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	02/27/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the plan of care was re-evaluated and revised for one of three sampled residents (Resident 1) who had on-going rash with complaints of itchiness. These failures had the potential to result in Resident 1 not receiving the necessary care and placed Resident 1 at risk for discomfort, physical decline and worsening skin condition.Findings:During a concurrent observation and interview on 2/26/2026 at 12:50 p.m., with Resident 1, Resident 1 was observed with generalized rash on the resident's back. Resident 1 stated he has had the rash for about one year, with complaints of itchiness especially at night. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 1's diagnoses included atrial fibrillation (an irregular, rapid heart rhythm originating in the atria [the heart's upper chamber]) and unspecified atrial flutter (a type of irregular heartbeat where the atria beat too rapidly).During a review of Resident 1's History and Physical (H&P) dated 7/29/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 2/4/2026, the MDS indicated Resident 1 had moderate cognitive impairment (problems with the ability to think, remember, and solve problems). The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) to perform Activities of Daily Living (ADLs) such as showering/bathing self, and lower body dressing.During a review of Resident 1's Physician's Orders dated 11/21/2025, the Orders indicated to administer the following treatment to Resident 1:Cleanse (rash) with normal saline ([N/S], a saltwater solution), pat dry, apply Ketoconazole External Cream (a medication used to treat infections caused by a fungus or yeast) 2%, topically (on a specific body surface such as the skin) to trunk (the central part of the body, excluding the head, neck, and limbs [arms and legs]), every shift for Dermatitis (a condition that causes swelling and irritation to the skin) for 30 days. Cleanse (rash) with N/S, pat dry, apply Triamcinolone Acetonide External Cream (medication used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions) 0.1%, topically to trunk every day shift for Dermatitis for 30 days. During a review of Resident 1's Care Plan titled, Resident with signs and symptoms related to Dermatitis, Site: Trunk dated 11/21/2025, the Care Plan goal indicated, Resident will have no complaints or scaly, flaky, itchy, red skin x 30 days and will have no allergic reaction (a/r) to Ketoconazole External Cream and Triamcinolone Acetonide Cream during treatment (Tx). The Care plan indicated a re-evaluation should be completed on 12/21/2025.During a review of Resident 1's Progress Notes, dated 12/2025, the Progress Notes did not indicate Resident 1's treatment and plan of care were re-evaluated on 12/21/2025. During a concurrent interview and record review on 2/27/2026 at 2:50 p.m., with Treatment Nurse (TN) 1, the following were reviewed:Resident 1's progress notes, dated 12/21/2025Resident 1's care plan (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled, Resident with signs and symptoms related to Dermatitis, Site: Trunk, dated 11/21/2025.TN 1 stated, resident's skin assessments were done daily and when treatment ends. TN 1 stated, when a resident's treatment ends, staff should notify the wound consultant regarding the status of the treatment to determine whether the current orders should be continued or changed (due to ineffectiveness). TN 1 stated Resident 1's plan of care was not revised or reevaluated (on 12/21/2025) to address whether the resident's dermatitis was resolved. During a concurrent interview and record review on 2/27/2026 at 4:15 p.m., with the Director of Nursing (DON) the following were reviewed:Resident 1's progress notes, dated 12/21/2025Resident 1's care plan titled, Resident with signs and symptoms related to Dermatitis, Site: Trunk, dated 11/21/2025.During an interview on 3/4/2026 at 2:49 p.m., with the DON, the DON stated the treatment nurse should reassess whether a resident's plan of care and treatment were working and (the re-evaluation) should be documented in the progress notes. The DON stated If Resident 1's care plan was not re-evaluated after the target date (of 12/21/2025), Resident 1's skin condition could have worsened.During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans, undated, the P&P 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 that are identified in the resident's comprehensive assessment. The P&P also indicated, The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of three sampled residents (Residents 2 and 3) received treatment and care in accordance with professional standards of practice by failing to:Ensure Licensed Nurses administered treatment for Resident 2's Candidiasis (common fungal skin infection characterized by a bright red, itchy rash) as ordered by the physician.Ensure the physician was notified and treatment orders were obtained when Resident 3 reported an itchy rash to the groin area on 1/31/2026.These failures placed Residents 2 and 3 at risk for discomfort, worsening skin conditions and hospitalization.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 2's diagnoses included Chronic Obstructive Pulmonary Disease, unspecified ([COPD] a chronic lung disease causing difficulty in breathing).During a review of Resident 2's History and Physical (H&P) dated 10/4/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool), dated 12/18/2025, the MDS indicated Resident 2 had no cognitive (ability to think, remember, and solve problems) impairment. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) to perform Activities of Daily Living (ADLs) such as toileting hygiene and showering/bathing self.During a review of Resident 2's Physician's Order dated 1/26/2026, the Order indicated the following treatment to Resident 2:Cleanse (rash) with normal saline ([N/S], a saltwater solution), pat dry, apply Triamcinolone Acetonide External Cream (medication used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions) 0.5% topically (on a specific body surface), under right and left breast every day and evening shift for Candidiasis for 14 days. During a review of Resident 2's Treatment Administration Record (TAR), for the month of 1/2026, the TAR did not indicate treatment and Triamcinolone were administered to Resident 2 during the evening shifts on 1/27/2026, 1/28/2026, 1/29/2026, and 1/31/2026.During a review of Resident 2's Physician's Orders dated 2/9/2026, the Orders indicated to administer the following treatment to Resident 2:Cleanse (rash) with N/S, pat dry, apply Nystatin Powder (medication used to treat fungal skin infections) to buttocks topically every day and every evening shift for Candidiasis for 30 days, Cleanse (rash) with N/S, pat dry, apply Nystatin Powder topically to perineal area (the surface of the body located between the anus and the genital organs) leave open to air every day and evening shift for Candidiasis for 30 days.Cleanse (rash) with N/S, pat dry, apply Triamcinolone Acetonide External Cream 0.5% topically to buttocks, leave open to air every day and evening shift for Candidiasis for 14 days. Cleanse (rash) with N/S, pat dry, apply Triamcinolone Acetonide External Cream 0.5% topically to perineal, leave open to air every day and evening shift for Candidiasis for 14 days. During a review of Resident 2's TAR, for the month of 2/2026, the TAR did not indicate Nystatin Powder and Triamcinolone Cream were administered to Resident 2 during the evening shifts on 2/11/2026, 2/12/2026, and 2/19/2026.During a concurrent interview and record review on 2/27/2026 at 1:40 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 2's TAR for the month of 1/2026 and 2/2026 were reviewed. LVN 1 stated licensed nurses did not administer Triamcinolone and treatment as ordered to Resident 2's left and right breasts during the evening shifts on 1/27/2026, 1/28/2026, 1/29/2026 and 1/31/2026. Licensed nurses did not administer Triamcinolone and Nystatin as ordered to the Resident's buttocks and perineal during the evening shifts on 2/11/2026, 2/12/2026 and 2/19/2026. During a concurrent interview and record review on 2/27/2026 at 2:50 p.m., with Treatment Nurse (TN) 1, Resident 2's TAR, for the month of 1/2026 and 2/2026, were reviewed. TN 1 stated Resident 2 did not receive (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	all her evening treatment and doses of Nystatin and Triamcinolone as ordered on 1/2026 and 2/2026. RN 1 stated it was important to ensure Resident 2 received her treatment twice a day to ensure Resident 2's skin issues could be resolved. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 3's diagnoses included pneumonia (an infection/inflammation of the lung), and epilepsy (a brain condition that causes seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness).During a review of Resident 3's H&P dated 10/31/2025, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had moderate cognitive impairment. 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) to perform ADLs such as oral and toileting hygiene.During a review of Resident 3's Progress Notes, dated 1/31/2026, the Progress Notes indicated Resident 3 complained of (c/o) itchiness to groin area, and had red, raised, rashes. The Progress Note indicated the physician was called, and awaiting response on treatment needed. During a concurrent interview and record review on 2/27/2026 at 1:40 p.m., with LVN 1, Resident 3's Progress Notes, dated 1/31/2026 and 2/1/2026, TAR for the months of 1/2026 and 2/2026, and 24-Hour Report (a communication tool used between nurses) dated 1/31/2026 were reviewed. LVN 1 stated there was no supporting documentation to indicate nurses were able to reach the physician regarding the resident's rash identified on 1/31/2026. LVN 1 stated treatment orders for Resident 3's rash were not obtained until 2/6/2026 (six days later). LVN 1 stated it was not acceptable to leave Resident 3 without treatment for her rash because it could cause the resident's symptoms to become worse. During a concurrent interview and record review on 2/27/2026 at 4:15 p.m., with the Director of Nursing (DON), the following records were reviewed:Resident 2's TAR, dated 1/2026 and 2/2026Resident 3's Progress Note dated, 1/31/2026 and 2/1/2026Resident 3's TAR, dated 1/2026 and 2/202624-Hour Report Sheet, dated 1/31/2026.The DON stated, the nurses did not administer all doses of Nystatin and Triamcinolone to Resident 2 for 1/2026 and 2/2026. The DON stated this could have caused Resident 2's skin condition to worsen. The DON stated all treatment should have been administered as ordered by the physician. The DON stated staff should have communicated to the upcoming shift if they were waiting for physician's orders to prevent symptoms from worsening for Resident 3. The DON stated not getting orders for Resident 3 until 6 days later was a delay of care. During a review of the facility's undated policy and procedure (P&P) titled, Medication Administration,, 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 in accordance with professional standards of practice in a manner to prevent contamination or infection.During a review of the facility's undated P&P titled, Change in a Resident's Condition or Status, 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. The P&P also indicated, The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been a need to alter the resident's medical treatment significantly.