STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555781	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Del Rio	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure, two of seven sampled residents, (Residents 6 and 7), were provided with a safe, clean and home-like environment.This deficient practice had the potential to result in violation of residents' rights.Findings:a). During a concurrent observation and interview on 10/29/2025 at 9:41 a.m. with Resident 6 in Resident 6's room, the bathroom wall had black and red spots, and bathroom door panel was damaged. Resident 6 stated 2 weeks ago, the Maintenance Supervisor (MS) had been notified about the broken bathroom door, and nothing was done about it. Resident 6 stated it was dangerous for his safety because when Resident 6 goes to the bathroom on his wheelchair, the door panel would come out and touch his leg. Resident 6 stated he got hurt (unspecified) 3 weeks ago because one of the paneling touched his foot and hurt Resident 6. Resident 6 stated the maintenance should fix it (the broken bathroom door) because he does not want to get hurt again.During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6's diagnoses included hypertension (HTN-high blood pressure) chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and heart failure (is a condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen.)During a review of Resident 6's History and Physical (H&P) dated 9/23/2025, the H&P indicated Resident 6 did not have the capacity to understand and make decisions.During a review of Residents 6's Minimum Data Set (MDS - a resident assessment tool) dated 8/4/2025, the MDS indicated Resident 6 had intact cognition. The MDS indicated Resident 1 required supervision or touching assistance with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer and mobility. During a concurrent observation and interview on 10/29/2025 at 9:58 a.m., with Housekeeping (HK) 1, HK 1stated Resident's 6's bathroom door had been broken for few weeks. HK 1 stated MS had been notified about Resident 6's broken bathroom door but was not written in the maintenance repair book. During an interview on 10/29/2025 at 10:05 a.m., the Housekeeping Supervisor (HKS) stated it was not acceptable that Resident 6's bathroom door was broken for a long time. The HKS stated Resident 6 could injure his foot while going to the bathroom. The HKS stated it is facility responsibility to ensure residents' safety. b). During a concurrent observation and interview on 10/29/2025 at 9:41 a.m., with MS in Resident 7's room, the MS observed the toilet sit cover broke in half. The MS stated the toilet sit cover should have been fixed so that Resident 7 will have a safe and home-like environment. During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 7's diagnoses included HTN, heart failure and schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions).During a review of Residents 7's MDS dated [DATE], the MDS indicated Resident 7 had moderate// cognitive impairment. The MDS indicated Resident 7 required supervision or touching assistance with ADLs such as dressing, toilet use, personal hygiene, transfer and mobility.During an interview on 10/29/2025 at 11:53 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated if Resident 7's toilet was broken, it placed Resident 7 at risk for skin injuries and fall. During an interview on 10/29/2025 at 1:00 p.m., with HK 2, HK 2 stated Resident 7's toilet seat was observed broken on 10/28/2025 but was not written in the maintenance book and the MS was not informed. During an interview on 10/29/2025 at 1:54 p.m. with MS, the MS stated if there was anything in residents' rooms broken and needing repair, the staff should write the information in the maintenance repair binder at the nurses' station. The MS stated the Maintenance Assistant (MA) would check the binder every morning. During an interview on 10/29/2025 at 2:20 p.m., with the Director of Nursing (DON), the DON stated the facility must ensure the residents' bathrooms, doors, toilet seats and walls are kept clean and in good working condition, and residents are provided with a safe and home-like environment. During a review of the facility's policy and procedures (P&P) titled, Safe and Homelike Environment, dated 1/2025, the P&P indicated the facility should provide residents with a safe, clean, comfortable and homelike environment. During a review of the facility's P&P titled, Maintenance Services, dated 1/2025, the P&P indicated the maintenance department is responsible for maintaining the building is in good repair and free from hazards.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to meet professional standards in preparing and administering medications to three of the five sampled residents' (Residents 1, 2, and 3). This deficient practice had the potential to violate residents' rights and placing the affected residents at risk for drug interactions.Findings: a). During an observation on 10/28/2025 at 9:32 a.m., in Resident 1's room, Licensed Vocational Nurse (LVN) 2 was observed preparing Resident 1'smedications, placed all the medications in a medication cup and told Resident 1, here are your medications. Resident 1 was heard asking LVN 2 the name of the medications before she took it. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing,) hypertension (HTN-high blood pressure) and encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition).During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool) dated 10/27/2025, the MDS indicated Resident 1 had moderate cognitive impairment. The MDS indicated Resident 1 required partial/ moderate assistance with activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer and mobility.During a review of Resident 1's Medication Administration Record (MAR) for 10/2025, the MAR indicated Resident 1 was administered on 10/28/2025 at 9 a.m. Amlodipine 10 milligrams (mg- a unit of measurement) for HTN, oxybutynin 5 mg for overactive bladder, gabapentin 100 mg for nerve pain) and multivitamin supplement. During an interview on 10/28/2025 at 12:10 p.m. with Resident 1, Resident 1 stated nurses never told her what medications she was given to take every day. Resident 1 stated the nurses should let the patients know what medications they are administering, especially if some patients could not talk. b). During a concurrent observation and interview on 10/28/2025 at 9:58 a.m., in Resident 2's room, LVN 3 was observed preparing Resident 2's medications, placed all medications in a plastic cup and gave the cup to Resident 2 without informing the resident what the medications were. LVN 3 stated the medications should have been given to the residents one a time to decrease the risk of any adverse reaction. LVN 3 stated it was Resident 2's right to know what medications he was taking and the nurses' responsibility to explain to the resident what each medication was for before administering them.During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 2's diagnoses included HTN, mood disorder (group of mental conditions characterized by persistent disturbance of mood, especially in the form of depression or euphoria or a combination of these,) sequelae of Vitamin C deficiency (lack of vitamin C).During a review of Resident 2's History and Physical (H&P) dated 10/10/2025, the H&P indicated Resident 2 had the capacity to make decisions for activities of daily living.During a review of Residents 2's MDS dated [DATE], the MDS indicated Resident 2 had moderate cognitive impairment. The MDS indicated Resident 2 was dependent on staff with ADLs such as dressing, toilet use, personal hygiene, transfer and mobility.During a review of Resident 2's MAR for 10/2025, the MAR indicated on 10/28/2025 at 9 a.m., Resident 2 was administered Amlodipine 5 mg, Ascorbic acid (vitamin C) 500 mg for vitamin c deficiency, Aspirin enteric coated (EC- delay release) 81 mg for stroke prophylaxis, Losartan 50 mg for HTN, Multivitamins with minerals for supplement, Depakote 250 mg for schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), seroquel 100 mg for psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality) manifested by delusions someone is out to harm him. During an interview on 10/28/2025 at 11:45 a.m., Resident 2 stated nurses never explain what medications he was given to drink. Resident 2 stated it was his right to know what medications he would take or whether he would take it or not. c). During a concurrent observation and interview on 10/28/2025 at 10:10 a.m., in Resident 3's room, LVN 1 had all of Resident 3's medications crushed in a plastic bag. LVN 1 administered Resident 3's medications via gastrostomy tube (a tube surgically inserted into the stomach for medications and nutrition administration). LVN 1 stated he usually put all medications in one bag and crush them. LVN 1 stated all the medications are going to the same place (unspecified). LVN 1 stated that after the medications were administered, the staff can monitor the residents. LVN 1 stated he does not know what the facility policy was on crushing the medications separate.During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 3's