| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555781 | A. Building<br>B. Wing | 05/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Villa Del Rio | 7002 Gage Avenue<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48778<br><br>Based on interview and record review, the facility failed to implement the care plan for one of three sampled residents (Resident 3) by failing to monitor the effectiveness of treatment for the resident's rash.<br><br>This failure had the potential for Resident 3's rash to worsen and lead to the resident's physical and psychosocial needs not being met.<br><br>Findings:<br><br>During a review of Resident 3's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. The Admission Record indicated Resident 3's diagnoses included Metabolic Encephalopathy (a brain disorder caused by problems in the body's chemistry, leading to changes in brain function) and Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).<br><br>During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool) dated 4/12/2025, the MDS indicated Resident 3 was cognitively intact (having the ability to think, remember, and solve problems). The MDS indicated Resident 3 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for Activities of Daily Living (ADLs) such upper body dressing and performing personal hygiene.<br><br>During a review of Resident 3's care plan titled, Resident with rashes to bilateral (both) knees, dated 5/23/2025, the care plan approach (interventions) indicated to monitor the effectiveness of Resident 3's treatment and call the physician as needed.<br><br>During a review of Resident 3's nursing progress notes dated 5/2025, the progress notes did not indicate nurses monitored for the effectiveness of Resident 3's treatment to the resident's rash after 5/23/2025.<br><br>During an interview on 5/28/2025 at 3:40 p.m. with the Director of Nursing (DON), the DON stated the purpose of Resident 3's care plan was to provide a plan on how to heal the resident's rash without complications. The DON stated the care plan was also to determine whether the interventions were working for the resident.<br><br>(continued on next page) |



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

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 5/29/2025 at 2:29 p.m. with the DON, Resident 3's care plan dated 5/23/2025, and nursing progress notes dated 5/2025 were reviewed. The DON stated, there was no supporting documentation to indicate nurses were monitoring the effectiveness of the treatment for Resident 3's rash as indicated in the resident's care plan.<br><br>During a review of facility policy and procedure (P&P) titled, Comprehensive Care Plans, dated 2025, the policy indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48778<br><br>Based on interview and record review the facility failed to ensure pain management was effective for one of three sampled residents (Resident 3) by failing to:<br><br>1. Reassess Resident 3's pain after administering Hydrocodone-Acetaminophen (Norco- a medication used to relieve pain), in a timely manner on 5/26/2025.<br><br>2. Reassess Resident 3's pain after administering Norco on 5/27/2025.<br><br>These failures had the potential to result in unresolved pain for Resident 3 and could negatively affect the resident's physical and psychosocial well-being.<br><br>Findings:<br><br>During a review of Resident 3's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. The Admission Record indicated Resident 3's diagnoses included Metabolic Encephalopathy (a brain disorder caused by problems in the body's chemistry, leading to changes in brain function) and Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).<br><br>During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool) dated 4/12/2025, the MDS indicated Resident 3 was cognitively intact (having the ability to think, remember, and solve problems). The MDS indicated Resident 3 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for Activities of Daily Living (ADLs) such upper body dressing and performing personal hygiene.<br><br>During a review of Resident 3's physician's order dated 5/7/2025, the physician's order indicated to administer Hydrocodone-Acetaminophen Tablet 10-325 milligrams (mg- unit of measurement) one tablet by mouth every 6 hours as needed for moderate to severe pain (pain rating reference 1-3 mild pain; 4-6 moderate pain; 7-10 severe pain) to Resident 3.<br><br>During a review of Resident 3's Medication Administration Record (MAR) dated 5/2025, the MAR indicated on 5/26/2025 at 9:42 a.m., Licensed Vocational Nurse (LVN) 6 administered Norco 10/325 mg. 1 tablet to Resident 3 for 6/10 pain. The MAR indicated on 5/27/2025 at 9 a.m., LVN 5 administered Norco 10/325 mg. 1 tablet to Resident 3 for 9/10 pain.<br><br>During a review of Resident 3's Progress Notes dated 5/26/2025, the Progress Notes indicated LVN 6 reassessed Resident 3's pain on 5/26/2025 at 2:23 p.m. (approximately 5 hours after administering Norco) and the resident's pain was 0/10.<br><br>During an interview on 5/27/2025 at 12:27 p.m. with Resident 3, Resident 3 stated he received a dose of Norco around 9 a.m. (on 5/27/2025) and the licensed nurse (unnamed) had not returned to ask Resident 3 if the Norco had relieved his pain.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 3's Progress Notes dated 5/27/2025, the Progress Notes did not indicate Resident 3's pain was reassessed to determine if the Norco (given on 5/27/2025 at 9 a.m.) relieved Resident 3's pain.<br><br>During a concurrent record reviews and interviews on 5/27/2025 at 3:10 p.m. and 5/28/2025 at 3:16 p.m. with the Director of Nurse (DON), Resident 3's MAR and Progress Notes dated 5/26/2025 and 5/27/2025 were reviewed. The DON stated on 5/26/2025, the licensed nurse (LVN 6) did not reassess Resident 3's pain timely after the resident was given Norco. The DON stated, after administering pain medication to residents, the licensed nurse should reassess the resident's pain after an hour of administering pain medication to ensure the resident's pain was relieved. The DON stated the was no documentation to indicate LVN 5 reassessed Resident 3's pain after the administering Norco to the resident on 5/27/2025 at 9 a.m. The DON also stated, failing to reassess the resident's pain in a timely manner could lead to the resident experiencing unrelieved pain.<br><br>During a review of facility's policy and procedure (P&P) titled, Pain Assessment and Management, dated 1/2025, the P&P indicated pain management is a multidisciplinary care process that includes the following: assessing the potential for pan, effectively recognizing the presence of pain, implementing approaches to pain, monitoring for the effectiveness of interventions and modifying approaches as necessary. The P&P indicated to document the resident's reported level of pain with adequate detail (i.e. enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary in accordance with the pain management program. The P&P indicated, upon completion of the pain assessment, the person conducting the assessment shall record the information contained from the assessment in the resident's medical record. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48778<br><br>Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN 5) documented the administration of Hydrocodone-Acetaminophen (Norco-a medication used to relieve pain) for one out of three sampled residents (Resident 3).<br><br>This failure placed Resident 3 at risk for medication errors, drug overdose and could lead to adverse drug events for the resident.<br><br>Findings:<br><br>During a review of Resident 3's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. The Admission Record indicated Resident 3's diagnoses included Metabolic Encephalopathy (a brain disorder caused by problems in the body's chemistry, leading to changes in brain function) and Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).<br><br>During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool) dated 4/12/2025, the MDS indicated Resident 3 was cognitively intact (having the ability to think, remember, and solve problems). The MDS indicated Resident 3 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for Activities of Daily Living (ADLs) such upper body dressing and performing personal hygiene.<br><br>During a review of Resident 3's Order Summary report dated 5/28/2025, the Order Summary indicated to administer Hydrocodone-Acetaminophen Tablet 10-325 mg tablet, one tablet by mouth every 6 hours as needed for moderate to severe pain to Resident 3.<br><br>During an interview on 5/27/2025 at 12:27 p.m. with Resident 3, Resident 3 stated he received a dose of Norco around 9 a.m. (on 5/27/25).<br><br>During a concurrent interview and record review on 5/28/2025 at 11:15 a.m. with LVN 5, Resident 3's Medication Administration Record (MAR) dated 5/27/2025 was reviewed. LVN 5 stated he administered a dose of Norco to Resident 3 on 5/27/2025 at around 9 a.m., however he was not able to document it because he had to attend to another resident and had forgotten to do so.<br><br>During an interview on 5/28/2025 at 3:07 p.m. with the Director of Nursing (DON), the DON stated, nurses should document immediately after administering medications to residents. The DON stated, failing to document medication administrations could lead to the residents receiving double doses of the medications and could lead to adverse drug reactions such as breathing issues.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of facility's P&P titled, Medication Administration, dated 1/2025, the P&P indicated Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. The P&P indicated, to sign the MAR after administering the medication and ensure that the six rights of medication administration are followed:<br><br>a.Right resident<br><br>b.Right drug<br><br>c.Right dosage<br><br>d.Right route<br><br>e.Right time<br><br>f.Right documentation |