

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  08/26/2025
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 0605  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.  (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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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure one of six sampled residents' (Resident 5) antipsychotic medication (medication that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior), which was given on an as needed basis (PRN), did not exceed 14 days. This deficient practice resulted in the lack of evaluation of Resident 5's medication. Findings: During a review of Resident 5's admission Record (Face Sheet), the admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia (a mental illness that is characterized by disturbances in thought) and anxiety disorder (overwhelming and uncontrollable fear and worry). During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool), dated 6/4/2025, the MDS indicated Resident 5's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 5 required setup or clean-up assistance with eating, oral hygiene, dressing, and personal hygiene. The MDS indicated Resident 5 received antipsychotic medication (medication that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior). During a review of Resident 5's History and Physical (H&amp;P), dated 5/29/2025, the H&amp;P indicated Resident 5 could make needs known but could not make medical decisions. During a review of Resident 5's Orders, order dated 5/29/2025, the Orders indicated to administer Resident 5 the following medications: 1. Haldol (an antipsychotic medication) 5 milligrams (mg, a unit of measurement) by mouth twice a day for psychosis (a loss of contact with reality) manifested by verbal aggression. 2. Haldol 5mg/milliliter (mL, a unit of measurement) intramuscularly (injection into the muscle), as needed (PRN) for psychosis manifested by verbal aggression. The order indicated to administer as a back up for each refusal of oral Haldol. During a review of Resident 5's Medication Administration Record (MAR), dated 6/2025, 7/2025, and 8/2025, the MAR indicated Resident 5's refusal of oral Haldol refusal and administration of PRN Haldol injection on the following days and times: 6/4/2024 - at 5 p.m. oral Haldol refused and PRN Haldol injection administered at 9:02 p.m. 6/23/2025 - at 5 p.m. oral Haldol refused and PRN Haldol injection administered at 6:38 p.m. 7/29/2025 - at 5 p.m. oral Haldol refused and PRN Haldol injection administered at 5:10 p.m. 8/3/2025 - at 9 a.m. oral Haldol refused and PRN Haldol injection administered at 9:03 a.m. 8/17/2025 - at 9 a.m. oral Haldol refused and PRN Haldol injection administered at 10:15 a.m. 8/18/2025 - at 9 a.m. oral Haldol refused and PRN Haldol injection administered at 10:10 a.m. During a review of Resident 5's Medication Regimen Review (MMR- monthly review of all medications to ensure they are safe, effective, and appropriate), dated 5/31/2025, the MMR indicated Resident 5 was receiving Haldol injection 5mg/mL for psychosis PRN for refusal of oral Haldol. The MMR indicated, per regulatory guidelines, orders for antipsychotic medications on a PRN basis must be limited to 14 days with no exceptions. If a new order for psychotropic medication is to be written, a direct examination of the resident by the attending physician or prescribing practitioner is required to determine if the medication is still needed. During a review of Resident 5's Psychiatric Note, dated 6/16/2025, the Note indicated, Staff report intermittent episodes of verbal abuse, aggressive behavior, and occasional refusal of oral medications, necessitating administration of [PRN] Haldol. Current treatment plan to be maintained. During an interview on 8/26/2025 at 11:54 a.m., with Pharmacist 1, Pharmacist 1 stated orders for PRN antipsychotic medication were limited to 14 days without any exceptions. Pharmacist 1 stated if the resident's physician wanted to continue the PRN antipsychotic medication, the physician had to examine the resident directly to determine if the medication was still required. During an interview on 8/26/2025 at 12:34 p.m., with the Medical Director (MD), the MD stated PRN antipsychotic medication was limited to 14 days and after 14 days, the order should be discontinued until the resident was evaluated by the psychiatrist. The MD stated if the psychiatrist orders a PRN antipsychotic medication for longer than 14 days, the facility was responsible for calling the psychiatrist to ensure the order was changed. The MD stated the evaluation by the psychiatrist was important to determine whether the current medication regimen was effective or if the regimen had to be adjusted. During an interview on 8/26/2025 at 1:17 p.m., with the Director of Nursing (DON), the DON stated Resident 5 received PRN Haldol when Resident 5 refused the oral Haldol. The DON stated Resident 5's PRN Haldol order exceeded the 14 days instead of being discontinued. The DON stated after 14 days, Resident 5's psychiatrist should have reevaluated Resident 5's need for PRN Haldol. The DON stated if Resident 5 was reevaluated every 14 days, Resident 5's psychiatric healthcare team would have evaluated her about twice a month, however Resident 5 was only seen once a month. The DON stated if Resident 5's</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review, the facility failed to complete and retain documentation of Background Reports for five of six sampled staff members (Registered Nurse [RN] 2, Licensed Vocational Nurse [LVN] 2, LVN 4, Treatment Nurse [TN] 1, and Certified Nursing Assistant [CNA] 2) in a timely manner. This deficient practice had the potential for RN 2, LVN 2, LVN 4, TN 1, and CNA 2's undetected history of abuse, neglect, exploitation, or misappropriation of resident property, if any, and to allow access to the residents in the facility. Findings: 1. During a concurrent interview and record review, on 8/26/2025 at 10:23 a.m., with Director of Staff Development (DSD) 1, Certified Nursing Assistant (CNA) 2's Employee File was reviewed. The Employee File did not contain documentation of CNA 2's Background Report. DSD 1 stated CNA 2's date of hire was 6/1/2018 and a background check should have been completed upon hire. DSD 1 stated the facility was bought into new ownership sometime in 2018 and many of the staff's documentation prior to the change-in-ownership was misplaced. 2. During a concurrent interview and record review, on 8/26/2025 at 10:25 a.m., with DSD 1, Licensed Vocational Nurse (LVN) 2's Employee File was reviewed. The Employee File did not contain documentation of LVN 2's Background Report. DSD 1 stated LVN 2's date of hire was 1/19/2018 and a background report should have been completed upon hire. DSD 1 stated the facility was responsible for retaining documentation of background checks to provide proof that each hired staff member was cleared to care for the residents. 3. During a concurrent interview and record review, on 8/26/2025 at 10:28 a.m., with DSD 1, LVN 4's Background Report, dated 4/24/2025, was reviewed. The Background Report indicated the following searches were still processing: Social Security Verification and Felony Including Misdemeanor or Other. DSD 1 stated LVN 4's date of hire was 4/13/2022 and the background report should have been completed upon hire. DSD 1 stated LVN 4's background report was conducted approximately three years after her hire date. DSD 1 stated LVN 4's background report was not completed due to two sections processing. DSD 1 stated LVN 4's background report should have been printed and reviewed once all sections were completed. 4. During a concurrent interview and record review, on 8/26/2025 at 10:29 a.m., Registered Nurse (RN) 2's Background Report, dated 3/9/2025, was reviewed. The Background Report did not indicate any criminal issues. DSD 1 stated RN 2's date of hire was 8/3/2023 and the background report should have been completed upon hire. DSD 1 stated RN 2's background report was conducted almost two years after her hire date. 5. During a concurrent interview and record review, on 8/26/2025 at 10:30 a.m., Treatment Nurse (TN) 1's Background Report, dated 4/24/2025, was reviewed. The Background Report did not indicate any criminal issues. DSD 1 stated TN 1's date of hire was 1/11/2025 and the background report should have been completed upon hire. DSD 1 stated TN 1's background report was conducted four months after her hire date. During an interview on 8/26/2025 at 10:38 a.m., with DSD 1, DSD 1 stated a background report was supposed to be conducted upon the staff member's hire date. DSD 1 stated prior to the staff member providing care to the residents, their license and/or certification were reviewed, and a thorough background check was done. DSD 1 stated ensuring the background report was completed assured the staff members were eligible to provide direct care for the residents and were safe to do so. DSD 1 stated by not completing the background checks upon hire, this placed the residents at risk of abuse, crime, and neglect from someone who potentially had history of such crimes. During an interview on 8/26/2025 at 1:05 p.m., with the Director of Nursing (DON), the DON stated the Human Resources Department, or the DSD were responsible for ensuring the newly hired nurses' background reports were completed. The DON stated the background checks were done upon hire to ensure the residents' safety. The DON stated the facility was responsible for knowing each of the nurses' background and ensure they did not have a criminal history where they could potentially hurt the residents. The DON stated retaining the records was necessary to refer to, if needed, and to provide proof that the staff member was cleared of any criminal history prior to working on the floor. The DON stated if a staff member had a criminal record of abuse or neglect and were to abuse a resident, that situation could have been prevented. During a review of the facility's Policy and Procedure (P&amp;P) titled, Employee Screening, revised 2025, the P&amp;P indicated, Background checks and verification of employment eligibility status will be conducted in accordance with our facility's established policies and procedures governing these issues.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to implement their policy and procedure titled Enteral Feedings-Safety Precautions to ensure one of four sampled residents, Resident 2 was in an upright 30-degree position during gastrostomy tube (G-tube- is a tube inserted through the belly that brings nutrition directly to the stomach) feeding. This failure had the potential to result in aspiration (occurs when food or liquid is breathed into the airways or lungs, instead of being swallowed), difficulty breathing, infections and impede progress to wellness. Findings: During a concurrent interview and observation on 08/20/2025 at 11:00 a.m. with the assigned Licensed Vocational Nurse (LVN 1), Resident 2 was observed lying in bed with the head of bed (HOB) at a 20-degree angle, while receiving gastrostomy tube (G-tube- is a tube inserted through the belly that brings nutrition directly to the stomach) feeding of Glucerna 1.2 calorie infusing at 60 cc (cubic centimeters) an hour. LVN 1 stated the head of the bed is lower than a 25-degree angle and it should be at a 30-35-degree angle to decrease the risk of aspirating from the feeding. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD- a common lung disease that makes it difficult to breathe), hemiplegia and hemiparesis following a cerebral infraction (hemiplegia is complete paralysis of one side of the body, while hemiparesis is partial weakness on one side, and both can be caused by a stroke), and aphasia (a neurological disorder that impairs the ability to communicate effectively) following stroke. During a review of Resident 2's Minimum Data Set (MDS- an assessment and care planning tool) dated 6/28/2025, indicated Resident 2 had unclear speech, sometimes understood, and sometimes understands. The MDS indicated Resident 2 was dependent (helper does all the effort) on staff for toileting hygiene, personal hygiene and showering/bathing. During a review of Resident 2's Order Summary Report, dated 8/20/2025, the order summary report indicated Enteral Feed Order every shift for Glucerna 1.2 at 60 cc an hour to deliver 1200 cc/1440 kilocalorie (kcal, unit of energy measurement commonly used in nutrition and food science) daily via g-tube or 20 hours or until completed. Keep head of bed elevated greater than 30-45 degrees at all times while feeding and at least 1 hour after feeding. During a review of Resident 2's care plan related to g-tube feeding, dated 07/12/2025, the care plan indicated Resident 2 was at risk for gastrointestinal (the stomach and intestines, along with the organs and processes involved in digestion, absorption of nutrients, and elimination of waste) complications related to tube feeding such as aspiration, dehydration and nausea, vomiting and diarrhea. The care plan goal indicated Resident 2 will tolerate tube feeding free from complications daily for 90 days. The care plan nursing interventions included elevating the head of the bed at least 30-45 degrees at all times during feeding and at least 1 hour after feeding, check tube placement/patency, and cleanse g-tube site daily and as needed for soilage/leakage or staining. During a review of the facility's policy and procedure titled Enteral Feedings-Safety Precautions revised 2025, indicated to ensure the safe administration of enteral nutrition all personnel responsible for preparing, storing and administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilities. The facility will remain current in and follow accepted best practices in enteral nutrition. Always elevate the head of the bed (HOB) at least 30 -45 during tube feeding and at least 1 hour after. Monitor the tube-fed resident for signs and symptoms of respiratory distress during feedings and medication administration.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 2 and LVN 5 explained the medications being administered to two of three sampled residents (Resident 9 and 10). This deficient practice had the potential to result in Resident 9 and 10 not knowing what medications were administered to them. Findings: a. During a review of Resident 9's admission Record (Face Sheet), the admission Record indicated Resident 9 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 9's Minimum Data Set (MDS- a resident assessment tool), dated 5/11/2025, the MDS indicated Resident 9's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 9 required supervision or touching assistance with eating, toileting, bathing, dressing, and personal hygiene. The MDS indicated Resident 9 took antipsychotic (medication that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior), antidepressant (medication to treat depression), and antiplatelet (medication prevent blood clots from forming) medication. During a review of Resident 9's History and Physical (H&amp;P), dated 6/20/2025, the H&amp;P indicated Resident 9 had fluctuating capacity to understand and make decisions. During a review of Resident 9's Orders, active orders on 8/26/2025, the Orders indicated to administer the following medications: 1. Acidophilus (medication to help digestive health) one capsule by mouth once a day for bowel management. Hold for loose stool. 2. Amantadine (medication used to treat the symptoms of Parkinson's disease and involuntary muscle movements) 100 milligrams (mg, unit of measurement), by mouth three times a day for Parkinson's disease. 3. Aspirin (antiplatelet medication) 81mg, by mouth once a day for cerebrovascular accident (CVA- stroke, loss of blood flow to a part of the brain). 4. Claritin (medication to treat allergy symptoms) 10mg, by mouth once a day, for seasonal allergies. 5. Colace (a stool softener) 250mg, by mouth twice a day for bowel management. Hold for loose stool. 6. Cranberry 450mg, by mouth once a day, for urinary tract infection (UTI- an infection in the bladder/urinary tract) prophylaxis (prevention). 7. Diltiazem (medication to treat high blood pressure) 180mg, by mouth once a day for hypertension (elevated blood pressure). Hold for systolic blood pressure ([SBP], the top number in a blood pressure reading, representing the pressure in the arteries when the heart beats and pumps blood out) less than 110 millimeters of mercury (mm Hg, unit of pressure measurement) or heart rate less than 60 beats per minute (bpm). 8. Flonase Allergy Relief Nasal Suspension (medication to treat allergy symptoms) 50 micrograms (unit of measurement) per actuation (single dose dispensed by an inhaler when pressed), one spray in each nostril once a day for seasonal allergies. 9. Gabapentin (medication to treat nerve pain) 100mg, by mouth three times a day for neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet). 10. Lexapro (an antidepressant medication) 20mg, by mouth once a day for depression manifested by constant crying. 11. Miralax Powder (a laxative to treat and prevent constipation) 17 grams (g, a unit of measurement) per scoop, by mouth once a day for constipation. Hold for loose stool. 12. Multivitamin-Minerals one tablet by mouth once a day as a supplement. 13. Prazosin (medication to treat high blood pressure) 2 mg, by mouth once a day for hypertension. Hold for SBP less than 110 mmHg or heart rate less than 60 bpm. 14. Risperdal (an antipsychotic medication) 2mg, by mouth twice a day, for psychosis manifested by delusions (false beliefs that are firmly held) that someone was out to get him. During an observation on 8/26/2025 at 7:59 a.m., in the hallway near the nurses' station, Licensed Vocational Nurse (LVN) 2 checked Resident 9's blood pressure, which was 126 mmHg, and heart rate which was 79 bpm. LVN 2 proceeded to prepare Resident 9's medications into a medication cup, the medications included: Acidophilus, Amantadine, Aspirin, Claritin, Colace, Cranberry, Diltiazem, Gabapentin, Lexapro, Multivitamin-Minerals, Prazosin, and Risperdal. LVN 2 mixed the Miralax with juice into a cup and shook the Flonase bottle. During an observation on 8/26/2025 at 8:03 a.m., in the hallway near the nurses' station, LVN 2 handed Resident 9 the medication cup and stated, Here are your medications. Resident 9 proceeded to take all the medications in the medication cup and drank the Miralax mixed with juice. LVN 2 sprayed the Flonase into each of Resident 9's nostrils. LVN 2 thanked Resident 9, documented the administration in Resident 9's electronic MAR (eMAR), performed hand hygiene, and moved on to the next resident. During an</p>		