STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555781	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER Villa Del Rio		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50379 Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled, Resident Examination and Assessment, which indicated the facility will assess a resident for any abnormalities in health status, such as abdominal distention, pain duration, severity and factors that worsen the pain, for one of three sampled residents (Resident 65), when Resident 65 complained of severe abdominal pain on 8/24/2024 at 11:00 p.m. and on 8/25/2024 at 2:30 p.m. This failure caused Resident 65 to be emotionally distressed (angry, scared, and frustrated), suffer severe pain for an extended period and was transferred to a general acute care hospital (GACH) for evaluation and treatment. Findings: During a review of Resident 65 ' s Admission Record, the Admission Record indicated Resident 65 was admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI- a bacterial infection in the organ that removes urine) and hereditary (inborn)and idiopathic (a disease of unknown cause) neuropathy (nerve pain). During a review of Resident 65 ' s physician orders dated 7/29/2024, the physician orders indicated the following: 1. Monitor level of pain every shift (using 0-10 pain scale). 2. Oxycodone-Acetaminophen (a strong pain medicine) 5 milligrams (mg)/ 300 mg one (1) tablet by mouth (PO) every six (6) hours (Q6hrs) as needed (PRN) for moderate to severe pain. 3. Monitor suprapubic catheter (a medical device that helps drain urine from the bladder through a small incision in the abdomen) drainage bag every shift and document signs and symptoms (S/S) of UTI such as bladder distention and burning sensation. 4. Change suprapubic catheter by wound care consultant every 6 months and PRN if blocked (obstructed) or pulled out. During a review of Resident 65 ' s History and Physical (H&P) dated 7/30/2024, the H&P indicated Resident 65 had the capacity to understand and make decisions. The H&P indicated Resident 65 had an intact suprapubic catheter. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555781	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 65 ' s Minimum Data Sheet ([MDS] a standardized care screening and assessment tool) dated 8/18/2024, the MDS indicated Resident 65 had an intact cognition (understanding). The MDS indicated Resident 65 had a suprapubic catheter. The MDS indicated Resident 65 required moderate assistance (helper does less than half the effort) with eating, maximal assistance (helper does more than half the effort) with oral hygiene and dependent with toileting hygiene, personal hygiene, showers, and upper and lower body dressing. The MDS indicated Resident 65 was dependent with toilet transfer, sit to stand position and chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair (or wheelchair). During a review of Resident 65 ' s Medication Administration Record (MAR) dated 8/25/2024, the MAR indicated Resident 65 had a pain level of 10/10 ([numeric pain scale] a pain scale used in a facility with 0 no pain, 1-3 mild pain, 4-6 moderate pain, 7-8 severe pain, 9-10 worst pain possible) during the 11:00 p.m. to 7:00 a.m. shift ([(11 p.m. on 8/24/2024 to 7 a.m. on 8/25/2024] no specific time indicated). The MAR indicated a signature next to Oxycodone on 8/25/2024 (time not specified), indicating the resident was medicated. During a review of Resident 65 ' s Nurses ' Notes dated 8/25/2024, at 1:03 a.m., the Nurses ' Notes indicated Resident 65 complained of abdominal pain. The notes did not indicate Resident 65 was assessed for the pain level and pain characteristics. The notes indicated Resident 65 was offered (unspecified) pain medication, but the resident refused. The Nurses ' Notes at 2:00 a.m. indicated Resident 65 was offered pain medication and he refused. The notes indicated Resident 65 requested to go to hospital, and that Resident 65 ' s doctor was notified on 8/25/2024 at 1:00 a.m. The nurse ' s note at 5:30 a.m. indicated Resident 65 ' s doctor called the facility and ordered Resident 65 be transferred to the GACH on 8/25/2024 at 10:30 a.m. The nurses ' notes at 2:30 p.m. indicated Resident 65 was picked up by the ambulance on 8/25/2024 at 2:30 p.m., with a pain level of 7/10 pain (severe pain). The nurses ' notes did not indicate any pain interventions were provided to Resident 65. During a review of the GACH emergency department (ED) notes dated 8/25/2024 at 7:10 p.m., the ED notes indicated Resident 65 arrived at the GACH on 8/25/2024 at 3:25 p.m. with a chief complaint of abdominal pain radiating (spreading) to the flank (sides of the body between ribs and hips) area that started last night on 8/24/2024. The ED notes indicated Resident 65 had gross pus (large amount of thick yellowish, whitish, or greenish fluid) from the suprapubic catheter and sepsis (a life-threatening complication of an infection). The ED notes indicated Resident 65 ' s suprapubic catheter was changed by the ED staff, and the abdominal pain improved. The ED notes indicated Resident 65 received antibiotics and pain medications, was admitted to the GACH for evaluation, treatment, and care for urinary tract infection, dehydration (body does not have enough water), and acute kidney injury (an abrupt decrease in kidney function). During an interview on 9/17/2024 at 4:23 p.m. with Resident 65, Resident 65 stated on 8/24/2024 at 11:00 p.m., he complained of severe abdominal pain to LVN 9 and Registered Nurse 4 (RN 4). Resident 65 stated LVN 9 and RN 4 did not assess his pain, and he suffered severe abdominal pain from 11:00 p.m., on 8/24/2024 to 8/25/2024, when he received treatment at the GACH. Resident 65 stated on 8/25/2024 at 2:00 a.m., he asked LVN 9 to call 911 (emergency phone number) because he could not handle the pain anymore. Resident 65 stated LVN 9 did not assess his pain or suprapubic catheter and did not call 911 to assess him or take him to a GACH. Resident 65 stated, Isuffered severe abdominal pain and felt angry, scared, and frustrated until I was transferred to the GACH on 8/25/2024 at 2:30 p.m. Resident 65 stated, I would rather be dead than re-experience the pain on 8/25/2024. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 9/18/2024 at 3:53 p.m., with RN 4, Resident 65 ' s care plan titled Potential for Pain, dated 7/25/2024, physician orders dated 7/29/2024, August 2024 MAR and nurses ' notes dated 8/24/2024 and 8/25/2024 were reviewed. RN 4 stated the care plan interventions indicated staff will assess Resident 65 ' s pain symptoms, identify the frequency, location, quality, onset, and how Resident 65 expressed pain, provide non-pharmacological interventions such as relaxation techniques, deep breathing exercises, proper positioning, and provide 1 to 1 interaction, monitor effectiveness of non-pharmacologic interventions, and notify the physician of increasing pain. RN 4 stated the nurses ' notes did not indicate Resident 65 was assessed when he complained of severe abdominal pain on 8/24/2024 and on 8/25/2024. RN 4 stated Resident 65 ' s suprapubic catheter should have been assessed for blockage (obstruction) and output because it might have been the cause of pain. RN 4 stated the nurse ' s assessment should have been documented in the progress notes. RN 4 stated, a blockage to the suprapubic catheter could result in pain, fever, and sepsis. RN 4 stated she did not know if Resident 65 had a fever, or his catheter was blocked when the resident complained of severe abdominal pain. RN 4 stated she did not assess Resident 65 ' s suprapubic catheter, or the location, frequency, duration, onset, and pattern of pain, on 8/24/2024 at 11:00 p.m., and 8/25/2024 at 2:30 p.m. RN 4 stated the failure to assess Resident 65 ' s pain for prompt interventions, caused the resident to experience severe pain for a long time (approximately 15 hours). RN 4 stated on 8/25/2024, during the 11:00 p.m. to 7:00 a.m. shift, the MAR indicated Resident 65 had a pain level of 10/10 (location unspecified) with a staff ' s initial next to Oxycodone on 8/25/2024 (time not specified), indicating the resident was medicated. RN 4 stated Resident 65 ' s nurses ' notes and MAR did not indicate Resident 65 ' s pain was assessed on 8/25/2024 prior to the medication administration (Oxycodone) and did not indicate a reassessment after the medicine was administered to evaluate for its effectiveness. RN 4 stated Resident 65 should have been assessed prior to and one hour after Resident 65 ' s Oxycodone administration. RN 4 stated when Resident 65 complained of 7/10 abdominal pain on 8/25/2024 at 2:30 p.m. (prior to ambulance transport to GACH), Resident 65 was not assessed. RN 4 stated Resident 65 ' s licensed nurse should have assessed the resident (Resident 65). RN 4 stated, the nurse ' s notes indicated Resident 65 asked LVN 9 to call the paramedics (medical emergency personnel). RN 4stated the nurses ' notes also indicated on 8/25/2024 at 3:00 a.m., Resident 65 ' s family member (FM 1), called LVN 9 and requested for LVN 9 to call the paramedics. During an interview on 9/18/2024 at 4:45 p.m., with the Director of Nursing (DON), the DON stated Resident 65 ' s unresolved pain should have been reassessed frequently and interventions provided according to the facility ' s policy and resident ' s plan of care. The DON stated Resident 65 ' s physician should have been notified of Resident 65 ' s pain condition. The DON stated pain assessment and reassessment could identify the cause of pain and guide interventions. The DON stated unresolved severe abdominal pain was considered a medical emergency (a serious condition that requires immediate medical attention to prevent a person's worsening health and death) requiring immediate transfer to a GACH. The DON stated the delay in providing interventions and addressing Resident 65 ' s severe pain could result in worsening condition and complications. During a review of the facility ' s undated policy and procedure (P&P) titled, Resident Examination and Assessment, the P&P indicated the facility will examine and assess the resident for any abnormalities in health status, such as abdominal distention and hardness, urine output if they were clear or cloudy, presence of foley catheter (a flexible tube that is inserted into the bladder through the urethra to drain urine), description, location, duration, severity of pain and factors that worsened the pain, current medication and treatments for pain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility ' s undated P&P titled, Pain Management, the P&P indicated the facility will ensure pain management was provided to residents who required such services consistent with professional standards of practice, the comprehensive person-centered care plan and the resident ' s goals and preferences. The P&P indicated pain assessment and evaluation should be done by nurses, practitioners and review resident ' s diagnosis or conditions and any additional factors that may have caused or contributed to pain, identifying the location, frequency, duration, onset, and pattern of pain. The P&P indicated staff will identify the current prescribed pain medications, dosage and frequency, resident ' s goals for pain management and the effectiveness of drugs and other treatments used in the past to treat pain. The P&P indicated, if the resident ' s pain was not controlled with the current treatment regimen, the practitioner should be notified.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50379 Based on interview and record review, the facility failed to provide pressure ulcer (damaged skin caused by staying in one position for too long) treatments as ordered by the physician for three of three sampled residents (Resident 83, Resident 16, Resident 9). This deficient practice had the potential to result in skin infections, delayed wound healing and worsening of pressure ulcers. Findings: During a review of the September 2024 Staff Assignment Sheets, the Staff Assignment Sheets indicated there was no treatment nurse assigned to perform wound care to residents on the following dates: 1. 9/1/2024 2. 9/2/2024 3. 9/3/2024 4. 9/4/2024 5. 9/7/2024 6. 9/8/2024 7. 9/9/2024 8. 9/12/2024 9. 9/13/2024 10. 9/14/2024 During a review of the Facility Assessment (document with resident population information and identified resources needed to provide the necessary person-centered care and services the residents require), dated 7/23/2024, the Facility Assessment indicated the facility would offer residents pressure prevention and care, skin care and wound care services. During a review of the requested list of residents with physician orders for wound care, the facility provided a list dated 9/16/2024 which indicated a total of 35 residents had wound care orders. During a review of the facility ' s undated Treatment Nurse Job Description, the Treatment Nurse Job Description indicated the treatment nurse must ensure residents with decubitus ulcers received appropriate prophylaxis and treatment, such as daily inspection and providing preventative health care services. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a). During a review of Resident 83 ' s Admission Record, the Admission Record indicated Resident 83 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis (a chronic sickness that effects the ability to see, touch, speak, and walk), muscle weakness, Stage 4 pressure ulcer (full thickness skin loss with extensive destruction; tissue death; or damage to muscle and bones) of the right buttock, and hereditary and idiopathic neuropathy (nerve pain and numbness). During a record review of Resident 83 ' s care plan titled, Pressure Ulcer Care Plans, dated 3/7/2024, the interventions indicated to provide wound care treatment as ordered by the physician, report changes in skin status to the physician, and monitor effectiveness of treatments as ordered. During a review of Resident 83 ' s History and Physical (H&P) dated 3/11/2024, the H&P indicated Resident 83 was alert and oriented to person only and could make needs known. The H&P indicated Resident 83 complained of pain in the buttock area due to pressure ulcers and pain, numbness, and tingling in upper and lower extremities dependent on bed position and cold exposure. During a review of Resident 83 ' s Minimum Data Sheet ([MDS] a standardized care screening and assessment tool) dated 8/2/2024, the MDS indicated Resident 83 had an intact cognition (understanding). The MDS indicated Resident 83 was at risk of developing pressure ulcers and had one unhealed, Stage 4 pressure injury. The MDS indicated Resident 83 was dependent (staff does all the effort, resident does none of the effort) with eating, oral hygiene, toileting hygiene, personal hygiene, showers, and upper and lower body dressing toilet transfer, sit to stand position and chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair or wheelchair). The MDS indicated Resident 83 required maximal assistance (staff does more than half the effort) to roll left and right in bed. During a record review of Resident 83 ' s Physician Orders dated 3/7/2024, the physician orders indicated to clean Resident 83 ' s right ischium (hip) Stage 4 pressure injury with NS ([normal saline] a liquid that cleans wounds), pat dry, pack with gauze (type of dressing) soaked with Dakin ' s solution (liquid that prevent wound infections), and cover with dry dressing (bandage) every day. During a review of Resident 83 ' s Wound assessment dated [DATE], the Wound Assessment indicated Resident 83 ' s sacrum pressure injury was a Stage 4 and measured 1 centimeter ([cm] a unit of measurement) in length, 1 cm in width, and 1 cm in depth before debridement (procedure that removes damaged, infected, or dead tissue from the wound). The Wound Assessment indicated Resident 83 ' s sacrum wound measured 1 cm in length, 1 cm in width, and 1.1 cm in depth after debridement. During a concurrent interview and record review on 9/18/2024 at 2:49 p.m. with Registered Nurse (RN 1), Resident 83 ' s Treatment Administration Records (TAR) dated 8/2024 and 9/2024 were reviewed. The TAR dated 8/17/2024, 8/18/2024, 8/24/2024, 8/25/2024, 8/30/2024, and 8/31/2024 were blank. The TAR dated 9/1/2024, 9/7/2024, 9/8/2024, 9/14/2024, and 9/15/2024 were blank. RN 1 stated if the dates on TAR were blank and had no staff initials, the wound care treatments were not done. b). During a review of Resident 16 ' s Admission Record, the Admission Record indicated Resident 16 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including hemiplegia (weakness of inability to move one side of the body) following cerebrovascular disease (condition that affects blood flow to the brain) and muscle wasting and atrophy (decrease in size of muscle tissue). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 16 ' s H&P dated 9/12/2023, the H&P indicated Resident 16 did not have the ability to understand and make decisions. During a review of Resident 16 ' s Skin Integrity Sheet dated and signed on 6/4/2024 and 6/11/2024, the Skin Integrity Sheet indicated on 6/4/2024, Resident 16 ' s sacrum wound was identified. The Skin Integrity Sheet indicated that wound was not staged and measured 3 cm in length, 2 cm in width, and 0.1 cm in depth. The Skin Integrity Sheet did not indicate previous identification of the pressure ulcer. On 6/11/2024, the Skin Integrity Sheet indicated Resident 16 ' s sacrum wound was Stage 4 and measured 1 cm in length, 1 cm in width, and 1 cm in depth. During a record review of Resident 16 ' s Physician Orders dated 6/4/2024, the Physician Orders indicated to clean Resident 16 ' s sacrum area with NS, pat dry, and cover with dry dressing daily until resolved. During a review of Resident 16 ' s MDS dated [DATE], the MDS indicated Resident 16 required substantial/maximal assistance (staff does more than half the effort) to roll left and right. The MDS indicated Resident 16 was at risk of developing pressure ulcers/injuries and did not have any unhealed pressure ulcers. During a review of Resident 16 ' s Wound assessment dated [DATE], The Wound Assessment indicated Resident 16 ' s sacrum was unstageable ([US] covered by a non-removable tissue, making it difficult to determine stage and the depth of the wound) pressure injury which measured 1.5 cm in length, 0.5 cm in width, and 0.1 cm in depth before debridement. The Wound Assessment indicated Resident 16 ' s sacrum wound measured 1.5 cm in length, 0.5 cm in width, and 0.15 cm in depth after debridement. During a review of Resident 16 ' s Wound assessment dated [DATE], the Wound Assessment indicated Resident 16 ' s unstageable sacrum wound measured 4 cm in length, 3 cm in width, and 0.1 cm in depth before debridement. The Wound Assessment indicated Resident 16 ' s sacrum wound measured 4 cm in length, 3 cm in width, and 0.15 cm in depth after debridement. The measurements after debridement indicate a 2.5 cm increase in length, 2.5 cm increase in width, and no change in depth. During a review of Resident 16 ' s Impaired Skin Integrity Care Plan dated 9/12/2024, the care plan indicated Resident 16 ' s skin integrity was impaired. The care plan indicated a goal for Resident 16 to experience optimal wound healing. The interventions indicated to administer treatment as prescribed and assess for signs of infection. During a concurrent interview and record review on 9/18/2024 at 4:20 p.m. with RN 4, Resident 16 ' s TAR dated 9/2024 were reviewed. RN 4 stated the TARs dated 9/7/2024, 9/8/2024, 9/14/2024, and 9/15/2024 were blank. RN 4 stated the blank fields in the TAR indicated wound care treatments were not performed on Resident 16. RN 4 stated when treatments were not performed, it placed Resident 16 ' s pressure sores at risk to worsen or become infected. c). During a review of Resident 9 ' s Admission Record, the Admission Record indicated Resident 9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including polyneuropathy (nerve damage that decreased the ability to move or feel). (continued on next page)

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During a review of Resident 9 ' s H&P dated 6/19/2024, the H&P indicated Resident 9 had fluctuating capacity to understand and make decisions. The H&P indicated Resident 9 ' s skin was warm and dry, no issues indicated.

During a review of Resident 9 ' s MDS dated [DATE], the MDS indicated Resident 9 had an intact cognition. The MDS indicated Resident 9 required moderate assistance to roll left and right, maximal assistance with oral hygiene, lower body dressing, personal hygiene, moving from sitting to lying and lying to sitting. The MD indicated Resident 9 was dependent on staff for toileting hygiene, showers, putting on and taking off footwear, and moving from sitting to standing, from bed to chair, to toilet, and to shower. The MDS indicated Resident 9 was at risk to develop pressure ulcers.

During a review of Resident 9 ' s Skin Integrity Sheet dated 8/5/2024, the Skin Integrity Sheet indicated Resident 9 had a sacral stage 2 pressure ulcer. The Skin Integrity Sheet did not indicate measurements or previous identification of the pressure injury. The treatment section indicated to cleanse with NS, pat dry, and apply Santyl every day.

During a review of Resident 9 ' s Physician Orders dated 8/5/2024, the Physician Orders indicated to cleanse the reopened wound with NS, apply Santyl, and cover with a dry dressing daily.

During a review of Resident 9 ' s Risk for Pressure Ulcer Care Plan dated 8/9/2024, the care plan indicated Resident 9 ' s reopened sacral wound was related to immobility and incontinence. The care plan indicated a goal for Resident 9 to have intact skin, and minimized episodes of redness, blisters, or discoloration in an area affected by pressure through 11/4/2024. The interventions indicated to cleanse with NS, pat dry, and apply Santyl daily until resolved and report changes in skin status to the physician.

During a review of Resident 9 ' s Wound assessment dated [DATE], The Wound Assessment indicated Resident 9 ' s sacrum (buttock) wound measured 0.75 cm in length, 0.75 cm in width, and 0.1 cm in depth before debridement. The Wound Assessment indicated Resident 16 ' s sacrum wound measured 0.75 cm in length, 0.75 cm in width, and 0.2 cm in depth after skin and fat were debrided (surgically removed).

During an interview on 9/18/2024 at 10:13 a.m. with RN 1, RN 1 stated RNs and Licensed Vocational Nurses (LVN) were responsible for providing wound care to residents and document when wound care had been done. RN 1 stated wound treatments must be performed according to physician ' s orders, including on Saturdays and Sundays.

During a concurrent interview and record review on 9/18/2024 at 4:20 p.m. with RN 4, Resident 9 ' s September 2024 TAR were reviewed. RN 4 stated the TARs dated 9/1/2024, 9/7/2024, 9/8/2024, 9/14/2024, and 9/15/2024 were blank. RN 4 stated the blank fields in the TAR indicated wound care treatment were not performed on Resident 9. RN 4 stated when treatments were not performed, it placed Resident 9 ' s pressure sores at risk to get worsen or become infected.

During an interview on 9/18/2024 at 11:24 a.m. with the Director of Nursing (DON), the DON stated the facility did not have a treatment nurse since April 2024. The DON stated LVNs, and RNs were responsible for providing all wound care as ordered. The DON stated she was not aware of residents missing wound treatments. The DON stated missed wound treatments could result in wound infection and worsening of the residents ' wound condition.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s undated policy and procedure (P&P) titled, Wound Treatment Guidelines, the P&P indicated wound treatments should be provided in accordance with physician orders and should be documented on the Treatment Administration Record. During a review of the facility ' s undated P&P titled, Wound Care, the P&P indicated the type, date, and time the wound care was given, the name, and the title and signature of the individual performing the wound care, should be recorded in the resident ' s medical record.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50379 Based on interview and record review, the facility failed to provide sufficient nursing staff to ensure quality nursing care are rendered to the residents in the facility and ensure all medications were administered as ordered by the physician to the 3 of 3 sampled residents (Residents 65, 8 and 83). This failure had the potential to providing poor-quality resident care and services, which can affect in maintaining the highest practicable physical, mental, and psychosocial well-being of the residents under the facility ' s care. Findings: a). During a review of the Direct Care Service Hours Per Patient Day ([DHPPD], a metric that measures the average number of hours required to care for each patient in a healthcare facility) form, the following were identified: On 9/2/2024, the average patient census indicated 169- the actual Certified Nurse Assistant (CNA) DHPPD was 2.27. On 9/3/2024, the average patient census indicated 168- the actual CNA DHPPD was 2.32. On 9/9/2024, the average patient census indicated 172- the actual CNA DHPPD was 2.34. On 9/11/2024, the average patient census indicated 174- the actual CNA DHPPD was 2.30. During an interview with CNA 10 on 9/17/2024 at 3:23 p.m., CNA 10 stated there have been multiple days CNA 10 was assigned to care for 20 or more residents. CNA 10 stated, because of the large numbers of residents assigned under their care, providing quality care to each assigned resident were difficult to meet. CNA 10 stated most residents were incontinent (unable to control the passing of urine and stool) of bowel and bladder elimination and were totally dependent with staff for cleaning and hygiene, changing clothes, bathing, turning, and repositioning every 2 hours, residents care needs had always been delayed and not attended to. During a concurrent interview and record review on 9/17/2024 at 4:30 p.m. with the Director of Nursing (DON), the Center Building Shift Assignments dated 9/1/2024 3:00 p.m. to 11:00 p.m. shift and Garden Building Shift Assignments dated 9/1/2024 and 9/2/2024 for 11:00 p.m. to 7:00 a.m. shifts were reviewed. The DON stated the 9/1/2024 3:00 p.m. to 11:00 p.m. shift assignment sheet indicated 5 CNAs were present and had 19-20 residents assigned per CNA at the Center Building Shift Assignment dated. The DON stated the 9/1/2024 11:00 p.m. to 7:00 a.m. shift assignment sheet indicated 3 CNAs were present with 28 residents assigned per CNA in the Garden Building. The DON stated basing on the review (9/1/2024 assignment sheet), there were not enough CNAs to provide quality care to the residents and this could result in poor care, pressure ulcer (damaged skin caused by staying in one position for too long) development, and sickness. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 9/17/2024 at 4:36 p.m. with the DON, the CNA DHPPD dated 9/2/2024 was reviewed. The DON stated the 9/2/2024 DHPPD indicated 2.27 actual CNA hours per resident. The DON stated, with the 2.24 actual CNA hours per resident, residents will not get the proper, quality care they (residents) deserved, and placed the residents at risk to develop pressure ulcers. The DON stated, the facility must provide at least 2.4 CNA hours per resident per day. b). During a review of Resident 65 ' s Admission Record, the Admission Record indicated Resident 65 was admitted to the facility on [DATE] with diagnoses including bipolar disorder (mental illness that causes extreme shifts in mood, energy, and activity levels), type two diabetes mellitus (inability to control level of sugar in blood), anemia (not having enough blood cells), and hereditary (inborn) and idiopathic (a disease of unknown cause) neuropathy (nerve pain). During a review of Resident 65 ' s History and Physical (H&P) dated 7/30/2024, the H&P indicated Resident 65 was alert and oriented and had the capacity to understand and make decisions. The H&P indicated Resident 65 had a colostomy (device that collects stool) and suprapubic catheter (device that collects urine) and was diagnosed with bipolar disorder (extreme mood swings, affecting a person's energy, activity levels, and concentration). During a review of Resident 65 ' s Minimum Data Sheet ([MDS] a standardized care screening and assessment tool) dated 8/18/2024, the MDS indicated Resident 65 had an intact cognition (understanding). The MDS indicated Resident 65 had a suprapubic catheter. The MDS indicated Resident 65 required moderate assistance (helper does less than half the effort) with eating, maximal assistance (helper does more than half the effort) with oral hygiene and dependent with toileting hygiene, personal hygiene, showers, and upper and lower body dressing. The MDS indicated Resident 65 was dependent with toilet transfer, sit to stand position and chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair (or wheelchair). During a review of Resident 65 ' s Physician Orders dated 9/2/2024, the physician orders indicated the following medication orders: 1. Ziprasidone (medication for mental illness) 20 milligrams (mg, a unit of measurement) by mouth twice per day (BID) for bipolar disorder manifested by (m/b) sudden and severe shifts in emotions (labile mood) 2. Gabapentin (medication for nerve pain) 300 mg capsule (cap) by mouth three times per day (TID) for neuropathy (numbness or weakness in nerves) 3. Insulin glargine (long-lasting medication that control blood sugar) injection (inj) 15 units (unit of measurement) every 12 hours (Q12 hours) for diabetes mellitus. Hold if blood sugar below 100. 4. Insulin lispro (fast-acting medication to control blood sugar) per sliding scale (dosage that changes according to the resident ' s blood sugar) before meals (AC Meals) and before bedtime (QHS) 5. Midodrine 10 mg 1 tablet (tab) by mouth, three times per day for low blood pressure (hypotension) 6. Morphine sulfate (a strong pain medication) extended release (ER) 15 mg by mouth every 12 hours for severe pain in the left lower leg (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Ferrous sulfate (iron supplement) 325 mg by mouth twice per day for anemia 8. Cyanocobalamin (Vitamin B12 supplement) 500 mg by mouth twice per day for two months for vitamin B12 deficiency During a concurrent interview and record review on 9/17/2024 at 1:36 p.m. with Registered Nurse 1 (RN 1), Resident 65 ' s Medication Administration Record (MAR), Nurses Notes, and Care Plans dated September 2024, were reviewed. RN 1 stated Resident 65 did not receive the following medications as indicated in the MAR: 1. ziprasidone on 9/2/2024, 9/3/2024, 9/4/2024, 9/5/2024, 9/6/2024, and 9/10/2024 at 5:00 p.m. and on 9/10/2024 at 9:00 a.m. 2. gabapentin on 9/10/2024 at 5:00 p.m. 3. insulin glargine on 9/6/2024, 9/10/2024, 9/15/2024 and 9/16/2024 at 9:00 p.m. 4. insulin lispro on 9/10/2024 at 4:30 p.m. 5. midodrine on 9/10/2024 and 9/16/2024 at 5:00 p.m. 6. ferrous sulfate on 9/10/2024 and 9/16/2024 at 5:00 p.m. 7. cyanocobalamin on 9/10/2024 and 9/16/2024 at 5:00 p.m. RN 1 stated, on those dates and time (above) there were not enough nurses to administer the medication. RN 1 stated, if residents did not receive their prescribed medications, it placed the affected residents at risk for worsening medical. During an interview on 9/17/24 at 4:23 p.m. with Resident 65, Resident 65 stated nursing staff at the facility do not reposition him without his (Resident 65 ' s) prompting. Resident 65 stated CNAs do not check the fullness of his colostomy (device that collects stool) and urostomy (device that collects urine) bags throughout the night. Resident 65 stated he monitored and managed his urine and stool output in the colostomy bag to avoid leakage. Resident 65 stated he would always wait up to 40 minutes for staff ' s assistance (unable to recall date on 9/2024) to empty the colostomy bag. Resident 65 stated he was frustrated and angered when CNAs did not reposition him and monitored the fullness of his urine and stool collection bags. Resident 65 stated he (Resident 65) had missed multiple medications in September 2024. Resident 65 stated, It made me frustrated not being able to take my medication the physician had ordered for me to take. c) During a review of Resident 8 ' s Admission Record, the Admission Record indicated Resident 8 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including extrapyramidal and movement disorder (uncontrollable movements), hyperlipidemia (high level of fat in blood), schizophrenia (mental illness that causes patients to confuse their thoughts with reality), and anxiety disorder (condition that causes intense fear and worry). During a review of Resident 8 ' s MDS dated [DATE], the MDS indicated Resident 8 had the capacity to understand and make her needs understood. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8 ' s Physician Orders dated 7/17/2024, the Physician Orders indicated the following medication orders: 1) Atorvastatin (medication for hyperlipidemia) 40 mg (milligram, a unit of measurement) one (1) tablet (tab) once per night (QHS) 2) Olanzapine (medication for schizophrenia) 5 mg 1 tab by mouth BID for schizophrenia manifested by (m/b) hallucinations (sensory experience that feel real but are not) 3) Risperidone (medication for schizophrenia) 2 mg 1 tab by mouth BID for schizophrenia m/b wandering (moving aimlessly) 4) Divalproex sodium (medication for schizophrenia) delayed release (DR) 250 mg 1 tab by mouth BID for schizophrenia m/b paranoia (a person ' s belief they are being harmed or deceived by others when they are not) 5) Monitor level of pain once QShift using numeric pain scale (using 0-10 pain scale) 6) Monitor schizophrenia behavior m/b paranoia. Chart frequency of occurrences Qshift related to Divalproex sodium medication. 7) Monitor schizophrenia behavior m/b hallucinations. Chart frequency of occurrences Qshift related to Olanzapine medication. 8) Monitor schizophrenia behavior m/b wandering. Chart frequency of occurrences Qshift related to Risperidone medication. During a concurrent interview and record review on 9/17/2024 at 1:13 p.m. with Licensed Vocational Nurse 3 (LVN 3), Resident 8 ' s MAR, Nurses Notes, and Care Plans for 9/2024 were reviewed. LVN 3 stated Resident 8 did not receive the following medications as indicated in the MAR: 1. atorvastatin on 9/10/2024 at 9:00 p.m. 2. divalproex sodium on 9/4/2024 at 5:00 p.m. 3. olanzapine on 9/10/2024 at 5:00 p.m. 4. risperidone on 9/10/2024 at 5:00 p.m. d). During a review of Resident 83 ' s Admission Record, the Admission Record indicated Resident 83 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis (a chronic sickness that effects the ability to see, touch, speak, and walk), muscle weakness, Stage 4 pressure ulcer (full thickness skin loss with extensive destruction; tissue death; or damage to muscle and bones) of the right buttock, and neuropathy (nerve pain and numbness). During a record review of Resident 83 ' s care plan titled, Pressure Ulcer Care Plans, dated 3/7/2024, the interventions indicated to provide wound care treatment as ordered by the physician, report changes in skin status to the physician, and monitor effectiveness of treatments as ordered. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 83 ' s Physician Orders dated 3/7/2024, the physician orders indicated to clean Resident 83 ' s right ischium (hip) Stage 4 pressure injury with normal saline ([NS] a liquid that cleans wounds), pat dry, pack with gauze (type of dressing) soaked with Dakin ' s solution (liquid that prevent wound infections), and cover with dry dressing (bandage) every day. During a review of Resident 83 ' s MDS dated [DATE], the MDS indicated Resident 83 had an intact cognition (understanding). The MDS indicated Resident 83 was at risk of developing pressure ulcers and had one unhealed, Stage 4 pressure injury. The MDS indicated Resident 83 was dependent (staff does all the effort, resident does none of the effort) with eating, oral hygiene, toileting hygiene, personal hygiene, showers, and upper and lower body dressing toilet transfer, sit to stand position and chair/bed-to-chair transfer . The MDS indicated Resident 83 required maximal assistance (staff does more than half the effort) to roll left and right in bed. During an interview on 9/18/2024 at 11:24 a.m. with the DON, the DON stated the RNs and LVNs should perform wound care in between performing other duties (passing medications). The DON stated, RNs and LVNs would not have enough time to complete residents ' wound care treatments. During a concurrent interview and record review on 9/18/2024 at 2:49 p.m. with Registered Nurse (RN 1), Resident 83 ' s Treatment Administration Records (TAR) for 8/2024 and 9/2024 were reviewed. The TAR dated 8/17/2024, 8/18/2024, 8/24/2024, 8/25/2024, 8/30/2024, and 8/31/2024 were blank. The TAR dated 9/1/2024, 9/7/2024, 9/8/2024, 9/14/2024, and 9/15/2024 were blank. RN 1 stated if the dates on TAR were blank and had no staff initials, the wound care treatments were not done. During a review of the facility ' s undated policy and procedure (P&P) titled, Nursing Services and Sufficient Staff, the P&P indicated the facility will supply sufficient personnel on a 24-hour basis to care for all residents to assure safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. During a review of the All Facilities Letter ([AFL] a letter from the Center for Health Care Quality (CHCQ), Licensing and Certification (L&C) Program to health facilities that are licensed or certified by L&C with information that include changes in requirements in healthcare, enforcement, new technologies, scope of practice, or general information that affects the health facility), dated 3/17/2021, the AFL indicated, in accordance with the Health and Safety Code (HSC) sections 1276.5 and 1276.65, and Welfare and Institution Code (W&I) section 14126.022, a minimum of 2.4 DHPPD shall be performed by CNAs. During a review of the facility ' s undated P&P titled, Physician Medication Orders, the P&P indicated medications shall be administered upon written order by a physician. During a review of the facility ' s undated P&P titled, Wound Treatment Guidelines, the P&P indicated wound treatments should be provided in accordance with physician orders and should be documented on the TAR.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 50379 Based on observation, interview, and record review, the facility failed to ensure: 1. Staffing information was including the actual number of hours worked by nursing staff, was completed, current and posted for two days. 2. Staffing data was readily available upon request. These failures had the potential for resident, staff and visitors to be unaware of the accurate number of clinical staff taking care of residents daily to meet the resident ' s needs. Findings: During an observation on 9/9/2024 at 8:05 a.m. at the Center Nursing Station, the Direct Care Service Hours Per Patient Day ([DHPPD] a form that displayed how much nursing care per resident, the facility was providing), dated 9/8/2024, indicated the Actual Total Direct Care Service Hours, Actual Total CNA Direct Care Service Hours, Actual DHPPD, and Actual CNA DHPPD were blank. During an observation on 9/10/2024 at 8:19 a.m. at the Center Nursing Station, the DHPPD, dated 9/9/2024, indicated the Actual Total Direct Care Service Hours, Actual Total CNA Direct Care Service Hours, Actual DHPPD, and Actual CNA DHPPD were blank. During an interview on 9/10/2024 at 12:40 p.m. with the Administrator (ADM), the Administrator stated that the Director of Staff Development (DSD) was responsible for calculating DHPPD hours and storing DHPPD forms after completion. During an interview on 9/10/2024 at 3:00 p.m. with the DSD, the DSD stated that the actual hour calculations for the last two days were unavailable and actual hour calculations had not been calculated since 2023. The DSD stated the facility could not provide the DHPPD for the year 2024 with actual hours calculated. During a review of the DHPPD form and instructions, dated 7/2019, the form and instructions indicated, information on the form must be legible, accurate and complete. The form indicated Actual Direct Care Service Hours and DHPPD sections must be completed at the end of each 24 hour patient day. The Instructions indicated, at the end of each patient day, the Director of Nursing (DON) or his/her designee shall review the information documented and sign the form verifying information was complete, true, and correct.