STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555781	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Del Rio	7002 Gage Avenue Bell Gardens, CA 90201

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interview and record review, the facility failed to ensure nursing staff closed the privacy curtain for four of ten sampled residents (Resident 5, Resident 6, Resident 7, and Resident 8) while receiving Activity of Daily Living (ADL) care. This deficient practice violated the resident's right for privacy and had the potential to affect the self-esteem, self-worth, and psychosocial well-being of Residents 5, 6, 7, and 8. Findings: a) During a review of Resident 5 ' s Admission Record, the Admission Record indicated Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including muscle weakness (loss of muscle strength), anxiety disorder (intense, excessive, and persistent worry and fear), and major depressive disorder (depressed mood and loss of interest.) During a review of Resident 5 ' s History and Physical (H&P) dated 1/29/2024, the H&P indicated Resident 5 did not have the capacity to make decisions. During a review of Resident 5 ' s Minimum Data Set ([MDS] a standardized care assessment and care screening tool), dated 8/1/2024, the MDS indicated Resident 5 was usually able to understand and be understood by others. The MDS indicated Resident 5 was totally dependent on staff for ADLs such as dressing, toilet use, personal hygiene, transfer (how the resident moved between surfaces to and from bed, chair, and wheelchair) and bed mobility (how the resident moved from lying to turning side to side). During a review of Resident 5 ' s Care Plan to address the resident ' s need for assistance with ADL ' s dated 11/3/2023, the Care Plan indicated nursing staff approach plan was to undress and dress appropriately and provide privacy for the resident. During a concurrent observation and interview on 9/5/2024 at 5:32 a.m. in Resident 5 ' s room with Certified Nurse Assistant (CNA) 6, CNA 6 was observed assisting Resident 5 with ADL care with the privacy curtains open and Resident 5 exposed. CNA 6 stated the privacy curtain should have been closed all the way while changing Resident 5 to promote privacy and had forgotten to close it. (continued on next page)

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

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b) During a review of resident 6 ' s Admission Record, the Admission Record indicated Resident 6 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Alzheimer ' s disease (brain disorder that slowly destroys memory and thinking skills), diabetes mellitus (abnormal blood glucose), and major depressive disorder. During a review of Resident 6 ' s MDS dated [DATE], the MDS indicated Resident 6 rarely/never understood others and was rarely/never understood by others. The MDS indicated Resident 6 was totally dependent on staff for ADLs such as dressing, toilet use, personal hygiene, transfer, and bed mobility. During a review of Resident 6 ' s Care Plan to address the resident ' s need for assistance with ADL ' s dated 6/26/2024, the Care Plan indicated nursing staff approach plan was to undress and dress appropriately and provide privacy for the resident. During a review of Resident 6 ' s H&P dated 7/2/2024, the H&P indicated Resident 6 did not have the capacity to make decisions. During a concurrent observation and interview on 9/5/2024 at 5:40 a.m. in Resident 6 ' s room with CNA 7, CNA 7 was observed providing ADL care to Resident 6 with the privacy curtains open and Resident 6 exposed. The CNA 7 stated the privacy curtains must be closed when providing care to provide privacy for the resident. c) During a review of resident 7 ' s Admission Record, the Admission Record indicated Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebral vascular disease (group of conditions that affected blood flow to the brain), chronic obstructive pulmonary disease (restricted airflow and breathing) and Schizophrenia (mental illness that affected a person's thoughts, feelings, and behaviors. During a review of Resident 7 ' s Care Plan to address the resident ' s need for assistance with ADL ' s dated 11/11/2023, the Care Plan indicated nursing staff approach plan was to undress and dress appropriately and provide privacy for the resident. During a review of Resident 7 ' s H&P dated 3/27/2024, the H&P indicated Resident 7 did not have the mental capacity to make medical decisions. During a review of Resident 7 ' s MDS dated [DATE], the MDS indicated Resident was usually able to understand and be understood by others. The MDS indicated Resident 7 was totally dependent on staff for ADLs such as dressing, toilet use, personal hygiene, and transfer. During a concurrent observation and interview on 9/5/2024 at 5:53 a.m. with CNA 8 in Resident 7 ' s room, CNA 8 was observed assisting Resident 7 with ADL care with privacy curtains and room door open with Resident 7 exposed. CNA 8 stated Resident 7 ' s privacy curtain was broken. CNA 8 also stated the door should have been closed for Resident 7 privacy. d) During a review of resident 8 ' s Admission Record, the Admission Record indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including pneumonia (lung infection) and sepsis (blood infection). (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8 ' s Care Plan dated 8/21/2023, the Care Plan indicated nursing staff approach plan was to undress and dress appropriately and provide privacy for the resident. During a review of Resident 8 ' s H&P dated 8/31/2023, the H&P indicated Resident 8 had fluctuating capacity to make decisions. During a review of Resident 8 ' s MDS dated [DATE], the MDS indicated Resident 8 was usually able to understand and be understood by others. The MDS indicated Resident 8 required partial to moderate assistance with ADLs such as dressing, toilet use, personal hygiene, and transfer. The MDS indicated Resident 8 required supervision or touching assistance with bed mobility. During a concurrent observation and interview on 9/5/2024 at 6:00 a.m. in Resident 8 ' s room, CNA 5 was observed assisting Resident 8 with ADL care with the privacy curtain open and Resident 8 exposed. CNA 5 stated she usually closed the curtain for privacy, however, did not think about closing the curtains when she came to change Resident 8. During an interview on 9/5/2024 at 8:39 a.m. with the Director of nursing (DON), the DON stated CNAs assist residents with ADL care and must close the curtains for privacy and dignity of the residents. The DON stated if curtains were not closing all the way, nurses needed to report it, so the curtain could be changed. The DON also stated nurses could close the doors for Residents privacy also. During a review of facility ' s undated policy and procedures (P&P) titled, Residents Rights, the P&P indicated the resident had the right to be treated with respect and dignity, personal privacy, and confidentiality of his or her personal and medical records. The P&P indicated personal privacy included accommodations, medical treatment, and personal care.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interview and record review, the facility failed to maintain residents' room temperature in a range of 71- and 81-degrees Fahrenheit (F) for three resident rooms (rooms [ROOM NUMBER]). This deficient practice placed the residents in the affective rooms at risk for hyperthermia (overheating), dehydration (body loses too much fluid and sodium [salt]) and heat stroke (life-threatening heat-related illness that occurs when the body rises to a dangerous level and cause dizziness, confusion, and loss of consciousness). Findings: a)During a review of resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a problem in the brain due by a chemical imbalance in the blood), chronic obstructive pulmonary disease (restricted airflow and breathing), and essential hypertension (high blood pressure). During a review of Resident 2 ' s History and Physical (H&P) dated 6/20/2024, the H&P indicated Resident 2 did have the mental capacity to make medical decisions. During a review of Resident 2 ' s Minimum Data Set ([MDS] a standardized care assessment and care screening tool), dated 6/5/2024, the MDS indicated Resident 2 was able to understand and be understood by others. The MDS indicated Resident 2 required supervision or touching assistance (staff provided verbal cues and/or touching/steadying assistance as resident completed activity) with Activities of Daily Living (ADLs) such as dressing, toilet use, personal hygiene, transfer, and bed mobility (how the resident roll from During a concurrent observation and interview on 9/3/2024 at 4:37 p.m. with the Maintenance Supervisor (MS), the temperatures in room [ROOM NUMBER] was 83 F, room [ROOM NUMBER] was 83 F and room [ROOM NUMBER] was 82 F. MS stated, the air conditioner (AC) broke sometime last week and the AC company was called for repairs however was busy and had to postpone coming to the facility until the following day (9/4/2024). During a concurrent observation and interview on 9/4/2024 at 10:35 a.m. with Resident 2 in Resident 2 ' s room (room [ROOM NUMBER]), Resident 2 stated the AC had not been working and it had been hot in his room for about one week. Resident 2 stated staff had placed a fan by his room entrance however it was still hot. Resident 2 also stated he would go outside to the patio because it was too hot in his room. b) During a review of resident 3 ' s Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including extrapyramidal and movement disorder (side effects from certain medications that cause involuntary movements) and essential hypertension. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3 ' s H&P dated 7/18/2024, the H&P indicated Resident 3 had the mental capacity to understand and make decisions. During a review of Resident 3 ' s MDS dated [DATE], the MDS indicated Resident 3 was able to understand and understood by others. The MDS indicated Resident 3 required supervision or touching assistance for personal hygiene, dressing and walking. During concurrent observation and interview on 9/4/2024 at 10:45 a.m. with Resident 3 in Resident 3 ' s room (room [ROOM NUMBER]), Resident 3 stated it has been too hot in his room lately and had been sweating a lot. Resident 3 stated he had informed the nurses two weeks ago it had been too hot in his room and nothing much had been done except for placing a fan at the entrance of the room. During an interview on 9/4/2024 at 2:00 p.m. with Maintenance Assistant (MA), MA stated, he was aware of the AC being broken around 8/28/2024 and had called the AC company on 8/30/2024, however the AC repairman could not come. MA stated, the AC repair company was coming today, 9/4/2024 (7 days later). MA stated, it was not acceptable for residents to be in a hot room with no AC for one week. MA stated the AC needed to be fix right away. During an interview on 9/4/2024 at 3:25 p.m. with Licensed Vocational Nurse (LVN) 1, The LVN 1 stated the facility was Resident ' s home and they need to be in a safe environment. The LVN 1 stated nurses need to make sure residents were comfortable and to meet the resident ' s needs. LVN 1 stated, elevated temperatures in resident ' s rooms were not safe and was not acceptable for residents. During an interview on 9/5/2024 at 8:39 a.m. with the Director of Nursing (DON), the DON stated, the facility needed to take care of residents and provide a homelike environment. The DON stated it is not acceptable to keep residents in hot rooms with a nonfunctioning AC during hot weather. The DON stated doing so, could lead to the residents getting sick from dehydration, heat stroke, and heat exhaustion (condition that happens when the body overheats which include heaving sweating and fast heart rate). During a review of the facility ' s undated Policy and Procedure (P&P) titled, Resident Rights, the P&P indicated, residents had the right to a safe, clean, comfortable, and Homelike environment, including but not limited to receiving treatment and supports for daily living safely. During a review of the facility ' s undated P&P titled, Safe and Homelike Environment, the P&P indicated the facility would maintain comfortable and safe temperature levels. The P&P indicated the facility should strive to keep the temperature in common resident areas between 71- and 81 F.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45657 Based on observation, interview, and record review, the facility failed to provide one of ten sampled residents (Resident 1) proper incontinence care when a towel was left inside the resident ' s adult brief. This deficient practice had the potential to cause skin breakdown and infection to Resident 1. Findings During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), acute respiratory failure (a condition that makes it difficult to breathe on your own), and cerebral infarction (damage to brain tissues due to a loss of oxygen in the area). During a review of Resident 1 ' s History and Physical (H&P), dated 4/5/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool) dated 6/26/2024, the MDS indicated Resident 1 rarely/never understood others and was rarely/never understood by others. The MDS indicated Resident 1 was totally dependent on staff for all Activities of Daily Living (ADLs) such as personal hygiene, showering, upper and lower body dressing, putting on footwear, rolling left and right in bed, sit to lying, lying to sitting on side of bed, sitting to standing, chair to bed transfer, toilet transfer, and shower transfer. During a review of Resident 1 ' s Care plan dated 4/25/2024, the Care Plan indicated Resident 1 was incontinent of bowel and bladder function (inability to control the flow of urine and stool from the body). The care plan indicated the nursing approach would be to check Resident 1 every two hours for soiled diaper and provide incontinence care for each episode and to keep the resident clean and dry. During a concurrent observation and interview on 9/3/2024 at 4:57 p.m. with Certified Nursing Assistant (CNA) 1 in Resident 1 ' s room, Resident 1 had a towel soaked with urine in his adult briefs. CNA 1 stated, Resident 1 had a towel in the adult brief and the towel was not supposed to be in the adult brief. CNA 1 stated the towel in the diaper could cause an infection to the resident. During an interview on 9/4/2024 at 4:32 p.m. with the Director of Staff Development (DSD), the DSD stated towels were not supposed to be in the adult briefs because if the towel was in the adult brief, the towel could be soaked with urine, and could cause an infection or cause a rash and skin damage to the resident. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/5/2024 at 8:40 a.m. with the Director of Nursing (DON), the DON stated towels were not supposed to be in adult briefs because the towels could make it hard to see if the adult briefs were wet. The DON stated, the towels could cause the area to get hot and cause a rash or skin breakdown to the resident. During a review of the facility ' s undated Policy and Procedure (P&P) titled, Urinary Continence and Incontinence-Assessment and Management, the P&P indicated the facility would appropriately screen for and manage individuals with urinary incontinence. The facility staff would provide appropriate services and treatment to help resident improve bladder function and prevent UTI ' s to the extent possible. During a review of the facility ' s P&P titled, Activities of Daily Living (ADLs), dated 2023, the P&P indicated a resident who was unable to carry out ADLs would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.