting Direct Care Daily Staffing Numbers.</p> <p>This deficient practice of posting inaccurate nurse staffing information could mislead the residents and visitors regarding facility staffing and could affect the quality of nursing care provided to the residents.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 6/13/25, at 2:37 p.m., with the Case Manager (CM), the CM stated the purpose of staff posting was to communicate how many staff were providing care to the residents. The CM stated, the 11pm-7am (night) shift &amp; 7 am -3pm (day) shift, posted dated 6/13/25 was not completed and the staff posting should be completed with staff actual work hours. The CM stated the CM would complete the actual hours on posting the next day. During the same observation, the facility's direct staffing information was not posted in the nurses' station and/or visible areas.</p> <p>During an interview on 6/13/25 at 3:39 p.m. with the Assistant Director of Nursing (ADON), the ADON stated staffing hours needed to be posted at the beginning of the shift and actual hours should be posted. The ADON stated the importance of posting the actual staffing was to determine the number of patients and the number of staff working to take care of the residents.</p> <p>During a record review on 6/13/25, with the CM and the ADON, the Posted Nurse Staffing Information actual total hours was not completed for 6/10/25, 6/11/25, and 6/12/25 for all three shifts.</p> <p>During a review of facility's Policy and Procedure titled, Posting Direct Care Daily Staffing Numbers, dated 2001, the P&amp;P indicated within 2 hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care is posted in prominent location (accessible to residents and visitors) and in clear and readable format. The actual time worked during that shift for each category and type of nursing staff, and total number of licensed and non-licensed nursing staff working for the posted shift.</p>		

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  06/13/2025
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	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to follow food storage handling practices in accordance with its Policy and Procedure (P&amp;P) by failing to:</p> <ol style="list-style-type: none"> <li>1. Remove expired food items from the refrigerator.</li> <li>2. Label food items with food item name, use by or expired date.</li> <li>3. Maintain a functional convection steamer (an oven that is designed to steam cook large quantities of food over multiple shelves).</li> </ol> <p>These deficient practices had the potential to result in foodborne illness (illness caused by consuming contaminated food or beverages) for the residents.</p> <p>Findings:</p> <p>1. During initial kitchen observation on 6/10/2025 at 7:50 AM, the kitchen staff did not remove expired food items from the refrigerator. One container of prunes had a use by date of 6/3/25 and one container of puree food was dated 6/9/25 indicating to be used for sack lunch, 4 pieces of half sandwiches).</p> <p>During a concurrent kitchen observation and interview with Food Service Worker (FSW) on 6/10/2025 at 2:21 PM, FSW stated the container of prunes, the container of puree food and four pieces of half sandwiches in the refrigerator were expired and should have been removed from the refrigerator. The FSW stated, the following food items were not properly labeled and should have been labeled with a use by or an expiration date:</p> <ol style="list-style-type: none"> <li>1. One container of purple grapes inside the kitchen refrigerator on the bottom shelf.</li> <li>2. One tray of fruit cups inside the kitchen on the top shelf.</li> <li>3. One tray of applesauce cups inside the kitchen on the second shelf.</li> <li>4. One plastic bag containing three green peppers and one orange pepper inside the kitchen on the second shelf.</li> <li>5. One undated plastic container of fortified milk on top of kitchen table in the fruit and vegetable preparation zone.</li> <li>6. One undated plastic container of sweetener on top of kitchen table in the fruit and vegetable preparation zone.</li> <li>7. One undated plastic container of thickener on top of kitchen table in the fruit and vegetable preparation zone.</li> <li>8. One undated tray of raw chicken inside walk-in freezer on the middle shelf.</li> </ol> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9. One undated tray of three pieces of pastrami meat inside the walk-in freezer in the kitchen on the bottom shelf.</p> <p>10. One tray of 11 fruit cups inside the kitchen refrigerator on the top shelf.</p> <p>The FSW stated properly labeling the food item with a use by or an expiration date would allow the staff to identify when the food items are expiring and when not to serve to the residents. The FSW stated expired food had the potential to cause harm to the residents.</p> <p>2. During a concurrent kitchen observation and interview with Dietary Aide (DA) on 6/10/2025 at 2:30 PM, the following food items were observed undated or unlabeled:</p> <ol style="list-style-type: none"> <li>1. One plastic container of fortified milk on top of kitchen table.</li> <li>2. One undated plastic container of Sweetener.</li> <li>3. One undated plastic container of thickener on top of kitchen table in the fruit and vegetable preparation zone.</li> </ol> <p>The DA stated, when food items were received, staff must label the food and all food items should have a label indicating received by and use by date to determine when the food would expire. The DA stated, using expred food could get the residents sick.</p> <p>During a kitchen interview with the Dietary Service Supervisor (DSS) on 6/10/25 at 2:41 PM, the DSS stated, labels were used to identify when food was not to be used or was expired. The DSS stated it was important not to use food that was expired because it could make the residents sick.</p> <p>During an interview with the Infection Prevention Nurse (IPN) on 6/11/25 at 10:46 AM, the IPN stated residents' food should be labeled with received date and expiration date because residents should not be served with expired food. The IPN stated, expired food could cause GI issues such as nausea, vomiting and dehydration, causing harm to the residents. If there was no expiration date on the food or if expired food was given to the residents, it could cause food poisoning and harm to the residents.</p> <p>During an interview with [NAME] 1 (C1) on 6/12/25 at 10:54 AM, C1 stated all food items should be labeled with open date and expiration date. C1 stated expired foods should be thrown right away.</p> <p>3. During a kitchen observation on 6/12/25 at 11:57 AM, [NAME] 2 (C2) opened the facility's convection steamer and screamed of pain when a tray of green beans from inside the commercial convection steamer fell on her and onto the floor.</p> <p>During a follow up kitchen observation of the commercial convection steamer on 6/12/25 at 12:00 PM, the commercial convection steamer had missing five supporting rails on the left side of the steamer.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview with the DSS on 6/12/25 at 12:10 PM, the DSS stated the commercial convection steamer should have been fixed and deemed safe to operate before dietary staff used it to prepare residents meals. The DSS also stated Maintenance Supervisor (MS) was aware of the missing rails and was waiting for the parts to fix it.</p> <p>During an interview with the FSW on 6/12/25 at 12:16 PM, the FSW stated due to the commercial convection steamer accident, the tray of green beans that fell to the floor would have to be remade causing the tray line to be late and the resident meal trays go out later than usual. The FSW also stated that since C1 had left the kitchen area to get medical assistance, the food items for dinner were not being prepared and therefore, dinner for the residents would also be late.</p> <p>During an interview with the DSS on 6/12/25 at 12:21 PM, the DSS stated when the facility does not maintain functional equipment in the kitchen area (the commercial convection steamer) it could lead to the residents' meal trays being served late.</p> <p>During an interview with the MS on 6/12/25 at 1:14 PM, the MS stated, malfunctioning of the commercial convectional steamer in the kitchen had the potential to affect residents' meals served late.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Food Labeling and Dating Policy, with effective date of 10/01/1995, the P&amp;P indicated, the facility has standardized procedures for labeling and dating all food items in the dietary department to ensure food safety, prevent foodborne illness, comply with California Department of Public Health regulations, and maintain quality standards for resident care. The P&amp;P indicated, all food items entering, stored within, or prepared in the dietary department must be properly labeled with identification and date information according to established food safety standards and regulatory requirements.</p> <p><b>B. Storage of Foods</b></p> <p><b>1. Dry Storage</b></p> <p>-Opened Packages: Label with opening date and discard date</p> <p>-Format: Opened: MM/DD/YY and Discard: MM/DD/YY</p> <p><b>2. Refrigerated Storage (32-40F)</b></p> <p>-Fresh Produce: Label with receiving date and use-by date</p> <p>-Leftovers: Label with preparation date and discard date (maximum 3 days)</p> <p><b>Frozen Storage (0F or below):</b></p> <p>Fresh Items Being Frozen: Label with contents, freezing date, and recommended use-by date.</p> <p><b>Daily Procedures:</b></p> <p>-Check all labeled items daily for expiration</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Remove and discard expired items immediately</p> <p>During a review of the facility's undated P&amp;P titled, Storage, the P&amp;P indicated food, and supplies will be stored in a safe and sanitary manner to ensure that food and supplies are safe to serve and use.</p> <p>Dry Storage:</p> <p>1. Flour, sugar and dry bulk items will be stored in metal or plastic containers with tight fitting covers .A label will be secured to the container with the name of product and date stored.</p> <p>During a review of the facility's undated P&amp;P titled, Storage, the P&amp;P indicated food, and supplies will be stored in a safe and sanitary manner to ensure that food and supplies are safe to serve and use.</p> <p>Prevention of Contamination Guidelines:</p> <p>2. Cover, label, date and refrigerate all leftovers as soon as serving is completed.</p> <p>8. Store all pre-poured beverages and pre-portioned foods in refrigerator, covered and labeled until ready to serve.</p> <p>During a review of the facility's P&amp;P titled, Building Systems General Maintenance Inspection, dated 1/1/99, the P&amp;P indicated to maintain building systems in good working order, inspecting them at intervals which comply with state, federal and company standards to repair as necessary. The P&amp;P indicated weekly inspections are conducted by maintenance staff on the condition of physical plant and equipment for residents and staff .and kitchen equipment, permanent or portable fixtures or equipment within the facility.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure bilateral (both sides) side rails pads were free from damaged, wear and tear, for one of one sampled resident (Resident 3).</p> <p>This deficient practice had potential to place Resident 3 at risk for injury from the use of damaged side rail pads.</p> <p>Findings:</p> <p>During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia (a group of conditions, decline in mental ability, that interfere with daily activities)and senile degeneration of the brain (a decline in mental abilities, particularly memory and thinking skills, often associated with old age).</p> <p>During a review of Resident 3's Care Plan (CP), dated 9/26/2022, the CP indicated Resident 3 was on side rail management as enabler (assistive device that aids with mobility). The CP's intervention indicated for nursing staff to check the side rails periodically for safety/security, to refer to maintenance [department] if and when necessary, and left and right one half (1/2) side rails with pads to minimize [the] risk of bruising/skin tears on [the] extremities (arms and legs).</p> <p>During a review of Resident 3's Order Summary Report (OSR), dated 11/14/2022, the OSR indicated a physician's order for staff to apply left and right &amp;frac12; side (partial) rails with pads as enabler for bed mobility and to prevent injury of [the] skin.</p> <p>During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 5/13/2025, the MDS indicated Resident 3's cognition (ability to understand and process information) was severely impaired. The MDS indicated, Resident 3 was dependent (helper did all of the effort, resident did none of the effort to complete the activity) on staff for eating, oral hygiene, toileting hygiene, showers, upper/lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>During an observation on 6/10/2025 at 8:28 am inside Resident 3's room, Resident 3 was awake, lying in bed on Resident 3's back with &amp;frac12; bilateral side rails up. The padded side rails were ripped and damaged.</p> <p>During an interview on 6/10/2025 at 10:25 am with the facility's Assistant Director of Nursing (ADON), the ADON stated the pads on Resident 3's side rails needed to be changed. The ADON stated the pads needed to be presentable and not ripped or damaged for Resident 3's safety and dignity.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Building Systems General Maintenance Inspection, dated 1/1/1999, the P&amp;P indicated for staff members to report any broken, loose, or otherwise defective equipment or fixtures to their immediate supervisors and/or the administrator and document their findings on the maintenance request log.</p>		