| 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 | 06/28/2025 |

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

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1), who was assessed as at risk for elopement (the act of leaving a facility unsupervised and without prior authorization) and diagnosed with paranoid schizophrenia (a mental illness that was characterized by disturbances in thought), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), hypertension (HTN- high blood pressure), and epilepsy (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) did not leave the facility through an unlocked and disarmed door, by failing to:<br><br>1. Supervise Resident 1's whereabouts who had behaviors of wandering to the exit door and waiting by the front door.<br><br>2. Ensure the licensed nursing staff on duty activated the exit door alarm at 7 p.m. on [DATE].<br><br>3. Ensure Resident 1's environment was safe and secured, as indicated in Resident 1's Elopement Risk Care Plan, when the exit door alarm was not manually armed by the licensed nursing staff on [DATE].<br><br>As a result, Resident 1 eloped from the facility on [DATE] at 10:13 p.m. and was found slumped over and deceased by the police on the roof of a building (not the facility's building) on [DATE].<br><br>On [DATE] at 4:08 p.m., an Immediate Jeopardy ([IJ], a situation in which the facility's noncompliance with one or more requirements of participation had cause, or was likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the Administrator (ADM) and the Director of Nursing (DON) due to the facility's failure to effectively monitor Resident 1's whereabouts, follow Resident 1's care plan, and ensure the exit door was manually armed before Resident 1 exited the facility building at 9:59 p.m. and subsequently eloped from the gated facility grounds 13 minutes after on [DATE].<br><br>On [DATE] at 11:30 a.m., the facility submitted an acceptable IJ Removal Plan (IJRP). After onsite verification of the IJRP implementation through observation, interview, and record review, the IJ was removed onsite at [DATE] at 4:33 p.m., in the presence of the ADM.<br><br>The IJRP included the following immediate actions:<br><br>(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 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 1. Review and update of the elopement risk evaluation for each resident to ensure all elopement risk residents were identified and monitored.<br><br>2. The Maintenance Director (MD) checked all the alarms functionality.<br><br>3. The maintenance staff were assigned to check the door alarms for proper functioning at the beginning and end of shift of their shift.<br><br>4. In-services were provided to maintenance staff regarding proper perimeter and door alarm checks documentation.<br><br>5. The maintenance staff performed a perimeter check to ensure the fences and the gates around the facility were not broken.<br><br>6. The 3 p.m. to 11 p.m. and the 11 p.m. to 7 a.m. licensed nurses would be assigned to check the exit door alarms during their routine rounds.<br><br>7. The licensed nurses would be assigned to turn on the exit door alarm on at 7 p.m. and the RN Supervisor on duty would check if the alarm was armed.<br><br>8. Staff and an alternate would be assigned at the exit points of the hallways from 7 p.m. to 7 a.m. in Building A. Assignments would be reflected on the Staffing Assignment Sheet under special needs.<br><br>9. Licensed Nurses will ensure that assigned staff for the exit doors of the secure building are in their designated location.<br><br>10. Staff must identify who exited the door and redirect the resident back inside the building once the exit door alarm is triggered.<br><br>11. A headcount would be done at the beginning of each shift, every two hours, and at the end of the shift to prevent elopement.<br><br>12. An update of elopement risk evaluations were completed on [DATE]. Out of an inhouse census of 165, a total of 24 residents are elopement risk. Care plans were completed for all 24 residents.<br><br>13. An in-service was given on [DATE] to 32 staff members and on [DATE] to 40 staff members regarding Head Counts and Shift Reports. An in-service was given on [DATE] to 39 staff members regarding procedure for door alarm activation and staff responsibility. An in-service was given on [DATE] to 14 staff members regarding head counts, shift reports and Safety and Supervision of Residents. An in-service was given on [DATE] to 15 staff members regarding the activation of door alarms to maintain safety for the wandering and elopement risk resident. An in-service was given on [DATE] to 18 staff members and on [DATE] to 22 staff members regarding safety and supervision of residents and elopement precautions.<br><br>14. In-services would be ongoing of the procedure to secure the exits and door alarm activation in Building A, until all staff are covered. As of [DATE] only 15 staff members have not been in-serviced due to not being on schedule at this time.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 15. In-services on Safety and Supervision of Residents & Elopements and Wandering to prevent elopement and other accidents/incidents, will be ongoing until all staff are covered, as of today only 15 staff members have not been in-serviced due to not being on schedule at this time. They will be in-serviced when they return to work.<br><br>16. The Nursing Supervisors, DON or Designee shall monitor compliance with the above plan of actions. Any episodes of non-compliance shall be reported to the Administrator for further corrective action, as necessary. The administrator shall report any findings to the Quality Assurance Committee (QA&A). The QA&A Committee shall review the systems and revise as necessary.<br><br>Findings:<br><br>a. During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility in Building A on [DATE] with diagnoses that included restlessness, agitation (a state of unease, restlessness, or disturbance), epilepsy, depression (a feeling of sadness and hopelessness), paranoid schizophrenia, anxiety (an overwhelming feeling of uneasiness), COPD, and HTN.<br><br>During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated [DATE], the MDS indicated Resident 1 had serious mental illness and severely impaired cognition (process of thinking). The MDS indicated Resident 1 required supervision for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as performing oral hygiene, toileting, upper and lower body dressing, and performing personal hygiene. The MDS indicated Resident 1 required supervision (helper provided verbal cues and, or touching, steadying or contact guard assistance as resident completes activity) when he walked beyond 10 feet (ft- a unit of measurement), transitioned from a sitting to a standing position, transferred from the bed to a chair, and transferred from the toilet.<br><br>During a review of Resident 1's History and Physical (H&P), dated [DATE], Resident 1's H&P indicated Resident 1 had fluctuating capacity to understand and make decisions.<br><br>During a review of Resident 1's Elopement Risk Evaluation, dated [DATE], Resident 1's evaluation indicated Resident 1 was at risk for elopement.<br><br>During a review of Resident 1's Care Plan, titled, Baseline Care Plan, dated [DATE], the Care Plan indicated Resident 1 was an elopement risk. The Care Plan indicated a plan of care would be implemented to meet Resident 1's needs while in the facility.<br><br>During a review of Resident 1's Nursing Progress Note, dated [DATE], the Nursing Progress Note indicated, on [DATE] at 11:10 p.m., a charge nurse informed Registered Nurse (RN) 2 that Resident 1 was last seen at approximately 10:41 p.m. by Licensed Vocational Nurse (LVN) 1. The note indicated a facility-wide search was conducted and was unsuccessful. The note indicated on [DATE] at 12:23 a.m., the local authorities were notified.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During a concurrent interview and record review on [DATE] at 1:30 p.m. with the Social Services Director (SSD), Resident 1's Social Service History and Initial Assessment, dated [DATE], was reviewed. The Social Service History and Initial Assessment indicated Resident 1 exhibited behaviors such as exit-seeking, agitation, aggressiveness, impulsiveness, and lack of safety awareness. The SSD stated he included Resident 1's behaviors of exit-seeking and lack of safety awareness in the assessment because Resident 1's Responsible Party (RP) 1 informed him of Resident 1's previous attempts to leave a previous facility and of the resident's exit-seeking behaviors. The SSD stated this information was not shared during the interdisciplinary care team (IDT, a group of healthcare professionals from different specialties who collaborated to provide comprehensive and coordinated care to individuals) meeting because Resident 1's exit-seeking behavior was not observed by the facility staff. The SSD stated he should have shared the information with the IDT and nursing staff to ensure person-centered safety interventions were included in Resident 1's plan of care.<br><br>During a concurrent interview and record review on [DATE] at 3:04 p.m., with Minimum Data Set Nurse (MDSN) 1, Resident 1's Care Plan titled At Risk for Elopement, dated [DATE], was reviewed. The Care Plan indicated Resident 1 continued to wander to the gate and sometimes waited by the front door. The Care Plan goals indicated to ensure Resident 1 was kept in a safe environment and free from injury daily. The Care Plan interventions indicated the facility was to 1) assure Resident 1's environment was kept safe and secured, and 2) ensure shift huddles (a quick meeting amongst nursing staff to communicate any important safety information about certain residents or reminders) at the beginning of each shift to make staff aware of residents with exit-seeking behaviors. MDSN 1 stated he initiated the Care Plan on [DATE] based on an interview with an unidentified licensed nurse who informed him (MDSN 1) that Resident 1 was observed walking around the unit, wandering around the nurses' station, and going out to the gate in the yard and patio during the evening shift. MDSN 1 stated the nurses performed room rounds every two hours to monitor Resident 1's whereabouts.<br><br>During a telephone interview on [DATE] at 3:12 p.m. with RP 1, RP 1 stated Resident 1 had a history of unsuccessful elopement attempts in a previous Skilled Nursing Facility (SNF) and was at high risk of absence without leave (AWOL, away without permission). RP 1 stated Resident 1 was not happy about being placed in a locked facility and wished to live in the woods. RP 1 stated she (RP 1) could see that Resident 1 was building up anger for being locked in a facility. RP 1 stated she notified LVN 3 prior to Resident 1's admission to the facility that Resident 1 had a history of elopement attempts.<br><br>During a concurrent observation and interview on [DATE] at 1:49 p.m. with the Administrator (ADM), the facility's security surveillance video footage, dated [DATE] from 9:59 p.m. to 10:13 p.m., was observed. The surveillance footage revealed on [DATE] at 9:59 p.m. Resident 1 exited his room located at the end of Hallway A (in Building A), adjacent to the exit door, and walked out the unlocked and disarmed exit door. The ADM stated there was no staff present in Hallway A when Resident 1 exited the building. The surveillance footage revealed Resident 1 walking in the back parking lot at 10:11 p.m., proceeded to walk down a road adjacent to the facility grounds (off the facility's property). Resident 1 was last observed leaving the facility from the parking lot at 10:13 p.m.<br><br>During a concurrent interview and record review on [DATE] at 2:47 p.m. with the DON, Resident 1's IDT Conference record, dated [DATE], was reviewed. The IDT conference record did not indicate Resident 1's history of elopement or exit seeking behavior was discussed. The DON stated that the IDT should have discussed Resident 1's history of elopement and wandering behavior and develop a plan to prevent elopement.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on [DATE] at 3:15 p.m. with the DON, the DON stated adequate supervision was important to prevent elopement, especially for residents with a known history of elopement attempts. The DON stated she was not aware Resident 1 had a prior history of elopement and exhibited exit-seeking behaviors. The DON stated the SSD should have made nursing aware of Resident 1's prior history of elopement and behaviors so proper interventions and adequate supervision could have been implemented. The DON stated the RN Supervisors were responsible for ensuring the care plan interventions were implemented and communicated with relevant staff every shift. The DON stated the lack of communication and implementation of effective shift huddle led to lack of adequate supervision for Resident 1, which placed Resident 1 at risk for elopement.<br><br>During a telephone interview on [DATE] at 10:04 a.m. with LVN 1, LVN 1 stated he worked the evening shift on [DATE] and was Resident 1's assigned nurse. LVN 1 stated he (LVN 1) was not made aware of Resident 1's history of elopement attempts or exit-seeking behaviors and nursing staff did not perform a huddle before the start of the shift. LVN 1 stated he was unsure if any staff were outside in the yard to supervise Resident 1 when the resident exited Building A. LVN 1 stated supervision was required for all residents to prevent elopement and avoid any incidents, accidents, and ensure safety. LVN 1 stated if he was aware of Resident 1's exit-seeking behaviors, he would have implemented a one-on-one supervision (1:1, a type of supervision that required a staff member to supervise a resident at all times) measures for Resident 1, placed his medication cart in front of Resident 1's room (Room A), while he charted, and assigned a certified nursing assistant (CNA) to monitor Resident 1's whereabouts.<br><br>During an interview and concurrent record review on [DATE] at 2:41 p.m. with RN 1, Resident 1's Care Plan titled At Risk for Elopement, dated [DATE], was reviewed. The Care Plan indicated Resident 1 continued to wander to the gate and sometimes waited by the front door. The Care Plan goals indicated to ensure Resident 1 would be kept in a safe environment and free from injury daily. The Care Plan interventions indicated the facility was to assure Resident 1's environment was kept safe and secure. RN 1 stated she did not read and was not made aware of the nursing goals and interventions identified in Resident 1's Care Plan. RN 1 stated she would have ensured Resident 1 received constant monitoring and supervision and would have assigned CNA to keep an eye on the resident if she had known of Resident 1's history of exit-seeking behavior, as indicated in Resident 1's Care Plan. RN 1 stated Resident 1 was at risk for elopement because he was newly admitted to the facility, new to the environment, and staff were unfamiliar with his behaviors. RN 1 stated the facility's elopement prevention and resident safety practices were to redirect residents away from the exit doors, unless a staff member was available to supervise the resident, ensure all exit door alarms were armed, inform staff of residents with exit-seeking behaviors, supervise residents at all times, perform a head count of the residents, and room rounds every two hours to ensure all residents were visible to staff.<br><br>b. During a review of Resident 2's admission Record, the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included polyosteoarthritis (diagnosis that means five or more of your joints have arthritis at the same time), COPD, and paranoid schizophrenia.<br><br>During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was moderately impaired. The MDS indicated Resident 2 required supervision with ADLs.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on [DATE] at 11:37 a.m. with Resident 2 (Resident 1's roommate), Resident 2 stated the exit door, located adjacent to his room, was not armed on [DATE]. Resident 2 stated he usually exited through the door around 9 p.m. or 10 p.m., or whenever he wished without triggering an alarm.<br><br>During a concurrent observation and interview on [DATE] at 1:04 p.m. with the ADM, Hallway A video footage, dated [DATE] and timed from 9:59 p.m. to 10:04 p.m., was reviewed. The video footage revealed Resident 1 opened the exit door and exited Building A unnoticed at 9:59 p.m. The video footage did not show the alarm had flashing lights and there was no staff observed running toward the exit door. The video footage revealed three minutes later at 10:02 p.m., CNA 1 exited Room B, located across from Room A, passed the exit door, and proceeded to walk away from the exit door towards the linen storage. The ADM stated the exit door alarm was not activated at 7 p.m. on [DATE], when Resident 1 eloped from the facility. The ADM stated it was important to ensure exit door alarms were armed to alert staff when a resident attempted to leave the facility.<br><br>During an interview on [DATE] at 1:07 p.m. with LVN 2, LVN 2 stated she worked the 3 p.m. to 11 p.m. shift on [DATE] and did not check if the exit doors were armed and did not hear the sound of an exit door alarm during that shift.<br><br>During an interview on [DATE] at 2:06 p.m. with RN 2, RN 2 stated she was the assigned RN Supervisor on [DATE] from 7 p.m. to 7 a.m. RN 2 stated all licensed nursing staff were expected to arm the exit door alarms at 7 p.m. or after the resident's smoke break at 8:30 p.m. RN 2 stated the exit door alarms alerted staff whenever a resident entered or exited Building A during the 3 p.m. to 11 p.m. and the 11 p.m. to 7 a.m. shifts. RN 2 stated she did not check if the exit door alarms were armed and did not recall hearing the distinct sound of the door alarm activate on [DATE] from 7 p.m. to 7 a.m. RN 2 stated Resident 1 was at an increased risk for elopement due to the unarmed exit door and she should have ensured the door alarms were on.<br><br>During an interview on [DATE] at 3:15 p.m. with the DON, the DON stated there were no systems in place to ensure all licensed nurses manually armed the exit door alarms and ensure the alarms were armed after 7 p. m. The DON stated there was an increased potential for a resident to elope if the alarms were not armed. The DON stated staff would not be aware if a resident was no longer in the building without the use of the alarms. The DON stated, if exit door alarms were armed on [DATE] at 7 p.m., staff could have been alerted when Resident 1 left the building.<br><br>During an interview on [DATE] at 10:04 a.m. with LVN 1, LVN 1 stated he worked the 3 p.m. to 11 p.m. shift on [DATE] and was Resident 1's assigned nurse. LVN 1 stated he did not arm the exit door because he was not in-serviced or advised to arm the exit door.<br><br>c. During a concurrent interview and record review on [DATE] at 2:40 p.m., with RN 1, Resident 1's At Risk for Elopement Care Plan, dated [DATE], was reviewed. The Care Plan interventions indicated the facility was to assure Resident 1's environment was kept safe and secure. RN 2 stated the specific care plan intervention meant licensed nurses were to ensure all exit door alarms were armed especially at night. RN 1 stated it was very important to know the whereabouts of the residents to ensure their safety, especially if the resident was new or recently admitted to the facility.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on [DATE] at 3:50 p.m., with the DON, the DON stated Resident 1's At Risk for Elopement Care Plan intervention to keep Resident 1's environment safe and secure meant the door alarms should have been armed on [DATE] at 7 p.m. The DON stated the unarmed exit door did not align with Resident 1's At Risk for Elopement Care Plan intervention of maintaining a safe and secure environment, and placed Resident 1 at an increased risk for any injuries or accidents to occur.<br><br>During a review of the facility's P&P titled, Safety and Supervision of Residents, dated 1/2025, the P&P indicated the facility's priorities was to keep the environment free from accident hazards, supervise and assist residents, and ensure residents' safety to prevent accidents. The P&P indicated the IDT shall analyze information obtained from assessments to identify any specific accident hazards or risks for each resident. The P&P indicated the care team shall target interventions to reduce the potential for accidents such as communicating specific interventions to all relevant staff; assigning responsibility for carrying out interventions; providing training as necessary; and ensuring interventions were implemented and documented.<br><br>During a review of the facility's P&P titled, Elopements and Wandering Residents, undated, the P&P indicated the facility was to ensure residents who were at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The P&P indicated elopement occurred when a resident left the premises or a safe area without authorization and, or any necessary supervision to do so. The P&P indicated adequate supervision would be provided to help prevent accidents or elopements. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Based on observation, interview, and record review, the facility failed to implement infection control practices by not ensuring the shower room and toilet was clean after use.<br><br>These deficient practices resulted in an unsanitary environment that increased the risks of infection among residents and staff.<br><br>Findings:<br><br>a. During a concurrent observation and interview on 6/24/2025 at 12:10 a.m. with the Maintenance Supervisor (MS), in Building A Shower Room B3, observed that the shower floor was wet. The MS stated the shower floor should not be wet and the staff should notify housekeeping to clean the shower room after use.<br><br>During an interview on 6/24/2025 at 12:21 p.m. with Maintenance Staff 1, Maintenance Staff 1 stated the wet floor placed residents at risk for cross-contamination (the transfer of harmful substances, like bacteria, from one item or surface to another).<br><br>During an interview on 6/24/2025 at 12:30 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated the nurses who used the shower room for resident showers should clean up the floor by picking up the dirty linen on the floor and keeping the floor dry because of infection control.<br><br>During an interview on 6/24/2025 at 12:37 p.m. with the Director of Nursing (DON), the DON stated the wet floor might produce mold and potentially cause respiratory issues among residents.<br><br>b. During a concurrent observation and interview on 6/24/2025 at 12:10 a.m. with the MS, in Building A Shower Room B3, the toilet bowl was observed with yellow and brown fluid. The MS stated the toilet was dirty.<br><br>During a concurrent observation and interview on 6/25/2025 at 2:47 p.m. with the DON, the photo of Shower Room B3's toilet, dated 6/24/2025 at 12:09 p.m., was observed. The photo revealed the toilet had no lid with yellow and brown fluid. The DON stated the toilet was dirty and should be flushed. The DON stated the toilet inside the shower room should not be dirty. The DON stated it could cause infection and get residents and staff sick.<br><br>During a review of the facility's Policy and Procedures (P&P) titled Standard Precautions Infection Control, undated, the P&P indicated Policies and procedures have been established for routine and targeted cleaning of environmental surfaces as indicated by the level of resident contact and degree of soiling.<br><br>During a review of the facility's P&P titled Quality of Life - Homelike Environment, dated 1/2025, the P&P indicated that The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include cleanliness.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's P&P titled Shower Room Cleaning, dated 2/1/2025, the P&P indicated the facility was Committed to providing a safe, clean, and hygienic environment for residents, staff, and visitors in accordance with regulatory guidance and industry best practices. The P&P further indicated that the staff should Adhere to all infection control precautions. |

| 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 | 06/28/2025 |

| 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 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>Based on observation, interview, and record review, the facility failed to provide a safe, sanitary, and comfortable environment for residents when the following occurred:<br><br>1.<br><br>Six out of the eight Geri chairs (specialized chair designed to provide comfortable and supportive seating for individuals with limited mobility) were broken and/or ripped in Building A.<br><br>2.<br><br>Two out of the eight shower chairs were broken and/or ripped in Building A.<br><br>These deficient practices resulted in an unsafe and uncomfortable environment that increased the risk of injury among residents and staff.<br><br>Findings:<br><br>1. During a concurrent observation and interview on 6/24/2025 at 11:57 a.m. with the Maintenance Supervisor (MS), in Building A Shower Room B1, a Geri chair was observed without a cushion on the backrest. The MS stated the Geri chair should have a cushion on the backrest for the residents' comfort.<br><br>During a concurrent observation and interview on 6/24/2025 at 12:05 a.m. with the MS, in Building A Shower Room B4, observed two Geri chairs with broken footrests, handrests, and backrests. One Geri chair's backrest was ripped with padding material exposed. All four handrests of both Geri chairs were ripped with padding material and wooden parts exposed. One Geri chair's footrest was broken and unable to be lift properly. Both Geri chairs' footrest flaps (a gap filler, a thin layer of flexible fabric that bridged the space between the backrest and the footrest of the Geri chair) were broken with the metal part of the footrests exposed. The MS stated the Geri chair footrest should have an intact flap to prevent residents' legs from touching the metal parts of the chair and prevent injuries. The MS stated he needed to replace the broken footrests, backrests, and handrests for safety.<br><br>During a concurrent observation and interview on 6/24/2025 at 12:10 p.m. with the MS, in Building A Shower Room B3, observed a Geri chair with a ripped left handrest. The MS stated he needed to change the ripped Geri chair handrest for residents' comfort and safety.<br><br>During an observation on 6/25/2025 at 8:53 a.m., in Building A Hallway A, surveyor observed a Geri chair with a broken left handrest. The Geri chair's left handrest's padding was ripped with the wooden and metal parts exposed.<br><br>2. During a concurrent observation and interview on 6/24/2025 at 12:05 p.m. with the MS, in Building A Shower Room B4, observed a shower chair with a ripped seat pad. The MS stated the shower chair seat pad needed to be changed for the residents' comfort and safety.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 555781 | A. Building<br>B. Wing | 06/28/2025 |

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| 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.

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|---|---|
| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 6/24/2025 at 12:13 p.m. with the MS, in Building A Shower Room B2, observed a shower chair with ripped backrest and no seat pad. The MS stated the shower chair backrest and seat pad needed to be changed for the residents' comfort and safety.<br><br>During an interview on 5/24/2025 at 12:37 p.m. with the Director of Nursing (DON), the DON stated the Geri chair was for residents who could not move their feet. The DON stated it was not comfortable for the residents when the Geri chair had no cushion or ripped bedrests and handrests. The DON stated the ripped backrests and handrests might scrape the residents' skin. The DON stated the facility should ensure the quality of care and residents' comfort by maintaining the facility's equipment.<br><br>During a review of the Manufacture Manual for the Geri chair, undated, the manual indicated that the recliner must be cared for appropriately to operate properly and safely. The manual indicated that the recliner should be inspected/ adjusted weekly to ensure the seat, back and/ or armrest upholstery have no rips and to replace if necessary.<br><br>During a review of the Job Descriptions for Maintenance Assistance, undated, the Job Descriptions indicated that the primary purpose of the maintenance assistance was to maintain the facility equipment in a safe and efficient manner to ensure a successful maintenance program was always maintained. The job description further indicated that the maintenance assistant should ensure that the facility and its equipment are properly maintained for residents' comfort and convenience.<br><br>During a review of the facility's Policy and Procedures (P&P) titled Quality of Life-Homelike Environment, dated 1/2025, the P&P indicated that Residents are provided with a safe, clean, comfortable and homelike environment. |