

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 12/11/2024
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)
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) had a representative acting on her behalf by failing to:</p> <ol style="list-style-type: none"> 1. Ensure Resident 1's Responsible Party (RP) 1's telephone number was indicated on Resident 1's Face Sheet. 2. Seek RP 1's telephone number after Resident 1 had a fall on 6/21/2024 and 8/7/2024. 3. Refer Resident 1 to the Public Guardian (an appointed person who manages the property, finances, and personal care of a person who was unable to properly care for themselves) when RP 1 was unable to be contacted. <p>These deficient practices resulted in RP 1 being unaware of Resident 1's falls and unable to participate in any decision-making regarding Resident 1's care. This deficient practice also resulted in Resident 1 not having a care representative who was actively involved in her care.</p> <p>Cross reference F580.</p> <p>Findings:</p> <p>During a review of Resident 1's Face Sheet, the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and hypertension (elevated blood pressure).</p> <p>During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 10/7/2024, the MDS indicated Resident 1's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 1 required supervision with oral hygiene, toileting, bathing, dressing, and personal hygiene.</p> <p>During a review of Resident 1's History and Physical (H&P), dated 3/27/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.</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 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/10/2024 at 4:36 p.m., with RP 1, RP 1 stated for the entire year of 2024, he had not received any phone calls from the facility regarding any updates on Resident 1's care. RP 1 stated Resident 1 was evaluated by multiple physicians prior to her admission to the facility and was assessed to not have the capacity to make medical decisions and that he (RP 1) would be the decision maker for Resident 1. RP 1 stated he was very concerned regarding Resident 1 because he (RP 1) was unaware of her current condition.</p> <p>During a concurrent interview and record review on 12/11/2024 at 11:20 a.m., with the Social Services Director (SSD), Resident 1's Face Sheet, dated 3/29/2024 was reviewed. The Face Sheet indicated RP 1 listed with his name and a home address. The Face Sheet did not indicate a telephone number to contact RP 1. The SSD stated there was no telephone number for RP 1 listed on Resident 1's Face Sheet. The SSD stated Resident 1 had never had the mental capacity to understand and make decisions and any decisions would be directed to RP 1. The SSD stated he was unable to locate RP 1's telephone number and there was no way of contacting RP 1 if they needed to. The SSD stated when the facility was unable to contact a resident's RP or next of kin, the facility was responsible for sending a referral to the Public Guardian office. The SSD stated this process would allow a person to be appointed to the resident for any healthcare decisions the resident could not make for themselves. The SSD stated he had been working at the facility since March of 2024 and to his knowledge, Resident 1 had not been referred to the Public Guardian office. The SSD stated another social services designee oversaw Resident 1's care and assumed it was being taken care of.</p> <p>During an interview on 12/11/2024 at 12:03 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated when a resident's RP needed to be contacted for notification of a change on condition, updates, or necessary consents, he would locate the Face Sheet in the resident's physical chart. LVN 1 stated if he were to see the RP's contact information was incomplete with no telephone number, he would go up the chain of command and inform the social worker and the Director of Nursing (DON) to obtain the contact information. LVN 1 stated it was very important to have RP 1's telephone number in the event something happened to Resident 1 and RP 1 had to make any medical decisions for the resident.</p> <p>During a concurrent interview and record review on 12/11/2024 at 12:11 p.m., with LVN 1, Resident 1's Nurses Notes dated 6/21/2024 and timed at 7:10 p.m. were reviewed. The Nurses Notes indicated Resident 1 was on monitoring for status post fall. The Nurses Notes did not indicate RP 1 was notified of Resident 1's fall. Resident 1's Nurses Notes, dated 8/7/2024 and timed at 3:10 p.m. were reviewed., the Nurses Notes indicated Resident 1 slipped and fell while walking to her bed. The Nurses Notes did not indicate RP 1 was notified of Resident 1's fall. LVN 1 stated RP 1 was not notified of either fall Resident 1 had on 6/21/2024 and 8/7/2024. LVN 1 stated RP 1 should have been notified with an update on Resident 1's condition. LVN 1 stated there was no indication in the Nurses Notes that any attempt to notify RP 1 was made. LVN 1 stated Resident 1 could have been sent to the hospital and complications could have arisen from Resident 1's fall and RP 1 would not have been aware. LVN 1 stated RP 1 put his trust in the facility to care for Resident 1 and it was the facility's duty to inform RP 1 of any change of condition Resident 1 may have so RP 1 could make an informed decision if needed.</p> <p>(continued on next page)</p>		

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<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/11/2024 at 12:47 p.m., with the Medical Records Director (MRD), the MRD stated it was a group effort between multiple departments that included medical records, business office, social services, and nursing to ensure all information on a resident's Face Sheet was complete and accurate. The MRD stated someone within those departments should have realized that RP 1's telephone number was not indicated on Resident 1's Face Sheet. The MRD stated if any staff member had contact with RP 1, they should have taken the initiative to procure RP 1's telephone number and inform her (MRD) so she could update Resident 1's Face Sheet.</p> <p>During a concurrent interview and record review on 12/11/2024 at 3 p.m., with Minimum Data Set Nurse (MDSN) 1, Resident 1's Interdisciplinary Team (IDT, group of different disciplines working together towards a common goal of a resident) Meeting/Care Conference Notes, dated 10/2/2024 was reviewed. The IDT Notes indicated RP 1 was contacted on 10/2/2024 at 2 p.m. but did not attend the meeting. MDSN 1 stated he contacted RP 1 to invite him to attend Resident 1's IDT Meeting on 10/2/2024. MDSN 1 stated on the Face Sheet in Resident 1's physical chart, there was no telephone number to contact RP 1 and he located RP 1's telephone number on Resident 1's prior Face Sheet from the medical records department. MDSN 1 stated he had not informed the MRD that Resident 1's current Face Sheet did not indicate RP 1's telephone number. MDSN 1 stated he should have informed the MRD so the MRD could have updated Resident 1's Face Sheet with RP 1's complete contact information. MDSN 1 stated in the event of an emergency or change in Resident 1's condition, RP 1 should be one of the first to be notified. MDSN 1 stated it was RP 1's right to be informed.</p> <p>During an interview on 12/11/2024 at 3:20 p.m., with the DON, the DON stated the facility should always have the RP's contact information readily available in any event that the RP had to be contacted. The DON stated if the RP's contact information was not indicated but someone had the contact information, they should write it down and let someone in medical records know so they could update the Face Sheet. The DON stated RP 1's contact information was not indicated on the Face Sheet and many staff members part of Resident 1's care did not know how to contact RP 1. The DON stated social services should have been involved to locate the contact information and to place a referral to the Public Guardian office if RP 1 could not be contacted. The DON stated if Resident 1 suffered any injury from her falls or had any change in her condition, there would be no one to make informed decisions regarding her care.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Advising Surrogate or Representative of Resident's Rights and Responsibilities , undated, the P&P indicated, Should a resident be declared incompetent or determined to be medically incapable of understanding his or her rights, the resident's surrogate and/or representative will be advised of the resident's rights and responsibilities . [The] facility will seek a health care decision, or any other decision or authorization, from a surrogate or representative (sponsor) only when the resident is determined to be incompetent in accordance with state law.</p> <p>During a review of the facility's P&P titled, Responsible Party , undated, the P&P indicated, When it is identified by the Physician and facility staff that a resident is not capable of making medical treatment/health care decisions there should be a responsible party or surrogate decision maker, the following procedure is to be followed: Social Services staff will clarify/notify the resident's responsible party or surrogate decision maker.</p> <p>(continued on next page)</p>		

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<p>F 0551</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 P&P titled, Change in Resident's Condition or Status , undated, the P&P indicated, [The] facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679</p> <p>Based on interview and record review, the facility failed to contact a resident's Responsible Party (RP) 1 for one of three sampled residents (Resident 1) after Resident 1 fell on [DATE] and 8/7/2024.</p> <p>This deficient practice resulted in RP 1 being unaware of Resident 1's fall incidents and unable to participate in any decision-making regarding Resident 1's care.</p> <p>Cross reference F551.</p> <p>Findings:</p> <p>During a review of Resident 1's Face Sheet, the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and hypertension (elevated blood pressure).</p> <p>During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 10/7/2024, the MDS indicated Resident 1's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 1 required supervision with oral hygiene, toileting, bathing, dressing, and personal hygiene.</p> <p>During a review of Resident 1's History and Physical (H&P), dated 3/27/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During an interview on 12/10/2024 at 4:36 p.m., with RP 1, RP 1 stated for the entire year of 2024, he had not received any telephone calls from the facility regarding any updates on Resident 1's care. RP 1 stated Resident 1 was evaluated by multiple physicians prior to her admission to the facility and assessed to not have the capacity to make medical decisions and that he (RP 1) would be the decision maker for Resident 1. RP 1 stated he was very concerned regarding Resident 1 because he (RP 1) was unaware of the resident's current condition.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 12/11/2024 at 12:11 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 1's Nurses Notes dated 6/21/2024 and timed at 7:10 p.m. were reviewed. The Nurses Notes indicated Resident 1 was on monitoring for status post fall. The Nurses Notes did not indicate RP 1 was notified of Resident 1's fall. Resident 1's Nurses Notes, dated 8/7/2024 and timed at 3:10 p.m. were reviewed., the Nurses Notes indicated Resident 1 slipped and fell while walking to her bed. The Nurses Notes did not indicate RP 1 was notified of Resident 1's fall. LVN 1 stated RP 1 was not notified of either fall Resident 1 had on 6/21/2024 and 8/7/2024. LVN 1 stated RP 1 should have been notified with an update on Resident 1's condition. LVN 1 stated there was no indication in the Nurses Notes that any attempt to notify RP 1 was made. LVN 1 stated Resident 1 could have been sent to the hospital and complications could have arisen from Resident 1's fall and RP 1 would not have been aware. LVN 1 stated RP 1 put his trust in the facility to care for Resident 1 and it was the facility's duty to inform RP 1 of any change of condition Resident 1 may have so RP 1 could make an informed decision if needed.</p> <p>During an interview on 12/11/2024 at 12:30 p.m., with Registered Nurse (RN) 1, RN 1 stated after a resident falls, the resident's physician and the RP were notified. RN 1 stated the family should be updated when the fall initially occurred, if the physician were to order any treatment, or in the event the resident was sent to the hospital. RN 1 stated there was no indication that any attempts to notify RP 1 of Resident 1's falls were made. RN 1 stated because RP 1 was not notified, RP 1 was unaware of any progress or decline Resident 1 may have had after the incidents.</p> <p>During an interview on 12/11/2024 at 3:20 p.m., with the Director of Nursing (DON), the DON stated after a resident sustained a change in condition, such as a fall, the resident's physician and RP were to be notified. The DON stated there should always be an attempt to call the RP and to leave a message if possible so the RP could return the call. The DON stated due to RP 1's telephone number not indicated on Resident 1's Face Sheet, the facility staff who were aware of the missing telephone number should have brought it to the attention of either her or social services so they could locate the telephone number. The DON stated there should be documentation in Resident 1's Nurses Notes that there was an attempt to notify RP 1, but no telephone number was indicated on the Face Sheet. The DON stated this would have prompted the process of obtaining the RP 1's telephone number. The DON stated RP 1 had the right to be notified of Resident 1's falls and to be given the opportunity to make any necessary medical decisions for Resident 1.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Change in Resident's Condition or Status , undated, the P&P indicated, [The] facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status.</p>		