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	04/24/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on observation, interview, and record review, the facility failed to: 1. Complete and timely submit the referral for probate conservatorship application (referral to the court to appoint a conservator [an appointed person to act or make decisions for a person who cannot make decisions for themselves]) for two of 13 sampled residents (Residents 114 and 41), whom did not have the capacity to make decisions. This deficient practice resulted in a delay in the process of obtaining a conservator, a lack of sound oversite of Resident 114 and 41's medical care and treatments, and improper notification of changes. 2. Ensure the Minimum Data Set (MDS, a resident assessment tool) reflected Resident 159's and Resident 39's preference to use an interpreter, and Resident 39's preferred language of Cantonese. 3. Provide Resident 58 with a communication board (a visual aid, typically a laminated sheet or panel, that uses symbols, pictures, or illustrations to help people communicate their needs, wants, and thoughts). These deficient practices placed Residents 159, 39, and 58 at risk of not being able to participate in their plan of care, and for staff to be unable to understand and meet the residents' needs. Cross Reference F552. Findings: 1. During a review of Resident 41's Admission Record (Face Sheet), the Face Sheet indicated Resident 41 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and mood disorder (conditions that primarily affect a person's emotional state, causing significant distress or impairment in their daily life). The Face Sheet indicated Resident 41 was self-responsible and did not have an emergency contact nor next of kin listed. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 41's Minimum Data Set ([MDS], a resident assessment tool), dated 2/7/2025, the MDS indicated Resident 41's cognition (process of thinking) was severely impaired. The MDS indicated Resident 41 required maximal assistance (helper does more than half the effort) with toileting, bathing, and lower body dressing. During a concurrent interview and record review on 4/23/2025 at 11:05 a.m., with the Social Services Director (SSD), Resident 41's History and Physical (H&P) dated 6/12/2024 and 2/3/2025, were reviewed. The SSD stated based on the H&Ps, Resident 41 did not have the capacity to understand and make decisions. The SSD stated Resident 41 did not have a family member as his responsible party nor an appointed conservator. The SSD stated he was unsure who was making medical decisions for Resident 41, however, Resident 41's Face Sheet indicated he was self-responsible so he would assume Resident 41 was making uninformed decisions for himself. The SSD stated Resident 41 was on his list of residents to refer for probate conservatorship, but the application was not completed nor submitted. The SSD stated Resident 41's referral should have been completed and submitted when Resident 41's physician deemed him unable to understand and make decisions to begin the process of obtaining a conservator. The SSD stated initiating the process would ensure a conservator was appointed to Resident 41 to support him and make informed medical decisions for him. The SSD stated Resident 41 was at risk of receiving treatments from the physician that Resident 41 would not be able to make an informed decision on receiving. During an interview on 4/23/2025 at 2:53 p.m., with the Director of Nursing (DON), the DON stated Resident 41 was unable to make decisions for himself due to his cognition. The DON stated Resident 41 should not be self-responsible and should have an appointed person to make medical decisions for him, to decide whether a treatment or medication were appropriate, and to decline if needed. 47858 2. During a review of Resident 114's Admission Record, the Admission Record indicated Resident 114 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 114's diagnoses included dementia, cerebral infarction (stroke, loss of blood flow to a part of the brain), aphasia (a disorder that makes it difficult to speak), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting right dominant side. During a review of Resident 114's MDS, dated [DATE], the MDS indicated Resident 114's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 114 was entirely dependent (helper does all the task) on staff for bathing, toileting, performing personal hygiene, sitting to standing, and transferring from the bed to a chair. The MDS indicated Resident 114 had an active diagnosis of a stroke. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/22/2025 at 12:29 p.m. with the SSD, Resident 114's H&P, dated 1/6/2025, Change of Condition Note, dated 1/14/2025, and Admission Record, was reviewed. The H&P indicated Resident 114 lacked the capacity to understand and make decisions. The Change of Condition Note indicated Resident 114 was self-responsible and no other responsible parties or emergency contacts were notified of 114's transfer to the General Acute Care Hospital (GACH). Resident 114's Admission Record indicated Resident 114 was self-responsible and had three emergency contacts listed with phone numbers that were no longer in service. The SSD stated the information on the Admission Record was incorrect and not updated. The SSD stated a resident would need an appointed public guardian if a resident did not have the capacity to understand and make decisions and did not have family members to aid the resident with making medical and financial decisions. The SSD stated Resident 114 required a public guardian to be informed and make decisions on her behalf. The SSD stated he did not begin the process to apply for a public guardian for Resident 114 (since 1/2025) because he did not know Resident 114 was deemed unable to make medical decisions and the facility did not update the Admission Record. The SSD stated the facility lacked a system to ensure the information on the Admission Record matched the information on the residents' H&P documentation. The SSD stated he would have applied for public guardianship for Resident 114 if Resident 114's Admission Record had been updated and he was made aware Resident 114's H&P indicated Resident 114 lacked the capacity to make medical decisions. The SSD stated this resulted in a lack of proper notification of Resident 114's responsible party when she was transferred to the GACH (on 1/14/2025) and had the potential to result incorrectly completed psychotropic medication (medications are drugs that affect the mind, emotions, and behavior) consent forms, and improper notification of changes for Resident 114 since 1/2025. The SSD stated all residents had the right to a responsible party or a public guardian to make sound medical and financial decisions and to be notified of medical changes. During a review of the facility's Policy and Procedure (P&P) titled, Responsible Party (undated), the P&P indicated the facility was to provide a mechanism by which medical treatment, or health care decisions can be made for a resident that includes but is not limited to family member, public guardian, conservator, who can take full responsibility for healthcare decisions. The P&P indicated the following when the Physician and facility staff deemed a resident incapable of making medical treatment/health care decisions. The P&P indicated: 1. Social Services staff would clarify or notify the resident's responsible party or surrogate decision maker. 2. When #1 has been clarified, the resident's responsible party/surrogate decision maker would become the responsible party and the resident's primary physician would be notified. During a review of the facility's P&P titled, Change in Resident's Condition or Status, revised 2025, the P&P indicated the facility would notify the resident's family or representative when there was a significant change in the resident's physical, mental, or psychosocial status and when a resident is transferred to a hospital, or treatment center. 3. During a review of Resident 39's Admission Record, the Admission Record indicated the facility admitted Resident 39 on 8/30/2022, and most recently readmitted Resident 39 on 11/23/2024. Resident 39's admitting diagnoses included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and depression (a persistent mood disorder characterized by a lasting feeling of sadness and loss of interest in activities). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 39's MDS, dated [DATE], the MDS indicated Resident 39's preferred language was English, and indicated Resident 39 did not need or want an interpreter to communicate with doctors or healthcare staff. The MDS indicated Resident 39 had moderate cognitive impairment. The MDS indicated Resident 39 required supervision or touch assistance from staff to clean her teeth, maintain personal hygiene, and dress her lower body. The MDS indicated Resident 39 required supervision or touch assistance from staff to transition from a sitting to standing position, transfer between surfaces, and to walk. During an observation on 4/22/2025 at 9:46 a.m., at Resident 39's bedside, observed a communication board which contained simple photos with Cantonese translations that allowed Resident 39 to convey simple needs. The communication board did not allow for more complex requests or those not already included on the communication board. During an interview on 4/23/2025 at 11:15 a.m., with Resident 39, Resident 39 stated she spoke Cantonese. During a concurrent interview and record review, on 4/23/2025 at 11:16 a.m., with MDSN 1, Resident 39's MDS, dated [DATE], was reviewed. MDSN 1 stated the MDS indicated Resident 39's preferred language was English, and indicated Resident 39 did not want or need an interpreter when talking to doctors or healthcare staff. MDSN 1 stated Resident 39 spoke some English so he assumed she preferred English and would not want or need an interpreter. MDSN 1 stated he did not ask the resident or her family to verify this information. During an interview on 4/23/2025 at 11:32 a.m., with Resident 39's Family Member (FM) 1, FM 1 stated Resident 39 spoke some English, but preferred to speak Cantonese and could better understand Cantonese. During an interview on 4/23/2025 at 12:16 p.m., with Certified Nurse Assistant (CNA) 3, CNA 3 stated Resident 39 did not speak English, but she did not know what language Resident 39 was speaking. CNA 3 stated she could not understand anything Resident 39 was saying. CNA 3 stated no one had communicated to her that Resident 39 spoke Cantonese. CNA 3 stated she would ask Resident 39 yes or no questions, and Resident 39 would answer in English with yes or no. CNA 3 stated she could not verify Resident 39 understood the question. During an interview on 4/24/2025 at 10:21 a.m., with Licensed Vocational Nurse (LVN) 4, LVN 4 stated he used his hands a lot and used simple yes or no questions when communicating with Resident 39. LVN 4 stated staff were unable to communicate beyond yes or no questions. LVN 4 stated he tried to administer Resident 39's scheduled medications, and Resident 39 refused all of them. LVN 4 stated he attempted to administer Resident 39's medications and explain them to her in English. LVN 4 stated he was not sure what Resident 39's primary language was, but he heard her speaking a non-English language. LVN 4 stated Resident 39 would benefit from an interpreter, but he did not use one when communicating with her. Stated he did not know if interpreter services were available for staff to use and had never been trained to use them. During an interview on 4/24/2025 at 11:17 a.m., with the Director of Staff Development (DSD), the DSD stated the facility had interpreter services available, but staff were not provided with training on how to access it. The DSD stated the communication boards available to the facility residents were for basic needs only and limited to simple communication. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. During a review of Resident 159's Admission Record, the Admission Record indicated the facility admitted Resident 159 on 2/6/2025. Resident 159's admitting diagnoses included COPD and depression. During a review of Resident 159's MDS, dated [DATE], the MDS indicated Resident 159's preferred language was Korean, and indicated Resident 159 did not want or need an interpreter when talking to doctors or healthcare staff. The MDS indicated Resident 159 had moderate cognitive impairment and required supervision or touch assistance from staff to clean his teeth, dress his upper and lower body, put on and take off his shoes, and maintain personal hygiene. During an interview on 4/21/2025 at 3:13 p.m., with Resident 159, Resident 159 stated the staff speak to him in English or Spanish, and he could not understand them most of the time. Resident 159 stated he had not observed staff using the Korean communication board at the bedside. During an interview on 4/23/2025 at 10:53 a.m., with CNA 3, CNA 3 stated she spoke to Resident 159 in English. CNA 3 stated she does the best she can to communicate with Resident 159, but did not use an interpreter or translation services. During a concurrent interview and record review, on 4/23/2025 at 11:02 a.m., with MDSN 1, Resident 159's MDS, dated [DATE], was reviewed. MDSN 1 stated the MDS indicated Resident 159's MDS indicated Resident 159's preferred language was Korean, and indicated Resident 159 did not want or need an interpreter when talking to doctors or healthcare staff. MDSN 1 stated he did not ask Resident 159 if he wanted or needed an interpreter. MDSN 1 stated Resident 159 spoke some English so he assumed he would not want or need an interpreter. During an interview on 4/23/2025 at 11:45 a.m., with LVN 1, LVN 1 stated Resident 159 barely spoke English, and stated she was not aware if interpreter services were available for staff use. LVN 1 stated it was important to talk to residents in their preferred language to prevent bias, to perform accurate assessments, and to ensure the resident understood their plan of care. LVN 1 stated it was also for the resident's safety. 5. During a concurrent observation and interview on 4/22/2025 at 8:54 a.m. while in Resident 58's room, Resident 58 was observed sitting in a wheelchair next to her bed. Resident 58 was alert and oriented. Resident 58 could not speak but was unable to state that she understood by shaking her head yes. Resident 58 did not have any type of communication board/device at bedside to assist her with communication. During a review of Resident 58's Admission Record (Face Sheet - front page of the chart that contains a summary of basic information about the resident), dated 4/24/2025, the admissions record indicated Resident 58 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses which included aphasia (a disorder that makes it difficult to speak) following a nontraumatic (not caused by a physical impact or force to the head) intracerebral hemorrhage (bleeding in the brain). During a review of Resident 58's History and Physical (H&P), dated 1/9/2025, the H&P indicated Resident 58's was bed-bound (confined to bed), non-verbal and alert and oriented to person. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 58's Minimum Data Set (MDS - a resident assessment tool), dated 1/24/2025, the MDS indicated Resident 58's cognitive skills (ability to think, remember and reason) for daily decision making were moderately impaired. The MDS indicated Resident 58 had no speech and could usually understand others but had limited ability to make concrete requests. The MDS indicated Resident 58 was dependent (helper does all the effort) for eating, toileting, and bathing. During a review of Resident 58's care plan titled, Communication, initiated on 12/4/2023, the care plan indicated Resident 58 had impaired communication as evidenced by an expressive problem (difficulty finding the right words), absent, slurred or unclear speech due to cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) and aphasia. The care plan indicated to use alternative communication tools such as signs or gestures. During an interview on 4/24/2025 at 8:49 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 58 did not have a communication device at bedside but believed she (Resident 58) would benefit from some type of communication board at the bedside. LVN 2 stated Resident 58 could not get the proper help she needed without a way for the staff to communicate with her. LVN 2 stated Resident 58 may have begun to feel sad or get become frustrated if she could not be understood. During a review of the facility's policy and procedure (P&P) titled Communicating with Persons with Limited English Proficiency, updated 1/2025, the P&P indicated staff were to ensure meaningful communication was provided to persons with LEP involving their medical conditions and treatment. The P&P indicated staff were to identify the language and communication needs of the LEP person. The P&P indicated all staff were to be trained in effective communication techniques, including the effective use of an interpreter. The P&P indicated communication boards were to be made available if needed.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) prior to administration of psychotropic medication (medications that affect the mind, emotions, and behavior) for five of seven sampled residents (Residents 41, 122, 114, 45, and 109) by failing to: 1. Obtain informed consent from Resident 41, who did not have the capacity to understand and make decisions, for the use of aripiprazole (an antipsychotic medication [a medication that affects the mind, emotions, and behavior]), Depakote (an anticonvulsant medication, a medication used to prevent or treat seizures and can be used to treat behavioral disorders), and Lexapro (an antidepressant [a medication used to treat depression, which is a mood disorder that causes a persistent feeling of sadness and loss of interest]). This deficient practice resulted in Resident 41, who was unable to understand and make decisions, making uninformed decisions about his care and unable to understand the use, side effects, and risks of taking psychotropic medications. 2. Obtain informed consent from Resident 122's Public Guardian ([PG], responsible for the care of individuals who were no longer able to make decisions or care for themselves) for the use of quetiapine (an antipsychotic medication), Depakote, and Trazodone (an antidepressant). This deficient practice resulted in the removal of Resident 122's PG's right to make decisions about the care and treatment Resident 122 received in the facility. 3. Renew Resident 114's psychotropic medication consent form every six months for Resident 114's prescribed daily dose of Haloperidol Oral Concentrate (an antipsychotic medication). 4. Ensure Resident 45 had a signed and completed informed psychotropic consent for Resident 45's prescribed monthly injection of Invega Sustenna (an antipsychotic). 5. Ensure Resident 109's informed consents for Abilify (an antipsychotic) was complete. These deficient practices resulted in the violation of Resident 114, 45, and 109's right to make an informed decision regarding the use of psychotropic medication and had the potential for increased the risk they could experience adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Cross Reference F550. Findings: (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a review of Resident 41's Admission Record, the Admission Record indicated Resident 41 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and mood disorder (conditions that primarily affect a person's emotional state, causing significant distress or impairment in their daily life). The Admission Record indicated Resident 41 was self-responsible and did not have an emergency contact nor next of kin listed. During a review of Resident 41's Minimum Data Set ([MDS], a resident assessment tool), dated 2/7/2025, the MDS indicated Resident 41's cognition (process of thinking) was severely impaired. The MDS indicated Resident 41 required maximal assistance (helper does more than half the effort) with toileting, bathing, and lower body dressing. The MDS indicated Resident 41 received antipsychotic, antidepressant, and anticonvulsant medication. During a review of Resident 41's History and Physical (H&P), dated 2/3/2025, the H&P indicated Resident 41 did not have the capacity to understand and make decisions. During a review of Resident 41's Orders, dated 2/3/2025, the Orders indicated to give: 1. Aripiprazole 10 milligrams (mg, a unit of measurement), one tablet by mouth at bedtime, for schizoaffective disorder manifested by screaming. 2. Depakote 125mg, three tablets by mouth, twice a day, for mood disorder as manifested by attempting to strike out. 3. Lexapro 5mg, one tablet by mouth, once a day, for depression manifested by crying. During a review of Resident 41's Medication Administration Record ([MAR], a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 2/1/2025 through 2/28/2025, the MAR indicated: 1. Resident 41 received the first dose of aripiprazole 10 mg on 2/3/2025 at 9 p.m. 2. Resident 41 received the first dose of Lexapro 5 mg on 2/4/2025 at 9 a.m. 3. Resident 41 received the first dose of Depakote 375 mg on 2/4/2025 at 9 a.m. During an interview on 4/23/2025 at 11:05 a.m., with the Social Services Director (SSD), the SSD stated Resident 41 was unable to understand and make decisions for himself therefore Resident 41 should not be consenting to medical treatments or medications. The SSD stated Resident 41 should have been referred to obtain a conservator (an appointed person to act or make decisions for a person who cannot make decisions for themselves) who would advocate for Resident 41 and determine whether a prescribed treatment or medication was appropriate for Resident 41 to receive. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/23/2025 at 2:55 p.m., with the Director of Nursing (DON), Resident 41's Informed Consents for Psychotherapeutic Drugs, dated 2/3/2025, were reviewed. The DON stated informed consent for the use of aripiprazole, Lexapro, and Depakote were obtained from Resident 41. The DON stated informed consent for those medications should not have been obtained from Resident 41 because he did not have the capacity to understand and make decisions. The DON stated the facility should have initiated the process to obtain a conservator for Resident 41 to ensure Resident 41 had an appointed person to make medical decisions for him, to decide whether a treatment or medication were appropriate, and to decline if needed. The DON stated Resident 41 may have agreed to the use of aripiprazole, Lexapro, and Depakote, but he did not fully understand the use, side effects, and risks of taking those psychotropic medications. 2. During a review of Resident 122's Admission Record, the Admission Recrd indicated Resident 122 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), anxiety disorder (condition characterized by excessive, persistent, and often irrational worry, fear, and nervousness that can often interfere with daily life), schizoaffective disorder, and major depressive disorder. The Admission Record indicated Resident 122 had an appointed Public Guardian (PG). During a review of Resident 122's MDS, dated [DATE], the MDS indicated Resident 122's cognition was intact. The MDS indicated Resident 122 required supervision with oral hygiene, toileting, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 122 received antipsychotic, antidepressant, and anticonvulsant medication. During a review of Resident 122's Orders, dated 1/16/2025, the Orders indicated to give: 1. Depakote 500 mg, one tablet by mouth, three times a day for schizoaffective disorder as manifested by attempting to strike out at staff when providing care. 2. Quetiapine 50 mg, one tablet by mouth, once a day for psychosis (a state where a person loses touch with reality, experiencing distortions in their thoughts and perceptions) as manifested by delusions (an unshakable belief in something that is untrue) that somebody is out to get him. 3. Quetiapine 100 mg, one tablet by mouth, at bedtime for psychosis as manifested by delusions that somebody is out to get him. 4. Trazodone 100 mg, one tablet by mouth, at bedtime for depression as manifested by verbalizing feelings of hopelessness. During a review of Resident 122's MAR, dated 1/1/2025 through 1/31/2025, the MAR indicated: 1. Resident 122 received the first dose of quetiapine 50 mg on 1/17/2025 at 9 a.m. 2. Resident 122 received the first dose of quetiapine 100 mg on 1/16/2025 at 9 p.m. 3. Resident 122 received the first dose of trazodone 100 mg on 1/16/2025 at 9 p.m. 4. Resident 122 received the first dose of Depakote 500 mg on 1/16/2025 at 1 p.m. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/2025 at 1:26 p.m., with Registered Nurse (RN) 1, RN 1 stated with any psychotropic medication order, the licensed nurse was responsible for obtaining informed consent from the resident or their responsible party (RP), whichever is applicable. RN 1 stated obtaining informed consent was necessary to ensure the resident and/or their RP were aware of the necessary use, the probable side effects, and the risks and benefits of the medication ordered. RN 1 stated during that time, any questions would be encouraged, and other necessary information would be provided. During a concurrent interview and record review on 4/23/2025 at 1:33 p.m., with RN 1, Resident 122's Informed Consent for Psychotherapeutic Drugs, undated, were reviewed. RN 1 stated her signature were on the Informed Consents for Resident 122's use of quetiapine, Depakote, and trazodone, however, the Informed Consents did not indicate who informed consent was obtained from nor the date. RN 1 stated when Resident 122 was readmitted on [DATE], informed consent for any psychotropic medications had to be obtained. RN 1 stated she could not recall why the Informed Consents were not completed; it was a possibility she was unable to speak with Resident 122's PG. RN 1 stated the Informed Consents for quetiapine, Depakote, and trazodone were not complete, which indicated informed consent was not obtained from Resident 122's PG prior to their administration to Resident 122. During an interview on 4/23/2025 at 3:15 p.m., with the DON, the DON stated due to Resident 122's incomplete Informed Consent forms for quetiapine, Depakote, and trazodone, it meant that Resident 122's PG was not given the opportunity to make an informed decision to proceed with the ordered treatment. The DON stated Resident 122's PG should have been given that opportunity as it was their right to make an informed decision regarding Resident 122's care. 47858 3. During a review of Resident 114's Admission Record, the Admission Record indicated Resident 114 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 114's diagnoses included dementia, cerebral infarction (stroke, loss of blood flow to a part of the brain), aphasia (a disorder that makes it difficult to speak), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the right dominant side. During a review of Resident 114's MDS, dated [DATE], the MDS indicated Resident 114's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 114 was entirely dependent (helper does all the task) on staff for bathing, toileting, performing personal hygiene, sitting to standing, and transferring from the bed to a chair. The MDS indicated Resident 114 had an active diagnosis of a stroke. During a review of Resident 114's H&P, dated 1/6/2025, the H&P indicated Resident 114 did not have the capacity to make medical decisions. (continued on next page)

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	555781	A. Building B. Wing	04/24/2025

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Villa Del Rio	7002 Gage Avenue Bell Gardens, CA 90201

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/22/2025 12:44 p.m. with the DON, Resident 114's Psychotropic Consent Form, dated 12/7/2022, H&P, dated 1/6/2025, Order Summary Report, dated 4/23/2025, and Resident 114's Admission Record were reviewed. The Psychotropic Consent Form indicated consent was obtained for the administration of Haloperidol Oral Concentrate (a drug used to treat mood disorders) 2 milligrams per milliliter (mg/mL- a unit of measurement) at bedtime for psychosis manifested by striking out on 12/7/2022. The H&P, dated 1/6/2025, indicated Resident 114 did not have the capacity to make medical decisions. The Order Summary Report indicated Resident 114 was recently ordered Haloperidol Oral Concentrate 2mg/mL at bedtime on 4/15/2025. Resident 114's Admission Record indicated Resident 114 was self-responsible and had three emergency contacts listed with phone numbers that were no longer in service. The DON stated Resident 114's Psychotropic Consent Form for Haldol was outdated. The DON stated current regulation required the consent forms to be renewed every six months. The DON stated a new Psychotropic Consent Form should have been obtained when a new order for Haldol was placed on 4/15/2025. The DON stated it was important to ensure informed consent was properly obtained and renewed so that the facility could ensure Resident 114's responsible party or public guardian was made aware of the risks and the benefits of the psychotropic medication that Resident 114 was ordered. 4. During a review of Resident 45's Admission Record, the Admission Record indicated Resident 45 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 45's diagnoses included dementia, schizoaffective disorder, and depression. During a review of Resident 45's MDS, dated [DATE], the MDS indicated Resident 45's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 45 partial, or moderate assistance (helper does less than half of the effort) for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent interview and record review on 4/23/2025 at 1:00 p.m. with Minimum Data Set Nurse (MDSN) 2, Resident 45's H&P, dated 1/25/2025, Order Summary Report, dated 4/23/2025, and all of Resident 45's Psychotropic Consent Forms, dated in 2025, were reviewed. The H&P, dated 1/25/2025, indicated Resident 45 did not have the capacity to make medical decisions. The Order Summary Report indicated Resident 45 was ordered an Invega Sustenna Intramuscular (in the muscle) Suspension Prefilled Syringe 117 milligrams per 0.75 milliliter (one syringe) to be injected intramuscularly one time a day starting on the 26th and ending on the 26th every month for self-harm picking own skin related to schizoaffective disorder. There were no consent forms for any of the psychotropic medications. MDSN 2 stated Resident 45 should have had a psychotropic consent form completed for Resident 45's order of the monthly Invega injection. MDSN 2 stated it was important the facility maintained documentation of Resident 45's psychotropic consent forms to ensure Resident 45's public guardian was made aware of the risks and the benefits of the psychotropic medication that Resident 45 was administered. 48343 5. During a review of Resident 109's Admission Record, the Admission Record indicated Resident 109 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizoaffective disorder, Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), bipolar disorder, and major depressive disorder. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 109's MDS, dated [DATE], the MDS indicated Resident 109's cognitive skills for daily living was moderately impaired. The MDS indicated Resident 109 required supervision or touching (helper provides verbal cues and/or touching assistance as resident completes activity) from staff for ADLs. The MDS indicated Resident 109 received antipsychotic medication. During a review of Resident 109's order summary report, dated 10/6/2024, the order summary report indicated, Resident 109's attending physician prescribed Abilify 15 mg by mouth once daily for schizoaffective disorder. During a concurrent interview and record review on 4/24/2025 at 9:40 a.m., with Licensed Vocational Nurse (LVN) 3, Resident 109's informed consent for psychotherapeutic drugs was reviewed. LVN 3 stated Resident 109's informed consent was missing both the resident's printed name and the date. LVN 3 stated Resident 109's informed consent was signed by an unidentified nurse and dated 7/27/2024. LVN 3 stated the informed consent did not indicate the nurse verified with the resident or resident's representative (RR) that the physician obtained informed consent prior to the initiation of Abilify. LVN 3 stated Resident 109's informed consent indicated the name of the resident and/or RR, his/her signature and date were blank. LVN 3 stated Resident 109's informed consent for the use of psychotropic medication Abilify was incomplete. LVN 3 stated licensed staff should have obtained the verification of Resident 109's informed consent and should have the resident's name and/or RR, signature and date. During an interview on 4/24/2025 at 3:45 p.m., with the DON, the DON stated the facility failed to ensure Resident 109's informed consent for Abilify was fully completed and the resident was fully informed of his treatment. The DON stated this violated the resident's right to make an informed decision about his treatment and could result in the resident receiving medication without understanding the reasons, risks and alternatives. During a review of the facility's policy and procedure (P&P) titled, Consent- Informed, revised 1/2025, the P&P indicated: 1. The nurse will witness that the informed consent has been obtained by the physician from the patient/resident of legal guardian for treatments, procedures, and psychotropics with significant risk. 2. The physician would sign and date the informed consent prior to treatment. 3. The resident would sign and date the informed consent prior to treatment.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to promote respect and dignity by failing to ensure dentures were provided for one of six sampled residents (Resident 40). This deficient practice negatively impacted Resident 40's quality of life and resulted in feelings of embarrassment due to her appearance and inability to chew her food. Findings: During a review of Resident 40's Admission Record, the admission record indicated Resident 40 was initially admitted on [DATE] and readmitted on [DATE] with the following diagnoses which included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), epilepsy (a brain condition that causes recurring seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 40's Minimum Data Set (MDS - a resident assessment tool), dated 2/8/2025, the MDS indicated Resident 40's cognition (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 40 could usually be understood and could usually understand others. The MDS indicated Resident 40 required set-up assistance (helper assists only prior to or following the activity) with eating and supervision (helper provides verbal cues and/or touching/steadying as resident completes the activity) for oral hygiene. The MDS indicated Resident 40 was edentulous (had no natural teeth). During a review of Resident 40's dental care assessment, dated 6/10/2024, the dental care assessment indicated a treatment recommendation for full upper dentures and full lower dentures. During a review of Resident 40's dental care assessment, dated 7/16/2024, the dental care assessment indicated Resident 40's upper and lower dentures were delivered to the facility and signed and dated by an unknown staff member. During a review of Resident 40's dental care annual assessment, dated 9/25/2024, the dental care annual assessment indicated Resident 40 was edentulous. During a review of Resident 40's Order Summary Report, dated 11/26/2024, the order summary report indicated a regular texture (a diet that requires no modifications in size) and thin consistency diet. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/21/2025 at 10:25 a.m., with Resident 40, Resident 40 was observed with no upper or lower teeth. Resident 40 stated she had all of her teeth when she was first admitted in the facility. Resident 40 stated she did not know what happened to her teeth. Resident 40 stated it was difficult to chew her food without any teeth. Resident 40 stated she did not have any dentures and was forced to gnaw on her food like a dog. Resident 40 stated, It's embarrassing, I look like an old lady! Resident 40 pressed her lips together and mumbled through her lips, I have to talk with my mouth closed so no one can tell I don't have teeth in my mouth. Resident 40 stated she would cover her mouth with her hand whenever she smiled. Resident 40 stated she asked nursing staff what happened to her teeth but stated the staff ignored her. During a concurrent observation and interview on 4/23/2025 at 12:05 p.m., with Licensed Vocational Nurse (LVN) 2, in Resident 40's room, LVN 2 observed Resident 40 in her room eating lunch. Resident 40 did not have any teeth. LVN 2 asked Resident 40 where her dentures were and the resident replied she did not know what happened to her dentures. Resident 40 stated, This is so embarrassing! LVN 2 stated Resident 40 was on a regular diet. LVN 2 stated she did not know where Resident 40's dentures were, and she was unaware Resident 40 had been eating a regular diet without her dentures. LVN 2 stated Resident 40 should have been on a mechanical soft (foods that are soft and easy to chew) diet because the resident was attempting to chew her food with no teeth. LVN 2 stated if Resident 40 had dentures she would have been able to chew her food without difficulty. During an interview on 4/24/2025 at 9:05 a.m. with the Social Services Director (SSD), the SSD stated the dentist gave the dentures to the resident and would have a staff member sign for the dentures. The SSD stated he was unaware Resident 40 received dentures. The SSD stated the staff that signed for the dentures should have notified him so that he could have added them to Resident 40's inventory list. The SSD also stated the nursing staff should have informed him Resident 40 did not have her dentures so that he could order a new pair. During an interview on 4/24/2025 at 9:32 a.m. with Certified Nurse Assistant (CNA) 8, CNA 8 stated she was unaware Resident 40 did not have teeth or dentures because she did not assist the resident with eating or oral care. During an interview on 4/24/2025 at 2:23 p.m. with the Director of Nursing (DON), the DON stated it was a dignity issue for Resident 40 because the resident was embarrassed about her appearance and did not have teeth to eat her meals. The DON stated the nursing staff should have made sure Resident 40 had her dentures when performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of the facility's policy and procedure (P&P) titled, Promoting/Maintaining Resident Dignity, updated January 2025, the P&P indicated, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment that maintains or enhances resident's quality of life. The P&P indicated all staff members are involved in providing care to residents to promote and maintain resident dignity and respect residents' rights. The P&P indicated when interacting with a resident, pay attention to the resident as an individual and groom and dress resident according to resident preference. During a review of the facility's P&P titled, Dentures, Cleaning and Storing, updated 2025, the P&P indicated the following: (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Provide denture care before breakfast and at bedtime. 2. Handle dentures carefully to prevent loss or breakage. 3. If resident is not chewing food thoroughly, report to supervisor. 4. Encourage resident to keep dentures in mouth as much as possible. 5. Store dentures whenever they are not in the resident's mouth and leave denture cup on resident's bedside stand within easy reach of resident. During of review of the facility's P&P titled, Routine Dental Care, updated 2025, the P&P indicated the nursing staff would conduct ongoing oral health assessment to assure that each resident received adequate oral hygiene. The P&P indicated routine dental care included: 1. An initial evaluation of the resident's dental needs. 2. Consultation with the resident staff and the dental consultant. 3. Daily dental and oral hygiene plan of care. 4. Preventative care and treatment.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure the call light was kept within reach for two of 32 sampled residents (Resident 82 and Resident 2). This deficient practice placed Resident 82 and Resident 2 at risk for injury related to falls and removed the residents' capability to exercise their right to request for assistance from staff. Findings: 1. During a review of Resident 82's Admission Record, the Admission Record indicated the facility admitted Resident 82 on 1/18/2023, and most recently readmitted Resident 82 on 4/4/2025. Resident 82's admitting diagnoses included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 82's Minimum Data Set (MDS, a resident assessment tool), dated 3/27/2025, the MDS indicated Resident 82 had some difficulty making decisions in new situations only. The MDS indicated Resident 82 required supervision or touch assistance from staff to transition from a sitting position to a standing position, and to walk. During a review of Resident 82's Fall Risk Evaluation, dated 4/4/2025, the assessment indicated Resident 82 was at risk for falls. During a review of Resident 82's care plan titled Falls, dated 4/18/2025, the care plan indicated Resident 82 was at risk for falls, and goals of care included minimization of fall related injuries by utilizing fall precautions. Care plan interventions to prevent falls included keeping Resident 82's call light within reach and ensuring Resident 82 was wearing appropriate footwear. During a concurrent observation and interview, on 4/21/2025 at 10:15 a.m., with Certified Nurse Assistant (CNA) 1, at Resident 82's bedside, Resident 82's call light was observed hanging behind his bedside dresser. CNA 1 stated the call light was not within Resident 82's reach and stated the call light should be within Resident 82's reach. During a concurrent observation and interview, on 4/22/2025 at 1:54 p.m., at Resident 82's bedside, with Resident 82, Resident 82's call light cord was observed coiled on his bedside dresser and disconnected from the call light outlet. Resident 82 stated his call light got loose, and could not recall when. During an observation on 4/22/2025 at 1:57 p.m., from Resident 82's doorway, Resident 82 was observed getting out of bed without staff supervision or touch assistance to press the call button on the wall at his bedside, above and behind his bedside dresser. Resident 82's had bare feet and was not wearing any footwear. Resident 82's gait appeared unsteady. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on 4/22/2025 at 1:59 p.m., with, CNA 2, Resident 82's call light cord was observed coiled on his bedside dresser and disconnected from the call light outlet. CNA 2 stated the call cord was supposed to be secured to the call light outlet in the wall. CNA 2 stated Resident 82 had to stand up to press the call light button. CNA 2 stated the call light should have been within Resident 82's reach so he could call for help, and stated Resident 82 could fall if he stood up or walked unassisted to press the call light. During an interview on 4/23/2025 at 10:43 a.m., Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 82 was at risk for falls. LVN 1 stated Resident 82's call light should be within reach at all times to all the resident to call for help. LVN 1 stated that if the call light was not within Resident 82's reach, Resident 82 was it risk for falls and injury. 48131 2. During a concurrent observation and interview on 4/21/2025 at 12:22 p.m., with Resident 2, observed Resident 2 sitting in her wheelchair next to her bed. Resident 2's call light device was observed hanging on the wall behind the head of the bed and out of reach of the resident. Resident 2 asked for something to eat. Resident 2 was asked if she was able to reach her call light. Resident 2 stated that she could not reach her call light and asked if the nurse could be called. During a review of Resident 2's Admission Record, dated 4/24/2025, the admission record indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses which included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), muscle wasting (weakening, shrinking, and loss of muscle), and dysphagia (difficulty swallowing) oropharyngeal (relating to the throat) phase. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition (ability to think and reason) was moderately impaired. The MDS indicated Resident 2 could usually be understood and could usually understand others. The MDS indicated Resident 2 required maximal assistance (helper does more than half the effort) for bathing and moderate assistance (helper does less than half the effort) for toileting and personal hygiene. The MDS indicated Resident 2 used a wheelchair as a mobility (to move freely from one place to another) device. During a review of Resident 2's Fall Risk Evaluation, dated 1/17/2025, the assessment indicated Resident 2 was at risk for falls. During a review of Resident 2's Care Plan titled Needs Assistance with ADLs (Activities of Daily Living - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), initiated on 1/17/2025, the care plan indicated Resident 2 was non-ambulatory (unable to walk) and required total assistance with locomotion (the ability and act of moving from one place to another) and walking in room and corridor. The care plan interventions indicated to have a call light within reach, answer the call light promptly, frequent assistance of needs and assist with purchasing personal supply items as needed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/21/2025 at 12:32 p.m., with LVN 2, LVN 2 observed Resident 2 sitting in her wheelchair with the call light located behind the head of the bed. LVN 2 stated Resident 2 could not reach the call light. LVN 2 stated the call light should have been within Resident 2's reach so that she was able to call out to get more food. LVN 2 stated not having the call light within reach prevented Resident 2 from being able to contact a nurse when she needed one. LVN 2 stated it was important to have the call light within reach so Resident 2 could call out if she needed assistance. During a review of the facility's policy and procedure (P&P) titled Falls and Fall Risk, Managing, updated 1/2025, the P&P indicated that based on evaluations, staff were to identify interventions related to the resident's specific fall risks to try and prevent the resident from falling and to try to minimize complications from falling. During a review of the facility's P&P titled Call Lights: Accessibility and Timely Response, updated 1/2025, the P&P indicated it was the facility's policy to assure a call light was available at the bedside to allow residents to call for assistance. During a review of the facility's P&P titled, Call Light: Accessibility and Timely Response, revised January 2025, the P&P indicated, With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of the resident and secured as needed.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to ensure one of six sampled residents' (Resident 154) Advance Directive (a legal document indicating resident preference on end-of-life treatment decisions) Acknowledgement form (form that indicates whether an individual has an Advance Directive or if an Advance Directive would like to be formulated) was accurately completed. This deficient practice resulted in an inaccurate and incomplete Advance Directive Acknowledgement and had the potential to result in confusion whether Resident 154 had an Advance Directive and if not, if Resident 154 wanted to formulate one. This deficient practice placed Resident 154 at risk of not receiving necessary care based on Resident 154's wishes. Findings: During a review of Resident 154's Admission Record (Face Sheet), the Face Sheet indicated Resident 154 was admitted to the facility on [DATE] with diagnosis of schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 154's History and Physical (H&P), dated 9/30/2024, the H&P indicated Resident 154 had fluctuating capacity to understand and make decisions. During a review of Resident 154's Minimum Data Set ([MDS], a resident assessment tool), dated 3/19/2025, the MDS indicated Resident 154's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 154 required moderate assistance (helper does less than half the effort) with toileting, bathing, and lower body dressing. During a review of Resident 154's Physician Orders for Life-Sustaining Treatment (POLST], a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life), dated 9/25/2024, the POLST did not indicate that an Advance Directive was discussed. During a concurrent interview and record review on 4/23/2025 at 9:44 a.m., with the Social Services Director (SSD), Resident 154's Advance Directive Acknowledgement, dated 9/25/2024, was reviewed. The SSD stated Resident 154's Acknowledgement form did not indicate whether Resident 154 would like to or had declined to formulate an Advance Directive. The SSD stated the social services department was responsible for educating and to review with the residents regarding Advance Directives to allow them to express their medical care wishes. The SSD stated because the Acknowledgement form was blank, the form indicated Resident 154 was not given the opportunity to go over it and formulate an Advance Directive, if he wanted to. The SSD stated Resident 154 had the right to decide whether he wanted to formulate an Advance Directive and to indicate preferences for end-of-life treatment decisions. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Residents' Rights Regarding Treatment and Advance Directives, revised 1/2025, the P&P indicated, It is the policy of this facility to support and facilitate a resident's right to request, refuse, and/or discontinue medical or surgical treatment and to formulate advance directives. The P&P indicated, On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on interview and record review, the facility failed to ensure a resident's public guardian (PG- an appointed individual that is responsible for the care of individuals who are no longer able to make decisions or care for themselves) or responsible party (RP), and physician were notified when two of nine sampled residents exhibited a change of condition (Residents 114, and 104) by failing to: 1. Ensure Resident 114's PG or RP were notified when the resident exhibited a change of condition and was transported to the General Acute Care Hospital (GACH). This deficient practice resulted in the delay of proper verification of Resident 114's appointed RP or PG, which led to a lack of RP or PG notification when Resident 114 exhibited a change of condition and was sent to the GACH 2. Ensure Resident 104's physician was notified when Resident 104 was non-compliant with wearing the [NAME] cardiac monitor (a device that continuous monitors heart rate) and when the resident's heart rate was outside parameters, as indicated by the physician orders. This deficient practice had the potential to result in an uncontrolled heart rate which could lead to complications such as dizziness, fatigue, fainting, cardiac arrest (when heart stops beating) and death Resident 104. Findings: 1. During a review of Resident 114's Admission Record, the Admission Record indicated Resident 114 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), cerebral infarction (stroke, loss of blood flow to a part of the brain), aphasia (a disorder that makes it difficult to speak), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the right dominant side. During a review of Resident 114's Minimum Data Set ([MDS], a resident assessment tool), dated 3/28/2025, the MDS indicated Resident 114's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 114 was entirely dependent (helper does all the tasks) on staff for bathing, toileting, performing personal hygiene, sitting to standing, and transferring from the bed to a chair. The MDS indicated Resident 114 had an active diagnosis of a stroke. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/22/2025 at 12:29 p.m. with the Social Services Designee (SSD), Resident 114's History and Physical (H&P), dated 1/6/2025, Change of Condition Note, dated 1/14/2025, and Admission Record, were reviewed. The H&P indicated Resident 114 lacked the capacity to understand and make decisions. The Change of Condition Note indicated Resident 114 was self-responsible and no other responsible parties or emergency contacts were notified of 114's transfer to the General Acute Care Hospital (GACH). Resident 114's Admission Record indicated Resident 114 was self-responsible and had three emergency contacts listed with phone numbers that were no longer in service. The SSD stated the information on the Admission Record was incorrect and not updated. The SSD stated a resident would need an appointed public guardian if a resident did not have the capacity to understand and make decisions and did not have family members to aid the resident with making medical and financial decisions. The SSD stated Resident 114 required a public guardian to be informed and make decisions on her behalf. The SSD stated he did not begin the process to apply for a public guardian for Resident 114 (since 1/2025) because he did not know Resident 114 was deemed unable to make medical decisions and the facility did not update the Admission Record. The SSD stated the facility lacked a system to ensure the information on the Admission Record matched the information on the residents' H&P documentation. The SSD stated he would have applied for public guardianship for Resident 114 if Resident 114's Admission Record had been updated, and he was made aware Resident 114's H&P indicated Resident 114 lacked the capacity to make medical decisions. The SSD stated this resulted in a lack of proper notification of Resident 114's responsible party when she was transferred to the GACH (on 1/14/2025). The SSD stated all residents had the right to a responsible party or a public guardian to be notified of medical changes of condition. During a concurrent interview and record review on 4/23/25 at 9:33 a.m., with Minimum Data Set Nurse (MDSN) 2, Resident 114's H&P, dated 1/6/2025, and Resident 114's Change of Condition Note, dated 1/14/2025, were reviewed. The H&P indicated Resident 114 lacked the capacity to understand and make decisions. The Change of Condition Note indicated Resident 114 was sent to the GACH due to bleeding gums and no attempt was made to notify Resident 114's RP, family member or PG of the event. MDSN 2 stated he authored the note and did not recall trying to call an RP for Resident 114 because Resident 114's Admission Record indicated Resident 114 was self-responsible. MDSN 2 stated he should have attempted to call the listed emergency contacts or made efforts to verify Resident 114's RP. MDSN 2 stated it was important to ensure RPs, family members, or PGs were informed of any changes of condition in their loved ones, especially if the resident is transferred out to the GACH because it was their right to be informed. 48343 2. During a review of Resident 104's Admission Record, the Admission Record indicated Resident 104 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included bradycardia (a slow heart rate), syncope (fainting), hypertension (HTN-high blood pressure), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 104's MDS, dated [DATE], the MDS indicated Resident 104's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 104 required supervision or touching (helper provides verbal cues and/or touching assistance as resident completes activity) from staff for Activity of Daily Living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting, a person performs daily to care for themselves). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/23/2025 at 12:58 p.m., with Licensed Vocational Nurse (LVN) 3, Resident 104's order summary report, dated 9/30/2024, and care plan with a focus for cardiac monitor, dated 5/22/24, was reviewed. LVN 3 stated Resident 104's order summary report indicated the facility shall monitor resident's heart rate every shift and notify the physician if the heart rate falls below 60 beats per minute (bpm). LVN 3 stated Resident 104's care plan interventions indicated the facility would monitor the heart rate as ordered and would notify the physician if the resident's heart rate falls below 60 bpm or exceeds 100 bpm. During a concurrent interview and record review on 4/23/2025 at 1:10 p.m., with LVN 3, Resident 104's weights and vitals summary (a record of a resident's temperature, heart rate, respiration, blood pressure, weight) from 1/1/2025 to 4/22/2025, was reviewed. LVN 3 stated the vitals summary indicated Resident 104's heart rate recorded as follows: 1. 1/14/2025 at 9:00 a.m., was 56 bpm 2. 2/6/2025 at 9:08 a.m., was 55 bpm 3. 2/13/2025 at 1:00 a.m., was 58 bpm 4. 2/15/2025 at 9:00 a.m., was 120 bmp 5. 3/4/2025 at 8:31 a.m., was 52 bpm 6. 3/6/2025 at 8:30 am., was 57 bpm 7. 4/14/2025 at 9:40 a.m., was 59 bpm LVN 3 stated Resident 104's heart rate was recorded below 60 bpm on six occasions and above 100 bpm once. LVN 3 stated there was no documented evidence that the physician was notified of the resident's abnormal heart rate readings, as required by the physician's order and care plan interventions. LVN 3 stated the failure to communicate these significant changes in condition with the residents' physician could lead to a delay in medical intervention, care and treatment, if necessary. During a concurrent interview and record review on 4/23/2025 at 3:35 p.m., with LVN 5, Resident 104's progress note, dated 1/3/2025 at 3:50 p.m., was reviewed. LVN 5 stated he created the progress note and documented the resident's condition. Resident 104 returned from the cardiovascular (heart doctor) appointment with a [NAME] cardiac monitor (a device that continuous monitors heart rate), which was to be worn continuously. LVN 5 stated he recalls that Resident 104 was non-compliant with the [NAME], and he (LVN 5) removed the device without notifying the doctor. LVN 5 stated he placed the device at the nurses' station and was not aware of what had happened with the [NAME] device afterwards. LVN 5 stated he did not recall notifying the change nurse and/or the Director of Nursing (DON). LVN 5 stated there was no documented evidence of any communication with the doctor regarding the [NAME] monitor and/or a scheduled follow-up appointment for the resident. LVN 5 stated it was important to ensure the doctor was notified of any changes in condition, to prevent delayed care and treatment, especially that the [NAME] was for monitoring Resident 104's heart rate continuously. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/2025 at 3:50 p.m., with DON, the DON stated the failure to communicate with Resident 104's doctor a significant change in condition could have resulted in delayed medical interventions, placing Resident 104 at increased risk for adverse outcomes such as syncope, cardiac instability, or cardiac arrest. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, revised 2025, the P&P indicated the facility would notify the resident's family or representative when there was a significant change in the resident's physical, mental, or psychosocial status and when a resident is transferred to a hospital, or treatment center. The P&P indicated the facility shall promptly notify the resident's physician when there was a refusal of treatment. During a review of the facility's P&P titled, Responsible Party (undated), the P&P indicated the facility was to provide a mechanism by which medical treatment, or health care decisions can be made for a resident that includes but is not limited to family member, public guardian, conservator, who can take full responsibility for healthcare decisions. The P&P indicated the following when the Physician and facility staff deemed a resident incapable of making medical treatment/health care decisions: 1. Social Services staff would clarify or notify the resident's responsible party or surrogate decision maker. 2. When #1 has been clarified, the resident's responsible party/surrogate decision maker would become the responsible party and the resident's primary physician would be notified.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) assessments for 5 of 32 sampled residents (Residents 82, 159, 39, 74, and 59) were completed and documented accurately. This deficient practice resulted in the transmission of inaccurate data to the Centers for Medicare and Medicaid Services (CMS) regarding the above residents' health status and unique healthcare needs. This deficient practice also created the potential for the above residents to not receive the care and interventions needed to reach their highest practicable physical and psychosocial well-being. Findings: 1. During a review of Resident 82's Admission Record, the Admission Record indicated the facility admitted Resident 82 on 1/18/2023, and most recently readmitted Resident 82 on 4/4/2025. Resident 82's admitting diagnoses included end stage renal disease (irreversible kidney failure) and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 82's physician order, dated 3/2/2025, the physician order indicated Resident 82 was on a regular texture (a diet where food has not had modifications to its texture), renal (a diet containing lower amounts of sodium, protein, potassium, and phosphorous), consistent carbohydrate (CCHO, a diet with a controlled amount of carbohydrates) diet. During a review of Resident 82's Minimum Data Set (MDS, a resident assessment tool), dated 3/27/2025, the MDS indicated Resident 82 had some difficulty making decisions in new situations only. The MDS indicated Resident 82 required supervision or touch assistance from staff to transition from a sitting position to a standing position, and to walk. During a concurrent observation and interview, on 4/21/2025 at 10:47 a.m., with Resident 82, at Resident 82's bedside, Resident 82's Permacath (a small catheter inserted into a large blood vessel for hemodialysis) to his right upper chest area. Resident 82 stated the Permacath was for his hemodialysis via Perma-cath. During a concurrent interview and record review, on 4/22/2025 at 3:05 p.m., with Minimum Data Set Nurse (MDSN) 1, Resident 82's MDS dated [DATE] was reviewed. MDSN 1 stated Resident 82's MDS indicated Resident 82 was receiving a modified texture diet, and did not indicate Resident 82 was on a renal CCHO therapeutic diet. MDSN 1 stated Resident 82's MDS was not accurate. During a concurrent interview and record review, on 4/23/2025 at 8:51 a.m., with MDSN 1, Resident 82's MDS dated [DATE] was reviewed. MDSN 1 stated Resident 82's MDS did not reflect Resident 82's hemodialysis treatments or the presence of his Perma-cath. MDSN 1 stated Resident 82's MDS was not accurate. MDSN 1 stated the MDS should be accurate because it guided the plan of care for Resident 82. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 39's Admission Record, the Admission Record indicated the facility admitted Resident 39 on 8/30/2022, and most recently readmitted Resident 39 on 11/23/2024. Resident 39's admitting diagnoses included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and depression (a persistent mood disorder characterized by a lasting feeling of sadness and loss of interest in activities). During a review of Resident 39's MDS, dated [DATE], the MDS indicated Resident 39's preferred language was English, and the MDS further indicated Resident 39 did not need or want an interpreter to communicate with doctors or healthcare staff. The MDS indicated Resident 39 had moderate cognitive impairment (problems with thinking ability, encompassing areas like memory, language, and executive functions). The MDS indicated Resident 39 required supervision or touch assistance from staff to clean her teeth, maintain personal hygiene, and dress her lower body. The MDS indicated Resident 39 required supervision or touch assistance from staff to transition from a sitting to standing position, transfer between surfaces, and to walk. During an observation on 4/22/2025 at 9:46 a.m., while at Resident 39's bedside, a communication board (a visual aid, typically a laminated sheet or panel, that uses symbols, pictures, or illustrations to help people communicate their needs, wants, and thoughts) which contained simple photos with Cantonese translations that allowed Resident 39 to convey simple needs. The communication board did not allow for more complex requests or those not already included on the communication board. During an interview on 4/23/2025 at 11:15 a.m., with Resident 39, Resident 39 stated she spoke Cantonese. During a concurrent interview and record review, on 4/23/2025 at 11:16 a.m., with MDSN 1, Resident 39's MDS, dated [DATE], was reviewed. MDSN 1 stated the MDS indicated Resident 39's preferred language was English, and indicated Resident 39 did not want or need an interpreter when talking to doctors or healthcare staff. MDSN 1 stated Resident 39 spoke some English so he assumed she preferred English and would not want or need an interpreter. MDSN 1 stated he did not ask the resident or her family to verify this information. During an interview on 4/23/2025 at 11:32 a.m., with Resident 39's Family Member (FM) 1, FM 1 stated Resident 39 spoke some English, but preferred to speak Cantonese and could better understand Cantonese. During an interview on 4/23/2025 at 12:16 p.m., with Certified Nurse Assistant (CNA) 3, CNA 3 stated Resident 39 did not speak English, but she did not know what language Resident 39 was speaking. CNA 3 stated she could not understand anything Resident 39 was saying. CNA 3 stated no one had communicated to her that Resident 39 spoke Cantonese. CNA 3 stated she would ask Resident 39 Yes or No questions, and Resident 39 would answer in English with Yes or No. CNA 3 stated she could not verify Resident 39 understood the question. 3. During a review of Resident 159's Admission Record, the Admission Record indicated the facility admitted Resident 159 on 2/6/2025. Resident 159's admitting diagnoses included COPD and depression. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 159's MDS, dated [DATE], the MDS indicated Resident 159's preferred language was Korean, and the MDS further indicated Resident 159 did not want or need an interpreter when talking to doctors or healthcare staff. The MDS indicated Resident 159 had moderate cognitive impairment and required supervision or touch assistance from staff to clean his teeth, dress his upper and lower body, put on and take off his shoes, and maintain personal hygiene. During an interview on 4/21/2025 at 3:13 p.m., with Resident 159, Resident 159 stated the staff speak to him in English or Spanish, and he could not understand them most of the time. Resident 159 stated he had not observed staff using the Korean communication board at the bedside. During an interview on 4/23/2025 at 10:53 a.m., with CNA 3, CNA 3 stated she spoke to Resident 159 in English. CNA 3 stated she Does the best she can to communicate with Resident 159, but did not use an interpreter or translation services. During a concurrent interview and record review, on 4/23/2025 at 11:02 a.m., with MDSN 1, Resident 159's MDS, dated [DATE], was reviewed. MDSN 1 stated the MDS indicated Resident 159's MDS indicated Resident 159's preferred language was Korean, and indicated Resident 159 did not want or need an interpreter when talking to doctors or healthcare staff. MDSN 1 stated he did not ask Resident 159 if he wanted or needed an interpreter. MDSN 1 stated Resident 159 spoke some English so he assumed he would not want or need an interpreter. 48343 4. During a review of Resident 74's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 74 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), hypertension ([HTN]-high blood pressure), epilepsy (a brain disorder), and DM. During a review of Resident 74's History and Physical (H&P), dated 5/13/2024, the H&P indicated Resident 74 had the capacity to understand and make decisions. During a review of Resident 74's MDS, dated [DATE], the MDS indicated Resident 74's cognitive (the ability to think and process information) skills for daily decision making were intact. The MDS indicated Resident 74 required moderate (helper does less than half the effort) assistance from staff for Activity of Daily Living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 74 was assessed as not having any oral and/or dental issues. During a concurrent observation and interview on 4/22/2025 at 1:50 p.m., while in Resident 74's room, with MDSN 1, Resident 74 was observed sitting on the bed. MDSN 1 stated Resident 74 did not have her upper and bottom teeth. MDSN 1 stated Resident 74 did not have her natural teeth and the MDS assessment should be coded correctly to reflect Resident 74's dental status. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During a review of Resident 59's Face Sheet, the Face Sheet indicated Resident 59 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), HTN, and epilepsy. During a review of Resident 59's MDS, dated [DATE], the MDS indicated Resident 59's cognitive skills for daily decision making were intact. The MDS indicated Resident 59 required supervision or touching (helper provides verbal cues and/or touching assistance as resident completes activity) from staff for ADLs. During a concurrent observation and interview on 4/23/2025 at 8:58 a.m., with Resident 59, while in Resident 59's room, Resident 59 was observed sitting on the bed, eating her breakfast. Resident 59 stated it was hard to chew the food because she did not have her natural teeth. Resident 59 stated her dentures felt loose and shifted during meals. During a concurrent interview and record review on 4/23/2025 at 1:50 p.m., with MDSN 1, Resident 59's MDS, dated [DATE] the section for oral/dental status was reviewed. MDSN 1 stated, the MDS indicated Resident 59 was assessed as not having any oral and/or dental issues. MDSN 1 stated Resident 59's MDS oral/dental status assessment was coded incorrectly as it did not reflect the resident's actual oral and/or dental status. MDSN 1 stated because Resident 59 did not have her natural teeth and she had dentures, the MDS should have been coded. MDSN 1 stated accuracy of the MDS assessment was important for, quality measures tools that help quality and measure healthcare process, outcome, and resident perceptions, and care plan for the residents. MDSN 1 stated inaccuracy of the MDS assessment had the potential to result in not meeting the resident's care needs and services. During a review of the facility's policy and procedure (P&P) titled Resident Assessment - RAI, updated 1/2025, the P&P indicated the facility makes a comprehensive assessment of each resident's needs, strengths, goals, life history, and preferences, which were to be documented in the MDS. The P&P indicated the assessment was to be completed through a process that included observation of, and communication with, the resident. During a review of the facility's P&P titled Certifying Accuracy of the Resident Assessment, updated January 2025, the P&P indicated all personnel who completed any portion of the Resident Assessment (MDS) were to certify the accuracy of that portion of the assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to ensure resident-centered care plans were developed and implemented for seven of 32 sampled residents (Residents 70, 41, 122, 59, 101, and 114). This deficient practice placed Residents 70, 41, 122, 74, 59, and 101 at risk of not receiving care and resident-centered interventions to meet and address their needs. Findings: 1. During a review of Resident 70's Admission Record, the Admission Record indicated Resident 70 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 70's admitting diagnoses included paranoid schizophrenia (a type of schizophrenia characterized by the presence of delusions and hallucinations, particularly persecutory delusions [believing others are trying to harm or plot against them]), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 70's psychiatry consults progress note, dated 3/3/2025, the progress note indicated Resident 70 had extreme aggression evidenced by striking out at others. During a review of Resident 70's Minimum Data Set (MDS, a resident assessment tool), dated 4/8/2025, the MDS indicated Resident 70 had moderate cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 70 displayed physical (e.g., hitting, kicking, pushing, scratching) and verbal (e.g., threatening, screaming, cursing) behavioral symptoms directed towards others for one (1) to three (3) days from 4/1/2025 to 4/8/2025. During a review of the document titled Report of Suspected Dependent Adult/Elder Abuse, dated 4/23/2025, the document indicated a female resident alleged Resident 70 crawled into her room and smacked her with an object. During an interview on 4/23/2025 at 11:57 a.m., with Certified Nurse Assistant (CNA) 6, CNA 6 stated Resident 70 was known to be aggressive with staff and other residents. During an interview on 4/24/2025 at 10:16 a.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated a care plan was not developed for Resident 70's verbal and physical aggression until 4/23/2025. LVN 3 stated verbal and physical aggression should be care-planned to ensure interventions were in place to monitor the behaviors and help to avoid further aggression and potential resident altercations. 47679 (continued on next page)

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Villa Del Rio	7002 Gage Avenue Bell Gardens, CA 90201

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 41's Admission Record, the Admission Record indicated Resident 41 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included major depressive, schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), mood disorder (conditions that primarily affect a person's emotional state, causing significant distress or impairment in their daily life), type two diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and atrial fibrillation (an irregular and often rapid heartbeat). During a review of Resident 41's History and Physical (H&P), dated 2/3/2025, the H&P indicated Resident 41 did not have the capacity to understand and make decisions. During a review of Resident 41's Orders, dated 2/3/2025, the Orders indicated to administer: a. Aripiprazole 10 milligrams (mg, a unit of measurement), one tablet by mouth at bedtime, for schizoaffective disorder manifested by screaming. b. Depakote (an anticonvulsant medication, a medication used to prevent or treat seizures and can be used to treat behavioral disorders) 125mg, three tablets by mouth, twice a day, for mood disorder as manifested by attempting to strike out. c. Lexapro (a medication used to treat depression, which is a mood disorder that causes a persistent feeling of sadness and loss of interest) 5 mg, one tablet by mouth, once a day, for depression manifested by crying. d. Eliquis (an anticoagulant medication, used to prevent blood clots from forming in the blood vessels and the heart) 2.5mg, one tablet by mouth, two times a day, for atrial fibrillation. e. Regular Insulin (controls the amount of sugar in the blood by moving it into the cells, where it can be used by the body for energy), inject per the sliding scale, subcutaneously (into the fatty tissue), two times a day for diabetes mellitus. During a review of Resident 41's MDS, dated [DATE], the MDS indicated Resident 41's cognition (process of thinking) was severely impaired. The MDS indicated Resident 41 required maximal assistance (helper does more than half the effort) with toileting, bathing, and lower body dressing. The MDS indicated Resident 41 received hypoglycemic, anticoagulant, antipsychotic, antidepressant, and anticonvulsant medication. During a concurrent interview and record review on 4/23/2025 at 1:04 p.m., with Minimum Data Set Nurse (MDSN) 2, Resident 41's Care Plans, dated 2/3/2025, were reviewed. MDSN 2 stated Resident 41 did not have any care plans that addressed his use of aripiprazole, Depakote, Lexapro, Eliquis, and Regular Insulin. MDSN 2 stated care plans should have been developed with interventions to monitor side effects and any other specific monitoring of each medication required. MDSN 2 stated aripiprazole, Depakote, and Lexapro were medications used to treat specific behaviors that required monitoring on every shift to determine the effectiveness of the medications. MDSN 2 stated Eliquis put Resident 41 at risk for bleeding which required monitoring, and the care plan would provide special instructions for any treatments that could cause bleeding. MDSN 2 stated Regular Insulin put Resident 41 at risk of low or high blood sugar levels and the care plan would specify the symptoms to monitor for and how to intervene. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 122's Admission Record, the Admission Record indicated Resident 122 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), anxiety disorder (condition characterized by excessive, persistent, and often irrational worry, fear, and nervousness that can often interfere with daily life), schizoaffective disorder, and major depressive disorder. During a review of Resident 122's MDS, dated [DATE], the MDS indicated Resident 122's cognition was intact. The MDS indicated Resident 122 required supervision with oral hygiene, toileting, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 122 received antipsychotic, antidepressant, and anticonvulsant medication. During a review of Resident 122's Orders, dated 1/16/2025, the Orders indicated to administer: a. Depakote 500 mg, one tablet by mouth, three times a day for schizoaffective disorder as manifested by attempting to strike out at staff when providing care. b. Quetiapine (an antipsychotic medication) 50 mg, one tablet by mouth, one time a day for psychosis (a state where a person loses touch with reality, experiencing distortions in their thoughts and perceptions) as manifested by delusions (an unshakable belief in something that is untrue) that somebody is out to get him. c. Quetiapine 100 mg, one tablet by mouth, at bedtime for psychosis as manifested by delusions that somebody is out to get him. d. Trazodone (an antidepressant medication) 100mg, one tablet by mouth, at bedtime for depression as manifested by verbalizing feelings of hopelessness. During a concurrent interview and record review on 4/23/2025 at 1:08 p.m., with MDSN 2, Resident 122's Care Plans, dated 1/16/2025 through 3/28/2025, were reviewed. MDSN 2 stated Resident 122 did not have any care plans that addressed his use of Depakote, quetiapine, and trazodone. MDSN 2 stated care plans should have been developed with interventions to monitor for side effects and any other specific monitoring each medication required. MDSN 2 stated Depakote, quetiapine, and trazodone were medications used to treat specific behaviors that required monitoring on every shift to determine the effectiveness of the medications. During an interview on 4/23/2025 at 10:18 a.m., with CNA 5, CNA 5 stated Resident 122's shower days were Monday and Thursdays and most times, Resident 122 would refuse to shower. CNA 5 stated she offered Resident 122 a shower throughout her shift, however, Resident 122 continued to refuse to shower. CNA 5 stated whenever Resident 122 refused to shower, the licensed nurse would be informed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/2025 at 11:34 a.m., with LVN 4, LVN 4 stated Resident 122 was alert and able to make his needs known. LVN 4 stated Resident 122 had the right to refuse showers, however, the nursing staff were responsible for educating Resident 122 on the risks and benefits of not showering. During a concurrent interview and record review on 4/23/2025 at 11:36 a.m., with LVN 4, Resident 122's Care Plans, dated 1/16/2025 through 3/28/2025, were reviewed. LVN 4 stated Resident 122 did not have a care plan to address his refusals of showers. LVN 4 stated when a resident refused any kind of care, that behavior had to be care-planned to communicate to the other staff, create a goal, and to develop interventions to monitor, to educate, and to provide the best care possible under the circumstances. During an interview on 4/23/2025 at 3:06 p.m., with the Director of Nursing (DON), the DON stated care plans were developed to ensure each resident received care tailored to their individual needs. The DON stated without care plans to guide the staff, the residents may not receive the care and services they need. During a review of the facility's P&P titled, Care Plans revised 1/2025, the P&P indicated, An individualized comprehensive care plan that includes measurable goals and timetables to meet the resident's medical, nursing, mental, and psychosocial needs is developed for each resident. During a review of the facility's P&P titled, Refusal of Treatment, undated, the P&P indicated, The Care Plan Team will assess the resident's needs and offer the resident alternative treatments, if available and pertinent, while continuing to provide other services outlined in the care plan. 48343 4. During a review of Resident 59's Admission Record, the Admission Record indicated Resident 59 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), hypertension ([HTN]-high blood pressure), and epilepsy (a brain disorder). During a review of Resident 59's MDS, dated [DATE], the MDS indicated Resident 59's cognitive (the ability to think and process information) skills for daily decision making was intact. The MDS indicated Resident 59 required supervision or touching (helper provides verbal cues and/or touching assistance as resident completes activity) from staff for Activity of Daily Living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent observation and interview on 4/22/2025 at 1:50 p.m., with MDSN 1, while in Resident 59's room, the MDSN 1 stated Resident 59 did not have her upper and bottom teeth. MDSN 1 stated Resident 59's dentures were placed on the top of Resident 59's bedside table. During a concurrent interview and record review on 4/23/2025 at 3:20 p.m., with MDSN 1, Resident 59's medical record, was reviewed. MDSN 1 was not able to locate a care plan for Resident 59's use of dentures. MDSN 1 stated there was no care plan for the use of dentures and there should have been a care plan initiated upon Resident 59's admission to the facility. MDSN 1 stated care planning serves as a communication tool among facility staff who provided care for residents at the facility. MDSN 1 stated if there was no care plan, the facility staff would not be able to provide quality of care to residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/24/2025 at 3:55 p.m., with the DON, the DON stated it was important for the facility licensed staff to develop a comprehensive care plan for each resident for continuity of care and services, based on resident needs and interventions. During a review of the facility's policy and procedure (P&P) titled Care Plans- Comprehensive revised 1/2025, the P&P indicated the facility would develop and maintain an individualized comprehensive care plan for each resident that would include measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs. 47858 5. During a review of Resident 101's Admission Record, the Admission Record indicated Resident 101 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 101's diagnoses included dementia, unspecified psychosis, and major depressive disorder (persistent feeling of sadness and loss of interest). During a review of Resident 101's MDS, dated [DATE], the MDS indicated Resident 101's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 101 required partial or moderate assistance (helper does less than half of the effort) when toileting, bathing, lower body dressing and sitting to standing. During a concurrent interview and record review on 4/23/2025 at 1 p.m. with MDSN 2, Resident 101's Order Summary Report, dated 4/22/2025, and all of Resident 101's Care Plans, dated 2024 to 2025, were reviewed. The Order Summary Report indicated Resident 101 was ordered clonazepam 0.5 mg one tablet by mouth, fluoxetine oral capsule 10mg one time a day for depression manifested by crying, and olanzapine oral tablet 5mg (Olanzapine) at bedtime for psychosis manifested by yelling and screaming. MDSN 2 stated there were no care plans to address Resident 101's behaviors of restlessness, crying, and screaming. MDSN 2 stated there were no care plans to address Resident 101's orders for clonazepam, fluoxetine, and olanzapine. MDSN 2 stated it was important to ensure all of Resident 101's behaviors were care planned to ensure care was appropriately rendered for Resident 101. MDSN 2 stated it was important to ensure care plans were in place for each psychotropic medication to monitor Resident 101's usage and side effects of the medication. MDSN 2 stated Resident 101 was at risk for 101 was at risk for mismanaged care and unmet short- and long-term goals for each psychotropic medication and behavior. 6. During a review of Resident 114's Admission Record, the Admission Record indicated Resident 114 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 114's diagnoses included dementia (a progressive state of decline in mental abilities), cerebral infarction (stroke, loss of blood flow to a part of the brain), aphasia (a disorder that makes it difficult to speak), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting right dominant side and a gastrostomy (a surgical opening fitted with a device to allow feedings to be administered). During a review of Resident 114's MDS, dated [DATE], the MDS indicated Resident 114's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 114 was entirely dependent (helper does all the tasks) on staff for bathing, toileting, performing personal hygiene, sitting to standing, and transferring from the bed to a chair. The MDS indicated Resident 114 had an active diagnosis of a stroke. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and review on 4/23/2025 at 9:33 a.m. with MDSN 2, all of 114's Care Plans, dated in 2024 to 2025, were reviewed. There were no care plans for Resident 114's diagnosis of a stroke and risk for (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) decline. MDSN 2 stated every diagnosis, including stroke, should have been care planned to ensure all proper interventions are implemented and tracked. MDSN 2 stated Resident 114 should have had a care plan implemented for Resident 114's risk for ADL decline to ensure all interventions were put in place. MDSN 2 stated the lack of an at risk for ADL decline and stroke care plan placed Resident 114 at risk for ADL decline. During a review of the facility's Policy and Procedure (P&P) titled, Care plans-Comprehensive revised 1/2025, the P&P indicated the facility would implement a care plan that was designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems. c. Build on the resident's strengths. d. Reflect the resident's expressed wishes regarding care and treatment goals. e. Reflect treatment goals, timetables and objectives in measurable outcomes. f. Identify the professional services that are responsible for each element of care. g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels. h. Enhance the optimal functioning of the resident by focusing on a rehabilitative program. i. Reflect currently recognized standards of practice for problem areas and conditions. 48131

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47679 Based on interview and record review, the facility failed to review and revise the care plan for three of 18 sampled residents (Residents 134, 114, and 104), by failing to: 1. Revise Resident 134's care plan (a document that helps nurses and other team care members organize aspects of resident care) and interventions (actions a nurse takes to implement a care plan, intend to improve the resident's comfort and health) after Resident 134 had an unwitnessed fall on 12/18/2024. This deficient practice had the potential to result in Resident 134 sustaining a major injury after another fall. 2. Ensure the Interdisciplinary Team (IDT) meeting was held quarterly and after Resident 114 was sent to the GACH (General Acute Hospital (GACH)) due to bleeding gums. This deficient practice resulted in a year-long delay in the revision, re-evaluation and implementation of Resident 114's care plans without the input from members of the IDT and Resident 114's responsible party or public guardian. 3. Revise Resident 104's care plan for cardiac monitoring after Resident 104 had a [NAME] cardiac monitor (a device that continuous monitors heart rate) in place. This deficient practice placed Resident 104 at risk for uncontrolled heart rate which could lead to complications such as dizziness, fatigue, fainting, cardiac arrest (when heart stops beating) and death. Findings: 1. During a review of Resident 134's Admission Record (Face Sheet), the Face Sheet indicated Resident 134 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizophrenia (a mental illness that is characterized by disturbances in thought), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 134's History and Physical (H&P), dated 12/17/2024, the H&P indicated Resident 134 had fluctuating capacity to understand and make decisions. During a review of Resident 134's Minimum Data Set ([MDS], a resident assessment tool), dated 12/18/2024, the MDS indicated Resident 134's cognition (process of thinking) was intact. The MDS indicated Resident 134 required supervision with oral hygiene, toileting, bathing, dressing, and personal hygiene. The MDS indicated Resident 134 had a fall and sustained a minor injury (skin tear, abrasion, superficial bruises). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 134's Change of Condition (COC), dated 12/18/2024, the COC indicated Resident 134 had a fall that resulted in mild redness on her left check and right knee pain. During a review of Resident 134's Fall Scene Investigation Report, dated 12/18/2024, the Report indicated Resident 134 was found on the floor next to her bed. The Report indicated Resident 134 stated she was not fully awake and attempted to use the restroom. During a concurrent interview and record review on 4/23/2025 at 2:35 p.m., with the Director of Nursing (DON), Resident 134's Care Plan, dated 12/15/2023, was reviewed. The DON stated Resident 134 had a Care Plan that addressed Resident 134's risk of falls and injuries. The DON stated the Care Plan was not revised after Resident 134 fell on [DATE] and should have been revised with additional interventions. The DON stated these interventions would guide the staff to better care for Resident 134. The DON stated new interventions were necessary to help prevent further falls and to prevent serious injury if another fall were to occur. 47858 2. During a review of Resident 114's Admission Record, the Admission Record indicated Resident 114 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 114's diagnoses included dementia (a progressive state of decline in mental abilities), cerebral infarction (stroke, loss of blood flow to a part of the brain), aphasia (a disorder that makes it difficult to speak), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the right dominant side. During a review of Resident 114's Minimum Data Set ([MDS], a resident assessment tool), dated 3/28/2025, the MDS indicated Resident 114's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 114 was entirely dependent (helper does all the tasks) on staff for bathing, toileting, performing personal hygiene, sitting to standing, and transferring from the bed to a chair. The MDS indicated Resident 114 had an active diagnosis of a stroke. During a concurrent interview and record review on 4/22/2025, at 12:29 p.m. with Social Services Designee (SSD), all of Resident 114's Interdisciplinary Team (IDT) Meeting Notes, dated 1/2024 to 4/2025, and Resident 114's Change of Condition Note, dated 1/14/2025, were reviewed. The SSD stated Resident 114's latest IDT note, dated 1/13/2024, indicated the next IDT meeting should have been held on 3/2024. There were no IDT Meeting Notes dated after 1/13/2024. The Change of Condition Note, dated 1/14/2025, indicated Resident 114 was sent to the GACH due to bleeding gums. There were no IDT Meeting Notes held on or after 1/14/2025. The SSD stated an IDT should have been held for Resident 114 every three months and after Resident 114 exhibited a change of condition on 1/14/2025. The SSD stated the lack of IDT meetings had the potential to lead to inappropriate care and missed opportunities to revise Resident 114's care plans. The SSD stated the lack of IDTs also did not allow Resident 114's RP or PG to be made aware of changes or participate in care planning for Resident 114. 48343 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 104's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 104 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included bradycardia (a slow heart rate), syncope (fainting), hypertension (HTN-high blood pressure), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 104's Minimum Data Set (MDS - a resident assessment tool), dated 1/12/2025, the MDS indicated Resident 104's cognitive (the ability to think and process information) skills for daily decision making were moderately impaired. The MDS indicated Resident 104 required supervision or touching (helper provides verbal cues and/or touching assistance as resident completes activity) from staff for Activity of Daily Living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent interview and record review on 4/23/2025 at 12:58 p.m., with Licensed Vocational Nurse (LVN) 3, Resident 104's progress note, dated 1/3/2025 at 3:50 p.m., and care plan with a focus for cardiac monitor, dated 5/22/24, were reviewed. LVN 3 stated the progress note indicated Resident 104 returned from cardiovascular (heart doctor) appointment with a [NAME] cardiac monitor which was to be worn continuously. LVN 3 stated Resident 104's care plan indicated interventions focusing on routine heart rate assessments; however, it did not address the interventions regarding the [NAME] monitor device that Resident 104 was to wear continuously. LVN 3 stated Resident 104's care plan should have been reviewed and revised to include updated interventions related to the [NAME] monitor, which was essential for the resident's continuous heart rate monitoring. During an interview on 4/24/2025 at 3:50 p.m., with the DON, the DON stated Resident 104's care plan addressing cardiac monitoring should have been revised to reflect the [NAME] device and Resident 104's continuous heart rate monitoring and would ensure staff providing care were aware of the resident's necessary interventions and when to notify the physician, if needed. During a review of the facility's policy and procedure (P&P) titled, Care Plans- Comprehensive revised 1/2025, the P&P indicated, Assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's condition change. The P&P indicated the Interdisciplinary Team was responsible for the review and updating of care plans when the resident was readmitted to the facility from a hospital stay and at least quarterly. During a review of the facility's P&P titled, Falls and Fall Risk, Managing revised 1/2025, the P&P indicated, If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to provide care and services to maintain good grooming and personal hygiene for one of six sampled residents (Resident 125) by failing to keep the resident's fingernails clean and neat. This failure had the potential to result in a negative impact on Resident 125's quality of life and self-esteem and had the potential to result in the development of an infection. Findings: During a concurrent observation and interview on 4/21/2025 at 10:41 a.m., with Resident 125, while in Resident 125's room, Resident 125's fingernails were long with a black substance underneath his fingernails. Resident 125 stated his fingernails looked long and that he would like to have his fingernails cut and cleaned. During a review of Resident 125's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 125 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), epilepsy (a brain disorder), dysphagia (difficulty swallowing), and muscle weakness (loss of muscle strength). During a review of Resident 125's Minimum Data Set ([MDS]- a resident assessment tool), dated 1/15/2025, the MDS indicated Resident 125's cognitive (the ability to think and process information) skills for daily decision making were intact. The MDS indicated Resident 125 required moderate (helper does less than half the effort) assistance from staff for Activity of Daily Living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation on 4/22/2025 at 3 p.m., while in Resident 125's room, Resident 125 had long fingernails and a black substance underneath his fingernails. During a concurrent observation and interview on 4/22//2025 at 3:08 p.m., with Certified Nursing Assistant (CNA) 6, while in Resident 125's room, Resident 125 had a black substance underneath his fingernails. CNA 6 stated Resident 125's fingernails were long and dirty. CNA 6 stated CNAs were responsible for cleaning the residents' fingernails daily and trimming, as needed. CNA 6 stated ensuring the residents' fingernails are clean was essential to prevent infection. CNA 6 stated it was important to keep Resident 125's fingernails clean and trimmed to prevent the growth of bacteria (infection). CNA 6 stated long, dirty fingernails had the potential to cause the resident to scratch his skin and if Resident 125 scratched himself hard enough, it could create an open wound and an increased risk of infection. CNA 6 stated having dirty fingernails was not sanitary because the resident will use her hands to hold utensils when eating and any bacteria could transfer into the body. (continued on next page)

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Villa Del Rio	7002 Gage Avenue Bell Gardens, CA 90201

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/2025 at 3:55 p.m., with the Director of Nursing (DON), the DON stated it was the CNA's responsibility to make sure the residents' fingernails are cleaned daily and trimmed, as needed. The DON stated residents should be provided with care and services necessary to maintain good personal hygiene. During a review of the facility's policy and procedure (P&P) titled Care of Fingernails/Toenails), revised 1/2025, the P&P indicated the facility would provide nail care including daily nail care and regular trimming to prevent skin problems around the nail bed and prevent the resident from accidentally scratching and injuring his or her skin. During a review of the facility's undated P&P titled Job Description Certified Nursing Assistant, the P&P indicated CNAs duties and responsibilities included to assist residents with nail care, clipping, trimming, and cleaning the fingernails.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on observation, interview, and record review, the facility failed to ensure proper hand-off / shift report (a process where nurses exchange vital patient information between shifts to ensure continuity of care and patient safety) was provided between nursing staff for one of six sampled residents (Resident 8). This deficient practice resulted in Resident 8 being exposed while in bed and left covered in feces. Findings: During an observation on 4/21/2025 at 12:50 p.m., in Resident 8's room, Resident 8 was observed lying in bed undressed and completely exposed from the hallway. Resident 8 was observed with feces covering her left shoulder, right hand and upper thigh. Resident 8's sheets were soiled with feces and the feces were also observed on the floor next to the resident's bed. Resident 8 was observed flailing her hands and yelling out loudly in Spanish. During a review of Resident 8's Admission Record, the Admission Record indicated Resident 8 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities) 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 8's Minimum Dat Set (MDS - a resident assessment tool), dated 1/31/2025, the MDS indicated Resident 8's cognition (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 8 was dependent (helper does all of the effort) with toileting, bathing, upper/lower body dressing, and personal hygiene. During a review of Resident 8's History and Physical (H&P), dated 3/7/2025, the H&P indicated Resident 8 did not have the capacity to understand and make decisions. During a review of Resident 8's Care Plan titled, Needs Assistance with Activities of Daily Living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), dated 11/25/2024, the Care Plan indicated Resident 8 body odor would be minimized and dressed appropriately daily. The Care Plan interventions indicated to assist Resident 8 as needed, provide frequent assistance of needs, keep resident clean and dry as much as possible, provide good skin care after elimination, and dress appropriately. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/21/2025 at 12:53 p.m., with Certified Nurse Assistant (CNA) 9, in Resident 8's room, Resident 8 was observed lying in bed, undressed, covered in feces and yelling out in Spanish. CNA 9 stated he was a new employee and had not received training on how to care for residents like Resident 8. CNA 9 stated he did not receive any report from the charge nurse that indicated Resident 8 had behaviors of taking off her diaper and undressing herself. CNA 9 stated Resident 8 appeared frustrated and should not be left undressed and covered in feces. CNA 9 stated he had attempted to change Resident 8 before lunch, but the resident was agitated (feeling of unease) and refusing care. CNA 9 stated he informed the charge nurse and was told to leave the resident alone and change her after his lunch. CNA 8 stated he had just returned from lunch but if he had known Resident 8 would take off her soiled diaper and undress herself, he would have checked on her sooner or changed her before he went to lunch. During an interview on 4/24/2025 at 12 :14 p.m., with the Director of Staff Development (DSD), the DSD stated he was aware of the incident that occurred with Resident 8. The DSD stated charge nurses were informed the day of the incident that they were responsible for communicating with the CNAs regarding the residents' care. The DSD stated it was CNA 9's first day off of orientation. The DSD stated hand-off report was not a part of the CNAs' orientation. The DSD stated a CNA 9 should have received a hand-off report so he would know what was going on with his assigned residents. The DSD also stated he had previously brought up to the charge nurses the importance of giving a hand-off report to registry (staff who work on an as-needed basis) and newly hired staff. The DSD stated better communication between the charge nurses CNAs could have prevented this from happening to Resident 8. During an interview on 4/24/2025 at 2:39 p.m., with the Director of Nursing (DON), the DON stated hand off or shift report has been a problem in the facility for the past year. The DON stated there is an extra hour in between shifts where the CNA from the previous shift should have given a shift report to the oncoming shift. During a review of the facility's policy and procedure (P&P) titled, Rounds Shift Report, updated January 2025, the P&P indicated, It is the policy of this facility to use round shift reporting to promote successful transfer of information between nursing staff at shift change in an effort to prevent adverse events, medication errors and medical mishaps. The P&P indicated all staff would be in-serviced on the use of the rounds shift report prior to implementation as well as upon hire and as needed.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the facility failed to provide services to maintain mobility (ability to move) for four out of 21 sampled residents (Residents 21, 28, 115, and 114) who had limited range of motion [(ROM) full movement potential of a joint (where two bones meet)] and mobility by failing to: a. Ensure the recommendations noted in the Joint Mobility assessment dated [DATE], for Restorative Nursing Aide (RNA) services, were provided to Resident 114. b. Develop and implement a care plan to address Resident 114's risk for activities of daily living decline and diagnosis of a stroke affecting the right side of her body. c. Ensure Resident 115 and Resident 28 were ordered RNA services. d. Ensure Resident 21's RNA services were resumed after the resident's readmission to the facility. These failures had the potential to result in joint mobility limitations for Residents 21, 28, 115, and 114. Cross reference F825 and F656. Findings: 1a. During a review of Resident 114's Admission Record, the Admission Record indicated Resident 114 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), cerebral infarction (stroke, loss of blood flow to a part of the brain), aphasia (a disorder that makes it difficult to speak), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting right dominant side and a gastrostomy (a surgical opening fitted with a device to allow feedings to be administered). During a review of Resident 114's Minimum Data Set ([MDS], a resident assessment tool), dated 3/28/2025, the MDS indicated Resident 114's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 114 was entirely dependent (helper does all the tasks) on staff for bathing, toileting, performing personal hygiene, sitting to standing, and transferring from the bed to a chair. The MDS indicated Resident 114 had an active diagnosis of a stroke. During a review of Resident 114's Order Summary Report, dated 4/23/2025, Resident 114 was ordered to have a physical therapy (PT) and occupational therapy (OT) evaluation (PT evaluations assesses a person's movement, strength, and range of motion. OT evaluation focuses on how those physical and cognitive skills impact daily activities) performed on 1/1/2023. The Order Summary Report did not indicate Resident 114 was ordered PT, OT and, or RNA services after the evaluations were ordered. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations made on 4/21/2025 at 9:30 a.m. and 4/24/2025 at 10:38 a.m., Resident 114 was non-verbal, and was positioned on her back in bed while her G-tube feeding was administered. Resident 114's arms and legs were bent. b. During a concurrent interview and review on 4/23/2025 at 9:33 a.m. with Minimum Data Set Nurse (MDSN) 2, all of Resident 114's Care Plans, dated in 2024 to 2025, were reviewed. There were no Care Plans for Resident 114's diagnosis of a stroke and risk for functional ADL decline. MDSN 2 stated every diagnosis, including stroke, should have been care planned to ensure all proper interventions are implemented and tracked. MDSN 2 stated Resident 114 should have had a care plan implemented for Resident 114's risk for ADL decline to ensure all interventions were put in place. MDSN 2 stated the lack of an at risk for ADL decline and stroke care plan placed Resident 114 at risk for ADL decline. During a concurrent interview and record review, on 4/23/2025, at 10:45 a.m. with the Director of Rehabilitation (DOR), Resident 114's Physical Therapy and Rehabilitation Notes, dated 1/2024 to 4/2025, and Resident 114's JMA, dated 12/7/2023, were reviewed. There were no notes to indicate Resident 114 had a formal Physical or Occupational Therapy Evaluation performed or had received RNA services. The JMA indicated a recommendation for RNA services for Resident 114. The DOR stated Resident 114 would have benefited from long-term RNA services to maintain Resident 114's ADL abilities and range of motion (the extent or limit to which a part of the body can be moved around a joint or a fixed point; the totality of movement a joint is capable of doing). The DOR stated he thought the nursing staff carried out his RNA recommendation for treatment in 2023 and assumed Resident 114 currently received RNA services. The lack of RNA orders and services for Resident 114 placed Resident 114 at risk for the development of contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) and ADL decline. 2. During a review of Resident 115's Admission Record, the Admission Record indicated Resident 115 was originally admitted to the facility on [DATE]. Resident 115's diagnoses included dementia (a progressive state of decline in mental abilities), depressive disorder (a mood disorder that causes persistent sadness) and anxiety (a feeling of uneasiness). During a review of Resident 115's MDS, dated [DATE], the MDS indicated Resident 115's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 115 required partial or moderate assistance (helper does less than half of the effort) for ADLs and bed mobility. The MDS indicated Resident 115 had an active diagnosis of non-traumatic brain dysfunction. During a review of Resident 115's Order Summary Report, dated 4/23/2025, the Order Summary Report did not indicate Resident 115 was ordered RNA Services. During observations made on 4/21/2025 at 9:30 a.m. and 4/24/2025 at 10:35 a.m., Resident 115 was positioned on her back in bed. During an interview on 4/21/2025, at 12:20 p.m. with Resident 115's Representative Party (RP) 1, RP 1 stated Resident 115 did not receive physical therapy services or RNA services and knows Resident 115 had been declining. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 4/23/2025, at 10:45 a.m. with the Director of Rehabilitation (DOR), Resident 115's Physical Therapy and Rehabilitation Notes, dated 2024 to 2025, and Resident 115's Physician Orders, dated 2024 to 2025, were reviewed. The Physical Therapy and Rehabilitation Notes and Resident 115's Physician Orders indicated Resident 115 was never ordered physical or occupational therapy and RNA services. The DOR stated Resident 115 was not placed on RNA services because of her advanced age and cognitive limitations. The DOR stated the two limiting factors that he identified were not listed limitations within the facility's policies regarding the provision of rehabilitation services. The DOR stated it was important that residents like Resident 115 are placed on RNA therapy to prevent ROM and ADL decline. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living, revised 2025, the P&P indicated the facility would provide a maintenance and restorative program to assist the resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment. 47679 3. During a review of Resident 28's Admission Record (Face Sheet), the Face Sheet indicated Resident 28 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included encephalopathy (a disorder or disease of the brain, often affecting its ability to function properly), multiple sclerosis (a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), and a Stage four pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) on the right buttock. During a review of Resident 28's History and Physical (H&P), dated 3/11/2024, the H&P indicated Resident 28 could make needs known but could not make medical decisions. During a review of Resident 28's MDS, dated [DATE], the MDS indicated Resident 28's cognition was moderately impaired. The MDS indicated Resident 28 had functional limitation impairment on both sides of the upper and lower extremities. The MDS indicated Resident 28 was dependent on staff's assistance with eating, oral hygiene, toileting, bathing, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 28 had a Stage four pressure ulcer. During a review of Resident 28's JMA, dated 4/5/2025, the JMA indicated Resident 28 had severe joint mobility limitations on the shoulders, elbows, wrists, fingers, hips, knees, and ankles. During a review of Resident 28's Order Summary Report, dated 4/23/2025, the Order Summary Report indicated to perform a physical and occupational therapy evaluation on 10/3/2024. The Order Summary Report did not indicate Resident 28 was ordered physical or occupational therapy, nor any orders for RNA services. During a concurrent observation and interview on 4/21/2025 at 10:03 a.m. with Resident 28 while in Resident 28's bedroom, Resident 28 was awake, fully dressed, and lying in bed. Both of Resident 28's elbows were bent, and both hands were in a closed fist position. Resident 28 stated he does not receive any therapy with the rehab department nor with the RNAs. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/2025 at 9:04 a.m., with the Director of Rehab (DOR), the DOR stated Resident 28 had severe contractures but was not receiving therapy from the rehab department nor RNA services. The DOR stated Resident 28 had a stage four pressure ulcer and due to Resident 28's wounds, the rehab department did not want to perform any range of motion ([ROM], full movement potential of a joint) exercises. During an interview on 4/23/2025 at 1:27 p.m., with Wound Specialist (WS) 1, WS 1 stated she was familiar with Resident 28's stage four pressure ulcer and has been following Resident 28's wound progress. WS 1 stated although Resident 28 had a stage four pressure ulcer and was susceptible to other wounds, she did not give any directive to restrict Resident 28's ROM exercises. During an interview on 4/24/2025 at 8:55 a.m., with the DOR, the DOR stated it was standard of practice to not provide ROM exercises to a resident who had an active wound. The DOR stated he did not consult with WS 1 about Resident 28's ROM restrictions but should have to create a collaborative plan for Resident 28. The DOR stated Resident 28 would benefit from ROM exercises to prevent his contractures from worsening and from other contractures from developing. During an interview on 4/24/2025 at 11:43 a.m., with the Director of Nursing (DON), the DON stated she had never heard of a resident not receiving ROM exercises because of the presence of wounds. The DON stated Resident 28 would benefit from RNA services to prevent decline, not only in his ROM abilities, but in his ability to participate in his activities of daily living ([ADLs], routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). 48131 4. During a review of Resident 21's Admission Record, the Admission Record indicated Resident 21 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses which included encephalopathy (a change in brain function), primary osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of both knees, and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 21's History and Physical (H&P), dated 3/28/2025, the H&P indicated Resident 21 had fluctuating capacity to understand and make decisions. During a review of Resident 21's Order Summary Report, dated 10/3/2024, the Order Summary Report indicated an order for RNA to ambulate Resident 21 with a front-wheeled walker daily, five times a week as tolerated. During a review of Resident 21's Order Summary Report, dated 10/29/2024, the Order Summary Report indicated Resident 21 had an order for RNA to ambulate Resident 21 with a front-wheeled walker daily, five times a week as tolerated with an end date of 3/20/2025. During a review of Resident 21's Nursing Progress Notes dated 3/11/2025 at 6:14 a.m., the Nursing Progress Notes indicated a telephone communication was received to transfer Resident 21 to a general acute care hospital (GACH). During a review of Resident 21's Nursing Progress Notes dated 3/25/2025, the Nursing Progress Notes indicated Resident 21 was readmitted to the facility from the GACH. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 21's Order Summary Report dated 4/24/2025, the Order Summary Report indicated Resident 21 was ordered a PT and OT evaluation on 3/25/2025. During a concurrent interview and record review on 4/24/2024 at 11:20 a.m., with the DOR, Resident 21's Order Summary Report for March 2025 was reviewed. The DOR stated RNA services were stopped on 3/20/2025 because the resident was discharged to the GACH. The DOR stated the order for RNA services should have been carried out by the nurses upon Resident 21's readmission to the facility. The DOR stated he did not resume the orders for RNA services because he was not notified by the nursing staff. The DOR stated Resident 21 should be receiving RNA services and the resident was at risk of declining because he was not receiving RNA services. During an interview on 4/24/2025 at 11:50 a.m., with RNA 1, RNA 1 stated Resident 21 was receiving RNA services prior to his hospitalization on [DATE], but when the resident returned to the facility, he was no longer receiving RNA services. RNA 1 stated Resident 21 received assistance with ambulation and benefitted from RNA services prior to his hospitalization . During an interview on 4/24/2025 at 2:54 p.m., with the DON, the DON stated RNA services do not continue once a resident is readmitted to the facility. The DON stated residents that were readmitted to the facility would be re-evaluated by the Rehabilitation Department to determine if services should be continued. The DON stated the nursing staff was not responsible for notifying the Rehabilitation Department of residents requiring rehabilitation evaluations upon readmission. During a review of the facility's P&P titled, Prevention of Decline in Range of Motion, revised 1/2025, the P&P indicated, Residents who entered the facility without limited range of motion would not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motion is unavoidable. The P&P indicated, Residents will receive services from restorative aides or therapists as needed.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure safety was maintained for three of five sampled residents (Resident 82, Resident 134, and Resident 2) by failing to: 1. Ensure Resident 82's call light was maintained within reach, and ensured Resident 82 was wearing non-slip footwear, as indicated in his fall risk care plan. 2. Ensure an Interdisciplinary Team ([IDT], a coordinated group of experts from several different fields) meeting was conducted after Resident 134 had an unwitnessed fall on 12/18/2024. 3. Ensure Resident 2, who had dysphagia (difficulty swallowing) did not eat from another resident's tray. These deficient practices placed Residents 82 and 134 at risk for falls and subsequent injuries. These deficient practices also placed Resident 2 at risk for choking and/or aspiration (the act of accidentally inhaling food, liquid, or other material into the airway and lungs) from consuming foods that were not a part of her mechanical-soft (chopped, ground or pureed foods for residents who have difficulty chewing or swallowing) diet. Findings: 1. During a review of Resident 82's Admission Record, the Admission Record indicated the facility admitted Resident 82 on 1/18/2023, and most recently readmitted Resident 82 on 4/4/2025. Resident 82's admitting diagnoses included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 82's Minimum Data Set (MDS, a resident assessment tool), dated 3/27/2025, the MDS indicated Resident 82 had some difficulty making decisions in new situations only. The MDS indicated Resident 82 required supervision or touch assistance from staff to transition from a sitting position to a standing position, and to walk. During a review of Resident 82's Fall Risk Evaluation, dated 4/4/2025, the assessment indicated Resident 82 was at risk for falls. During a review of Resident 82's care plan titled Falls, dated 4/18/2025, the care plan indicated Resident 82 was at risk for falls, and goals of care included minimization of fall related injuries by utilizing fall precautions. Care plan interventions to prevent falls included keeping Resident 82's call light within reach and ensuring Resident 82 was wearing appropriate footwear. During a concurrent observation and interview, on 4/21/2025 at 10:15 a.m., with Certified Nurse Assistant (CNA) 1, at Resident 82's bedside, Resident 82's call light was observed hanging behind his bedside dresser. CNA 1 stated the call light was not within Resident 82's reach and stated the call light should be within Resident 82's reach. (continued on next page)

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	555781	A. Building B. Wing	04/24/2025

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Villa Del Rio	7002 Gage Avenue Bell Gardens, CA 90201

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview, on 4/22/2025 at 1:54 p.m., while at Resident 82's bedside, with Resident 82, Resident 82's call light cord was observed coiled on his bedside dresser and disconnected from the call light outlet. Resident 82 stated his call light got loose, but he could not recall when. During an observation on 4/22/2025 at 1:57 p.m., from Resident 82's doorway, Resident 82 was observed getting out of bed without staff supervision or touch assistance to press the call button on the wall at his bedside, above and behind his bedside dresser. Resident 82 had bare feet and was not wearing any footwear. Resident 82's gait appeared unsteady. During a concurrent observation and interview, on 4/22/2025 at 1:59 p.m., with, CNA 2, Resident 82's call light cord was observed coiled on his bedside dresser and disconnected from the call light outlet. CNA 2 stated the call cord was supposed to be secured to the call light outlet in the wall. CNA 2 stated Resident 82 had to stand up to press the call light button. CNA 2 stated the call light should have been within Resident 82's reach so he could call for help, and stated Resident 82 could fall if he stood up or walked unassisted to press the call light. During an interview on 4/23/2025 at 10:43 a.m., Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 82 was at risk for falls. LVN 1 stated Resident 82's call light should always be within reach to all the resident to call for help. LVN 1 stated that if the call light was not within Resident 82's reach, Resident 82 was it risk fEdits SR or falls and injury. During a review of the facility's policy and procedure (P&P) titled Falls and Fall Risk, Managing, updated 1/2025, the P&P indicated that based on evaluations, staff were to identify interventions related to the resident's specific fall risks to try and prevent the resident from falling and to try to minimize complications from falling. 47679 2. During a review of Resident 134's Admission Record (Face Sheet), the Face Sheet indicated Resident 134 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 134's History and Physical (H&P), dated 12/17/2024, the H&P indicated Resident 134 had fluctuating capacity to understand and make decisions. During a review of Resident 134's MDS, dated [DATE], the MDS indicated Resident 134's cognition (process of thinking) was intact. The MDS indicated Resident 134 required supervision with oral hygiene, toileting, bathing, dressing, and personal hygiene. The MDS indicated Resident 134 had a fall and sustained minor injury (skin tear, abrasion, superficial bruises). During a review of Resident 134's Change of Condition (COC), dated 12/18/2024, the COC indicated Resident 134 had a fall that resulted in mild redness on her left check and right knee pain. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 134's Fall Scene Investigation Report, dated 12/18/2024, the Report indicated Resident 134 was found on the floor next to her bed. The Report indicated Resident 134 stated she was not fully awake and attempted to use the restroom. During a concurrent interview and record review on 4/23/2025 at 2:41 p.m., with the Director of Nursing (DON), Resident 134's Fall/Accident Checklist, dated 12/18/2024, was reviewed. The Checklist indicated, IDT to meet within 24 hours of the fall incident to review and initiate a root cause analysis for the fall incident. The DON stated every part of the Checklist had to be done after a resident sustained a fall. The DON stated the IDT did not meet after Resident 134 fell on [DATE]. The DON stated the purpose of the meeting was for all the departments to come together to determine the cause of Resident 134's fall and to develop interventions to preventing serious injury from occurring if Resident 134 were to fall again. The DON stated without an IDT meeting to collaborate and develop preventative interventions, Resident 134 was at risk for repeat falls and potentially suffer serious injuries. During a review of the facility's P&P titled, Falls and Fall Risk, Managing, revised 1/2025, the P&P indicated, If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 48131 3. During a concurrent observation and interview on 4/21/2025 at 12:22 p.m., with Resident 2, Resident 2 was observed sitting in her wheelchair next to her bed. Resident 2 stated she was hungry and asked if she could be taken to the vending machine to buy something to eat. Resident 2 was then observed leaving her room in her wheelchair and rolling her wheelchair up to a food cart outside of her room. The food cart contained partially eaten food from other resident's lunch trays. Resident 2 was observed immediately grabbing a roll from the tray cart and biting into it. Resident 2 took the roll and an open carton of milk from an unknown resident's tray back to her room. Resident 2 stated she was eating the food from the tray cart because there was nothing wrong with the food. Resident 2 stated, If they didn't want me to eat the food then they should have gotten me something else to eat. During a review of Resident 2's Admission Record, the admission record indicated Resident 2 was initially admitted on [DATE] and readmitted on [DATE] with the following diagnoses which included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and dysphagia oropharyngeal (relating to the throat) phase. During a review of Resident 2's Order Summary Report, dated 4/24/2024, the order summary indicated Resident 2 had an active order started on 10/8/2024 for a NAS (no added salt), CCHO (controlled carbohydrates - a dietary approach where there is a consistent amount of carbohydrates) diet, with a mechanical soft texture, and regular, thin consistency. During a review of Resident 2's Care Plan titled, Potential for Weight Loss, initiated on 1/17/2025, the care plan indicated to observe resident at mealtimes to assess eating patterns. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2's Social Service History and Initial Assessment, dated 1/17/2025, the social service assessment indicated Resident 2 had difficulty controlling behavior, was impulsive and had a lack of safety awareness. During a review of Resident 2's Care Plan titled, Oropharyngeal Dysphasia and Aspiration Risk, initiated on 1/18/2025, the care plan indicated Resident 2's goal was to have safe consumption of least restrictive diet and without signs and symptoms of aspiration. The care plan indicated Resident 2's plan was to have a slow feeding rate, take small bites/sips and to check for pocketed (concealing in cheeks or mouth rather than swallowing as intended) foods. During a review of Resident 2's Speech Therapy Evaluation and Plan of Treatment, dated 1/18/2025, the evaluation indicated Resident 2 was referred to speech therapy for dysphagia services due to a decline in oral/pharyngeal function, safety during oral intake, increased signs/symptoms of dysphagia and high-risk for aspiration. 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 could usually be understood and could usually understand others. The MDS indicated Resident 2 required maximal assistance (helper does more than half the effort) for bathing and moderate assistance (helper does less than half the effort) for toileting and personal hygiene. The MDS indicated Resident 2 used a wheelchair for mobility (to move freely from one place to another) device. During a concurrent observation and interview on 4/21/2025 at 12:36 p.m., with LVN 2, LVN 2 observed Resident 2 with a roll and an opened carton of milk on her bedside table that the resident had retrieved from the food cart in the hallway. LVN 2 stated Resident 2 took food off the dirty tray on the food cart. LVN 2 stated it was unsafe for Resident 2 to eat off the dirty food tray because she could choke or have an allergic reaction from eating food that was not on her diet. LVN 2 stated the food cart should have had closed doors so the residents would not have access to the dirty trays. During a concurrent observation and interview on 4/23/2025 at 12:36 p.m., with CNA 4, CNA 4 was standing in the hallway outside of Resident 2's room in front of the lunch food cart. CNA 4 stated he was monitoring the food cart to ensure residents did not take food from the cart. CNA 4 stated the monitoring was done to prevent residents from eating something that was not on their diet and to prevent cross contamination. During a concurrent interview and record review on 4/23/2025 at 3:34 p.m., with Registered Nurse (RN) 1, Resident 2's diagnoses, care plan, and diet order were reviewed. RN 1 stated Resident 2 was diagnosed with dysphasia and was ordered a mechanical soft diet. RN 1 stated Resident 2's care plan indicated the resident was at risk for aspiration. RN 1 stated it was important to ensure Resident 2 was eating the right type of food to prevent choking and aspiration. During an interview on 4/24/2025 at 8:31 a.m., with the Infection Preventionist (IP), the IP stated he observed Resident 2 eating from the plate of another resident while she was in the hallway on 4/21/2025. The IP stated he immediately summoned a nurse because of diet and choking issues. The IP stated someone should have been watching Resident 2 and redirecting her from the food cart in the hallway. The IP stated Resident 2 could catch germs from and become ill from eating from another resident's tray. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Dysphagia, updated January 2025, the P&P indicated the following: 1. The staff and physician will monitor the progress of individuals with swallowing difficulties; for example, ease of eating, improvement of symptoms, and resolution of underlying causes. 2. For individuals who have modified consistency diets, the staff will monitor for, and report to the physician, how the resident is tolerating any altered consistency diet and identify evidence of complications. During a review of the facility's P&P titled, Foreign Body Airway Obstruction Management (Choking), updated January 2025, the P&P indicated the facility would ensure that residents who have impaired swallowing issues and are on an altered diet are receiving the appropriate diet.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 47286 Based on interview and record review, the facility failed to ensure post-dialysis monitoring was conducted after one of one sampled resident (Resident 82) returned from hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). This deficient practice had the potential to place Resident 82 at risk for unidentified complications following hemodialysis, such as bleeding from the hemodialysis access site and low blood pressure. Findings: During a review of Resident 82's Admission Record, the Admission Record indicated the facility admitted Resident 82 on 1/18/2023, and most recently readmitted Resident 82 on 4/4/2025. Resident 82's admitting diagnoses included end stage renal disease (irreversible kidney failure) and dependence on hemodialysis. During a review of Resident 82's Minimum Data Set (MDS, a resident assessment tool), dated 3/27/2025, the MDS indicated Resident 82 had some difficulty making decisions in new situations only. The MDS indicated Resident 82 required supervision or touch assistance from staff to transition from a sitting position to a standing position, and to walk. During a review of Resident 82's record titled Review of Nurses Dialysis Documentation, dated 4/9/2025, the document indicated post-dialysis monitoring was not conducted. During a review of Resident 82's record titled Review of Nurses Dialysis Documentation, dated 4/21/2025, the document indicated post-dialysis monitoring was not conducted. During a concurrent interview and record review, on 4/22/2025 at 3:15 p.m., with Licensed Vocational Nurse (LVN) 3, Resident 82's records titled Nurses Dialysis Documentation, dated 4/9/2025 and 4/21/2025, were reviewed. LVN 3 stated the records did not indicate post-dialysis monitoring was conducted on 4/9/2025 or 4/21/2025, after Resident 82 returned from his hemodialysis appointment. LVN 3 stated it was important to conduct post-hemodialysis monitoring for resident safety, and stated possible complications after dialysis included difficulty breathing, chest pain, bleeding at the catheter site, and swelling. LVN 3 stated post-dialysis monitoring and documentation was to be done as soon as the resident returned to the facility. During a review of the facility's policy and procedure (P&P) titled Hemodialysis, updated 1/2025, the P&P indicated staff were to conduct ongoing assessment and oversight of the resident before, during, and after dialysis treatments, including monitoring of the resident's condition for complications.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679 Based on interview and record review, the facility failed to develop a care plan for dementia (a progressive state of decline in mental abilities) for two out of six sampled residents (Residents 41 and 101). This failure had the potential to result in inappropriate care and delivery of medical services provided to Resident 41 and Resident 101. Findings: 1. During a review of Resident 41's Admission Record, the Admission Record indicated Resident 41 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and mood disorder (conditions that primarily affect a person's emotional state, causing significant distress or impairment in their daily life). During a review of Resident 41's Minimum Data Set ([MDS], a resident assessment tool), dated 2/7/2025, the MDS indicated Resident 41's cognition (process of thinking) was severely impaired. The MDS indicated Resident 41 required maximal assistance (helper does more than half the effort) with toileting, bathing, and lower body dressing. During a review of Resident 41's History and Physical (H&P), dated 2/3/2025, the H&P indicated Resident 41 did not have the capacity to understand and make decisions. During a concurrent interview and record review on 4/23/2025 at 1 p.m., with Minimum Data Set Nurse (MDSN) 2, Resident 41's Care Plans, dated 2/3/2025, were reviewed. MDSN 2 stated Resident 41 did not have a care plan addressing his dementia diagnosis. MDSN 2 stated a care plan addressing Resident 41's dementia diagnosis was necessary to create individualized goals for Resident 41 and develop interventions to ensure Resident 41 has a routine with his activities of daily living ([ADLs], activities such as bathing, dressing and toileting a person performs daily) and overall, receives the appropriate care based on the nurses' assessments. MDSN 2 stated the care plan would direct the licensed nurses to monitor Resident 41's progression or decline since dementia is a progressive type of disease. MDSN 2 stated monitoring Resident 41's progression would allow for revisions of interventions to provide the best care to Resident 41. MDSN 2 stated without the necessary care plan, Resident 41 was at risk of not receiving the proper care specific to Resident 41's dementia diagnosis, which could result in a decline in Resident 41's overall health and function. During an interview on 4/23/2025 at 2:51 p.m., with the Director of Nursing (DON), the DON stated residents with dementia may require additional assistance with their ADLs and individualized care because dementia affects each individual differently. The DON stated Resident 41 should have had a care plan for his dementia diagnosis to help guide the facility's staff on how to care for him and to address his specific needs. The DON stated care plans were individualized and patient-centered and without one, Resident 41 was at risk of not receiving the specific care he would need. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47858 2. During a review of Resident 101's Admission Record, the Admission Record indicated Resident 101 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 101's diagnoses included dementia, unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and major depressive disorder. During a review of Resident 101's MDS, dated [DATE], the MDS indicated Resident 101's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 101 required partial or moderate assistance (helper does less than half of the effort) when toileting, bathing, lower body dressing and sitting to standing. During a concurrent interview and record review on 4/23/2025 at 1:00 p.m. with MDSN 2, Resident 101's Admission Record and all of Resident 101's Care Plans, dated 2024 to 2025, were reviewed. The Admission Record indicated Resident 101 was diagnosed with dementia. MDSN 2 stated there were no care plans in place to address Resident 101's diagnosis of dementia. MDSN 2 stated Resident 101 should have had a care plan for dementia to identify any problems of concern and establish goals for Resident 101's behaviors associated with dementia. MDSN 2 stated Resident 101 was at risk for mismanaged care and unmet short- and long-term goals. During a review of the facility's policy and procedure (P&P) titled, Dementia, revised 1/2025, the P&P indicated, The staff will monitor the individual with dementia for changes in condition and decline in function and will report these findings to the physician. The physician will help staff adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, etc. During a review of the facility's P&P titled, Care Plans, revised 1/2025, the P&P indicated, An individualized comprehensive care plan that includes measurable goals and timetables to meet the resident's medical, nursing, mental, and psychosocial needs is developed for each resident.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131 Based on interview and record review, the facility failed to follow the parameters for administering Glucotrol ([Glipizide] - lowers sugar levels in the blood) for one of six sampled resident (Resident 60). This deficient practice had the potential to cause hypoglycemia (low blood sugar [BS]) levels for Resident 60. Findings: During a review of Resident 60's Admission Record, the Admission Record indicated Resident 60 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (HTN - high blood pressure). During a review of Resident 60's Minimum Data Set (MDS - a resident assessment tool) dated 2/26/2025, the MDS indicated Resident 60's cognitive skills (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 60 required supervision (helper assists only prior to or following the activity) with eating and required maximal assistance (helper does more than half the effort) for toileting, bathing, and lower body dressing. The MDS also indicated Resident 60 was taking a hypoglycemic (used to lower blood sugar levels) medication since admission. During a review of Resident 60's History and Physical (H&P) dated 2/22/2025, the H&P indicated Resident 60 had the capacity to understand and make decisions. During a review of Resident 60's Order Summary Report, dated 2/20/2025, the Order Summary Report indicated Glucotrol (Glipizide) Oral Tablet 10 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount) by mouth one time a day for DM. Hold for BS less than 120 mg per deciliter (unit of measurement, mg/dL). During a concurrent interview and record review on 4/24/2025, at 1:49 p.m., with Licensed Vocational Nurse (LVN) 2, Resident 60's Order Summary Report and Medication Administration Record (MAR) for April 2025 were reviewed. LVN 2 stated Resident 60's Glipizide was to be held for a BS less than 120 mg/dL. LVN 2 stated administering Glipizide for a BS less than 120 mg/dL could cause Resident 60's BS to drop further. LVN 2 stated Resident 60 was administered Glipizide for a BS levels that were less than 120 mg/dL on the following days: 1. 4/10/2025 for a BS of 118 mg/dL. 2. 4/17/2025 for a BS of 119 mg/dL. 3. 4/22/2025 for a BS of 103 mg/dL. 4. 4/23/2025 for a BS of 115 mg/dL. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. 4/24/2025 for a BS of 97 mg/dL. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, updated January 2025, the P&P indicated, Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 47679 Based on interview and record review, the facility failed to provide a refrigerator to store residents' food brought from visitors. This deficient practice resulted in staff disposing of residents' leftover food brought from visitors that could have been stored in a refrigerator. Findings: During an interview on 4/22/2025 at 8:54 a.m., with the Dietary Supervisor (DS), the DS stated there are no separate refrigerators available for residents' foods brought in from visitors. The DS stated leftover food brought in from visitors would be stored in the discretion of the nursing department. During an interview on 4/22/2025 at 9:05 a.m., with the Infection Preventionist (IP), the IP stated residents were allowed to receive food brought in from visitors or if they have the food delivered to the facility. The IP stated the leftover food that was shelf steady (food products that can be stored at room temperature for a prolonged period without spoiling or requiring refrigeration) would be stored at the resident's bedside, however, foods that required refrigeration to prevent spoiling would be thrown out. The IP stated the facility did not have a refrigerator dedicated solely for residents' personal food. The IP stated this was an inconvenience for residents who do not finish their food and would like to save it for later. During a review of the facility's policy and procedure (P&P) titled, Safe Handling for Foods from Visitors revised 2/2023, the P&P indicated when food items were intended for later consumption, the responsible facility staff member will determine if food items are shelf stable and whether they could be stored in the resident room or stored under refrigeration.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the Rehabilitation Department failed to perform formal physical therapy (PT) and occupational therapy (OT) evaluations (PT evaluations to assess a person's movement, strength, and range of motion. OT evaluation focuses on how those physical and cognitive skills impact daily activities) as ordered by the physician to prevent decline and maintain the functional status and, or functional levels for two of six sampled residents (Resident 114 and Resident 28). These failures resulted in a year-long delay of the initiation of treatment and services to prevent decline and maintain the functional status and levels of Resident 114 and Resident 28. These failures had the potential to increase the risk of the development or worsening of contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff), which could have led to further functional decline for Resident 114 and Resident 28. Cross reference F656 and F688. Findings: 1. During a review of Resident 114's Admission Record, the Admission Record indicated Resident 114 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), cerebral infarction (stroke, loss of blood flow to a part of the brain), aphasia (a disorder that makes it difficult to speak), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting right dominant side and a gastrostomy (a surgical opening fitted with a device to allow feedings to be administered). During a review of Resident 114's Activities of Daily Living (ADL- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) Care Plan, dated 12/10/2024, the ADL Care Plan indicated Resident 114 required extensive assistance with bed mobility, eating, toileting, and transfers. During a review of Resident 114's Minimum Data Set ([MDS], a resident assessment tool), dated 3/28/2025, the MDS indicated Resident 114's cognitive skills (ability to think and reason) for daily decision making was severely impaired. The MDS indicated Resident 114 was entirely dependent (helper does all the task) on staff for bathing, toileting, performing personal hygiene, sitting to standing, and transferring from the bed to a chair. The MDS indicated Resident 114 had an active diagnosis of a stroke (loss of blood flow to a part of the brain). During a review of Resident 114's Order Summary Report, dated 4/23/2025, Resident 114 was ordered to have a PT and OT evaluation performed on 1/1/2023. The Order Summary Report did not indicate Resident 114 was ordered PT, OT, or RNA services after the evaluations were ordered on 1/1/2023. During observations made on 4/21/2025 at 9:30 a.m. and on 4/24/2025 at 10:38 a.m., Resident 114 was non-verbal, and was positioned on her back in bed while her g-tube feeding (liquid nutrition delivered directly to the stomach) was administered. Resident 114's arms and legs were bent. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/23/2025 at 9:33 a.m. with Minimum Data Set Nurse (MDSN) 2, all of Resident 114's Care Plans, dated from 2024 to 2025, were reviewed. There were no Care Plans for Resident 114's diagnosis of a stroke and risk for functional ADL decline. MDSN 2 stated every diagnosis, including stroke, should have been care planned to ensure all proper interventions are implemented and tracked. MDSN 2 stated Resident 114 should have had a care plan implemented for Resident 114's risk for ADL decline to ensure all interventions were put in place. MDSN 2 stated the lack of an At risk for ADL decline and Stroke care plan placed Resident 114 at risk for ADL decline. During a concurrent interview and record review, on 4/23/2025, at 10:45 a.m. with the Director of Rehabilitation (DOR), Resident 114's Physical Therapy and Rehabilitation Notes, dated 1/2024 to 4/2025, and Resident 114's Joint Mobility Assessment ([JMA] brief assessment of a resident's range of motion in both arms and both legs), dated 12/7/2023, were reviewed. There were no notes to indicate Resident 114 had a formal PT and OT evaluation performed or received RNA services. The JMA, dated 12/7/2023, indicated Resident 114 was recommended to be provided with RNA services. The DOR stated Resident 114 would have benefited from long-term RNA services to maintain Resident 114's ADL abilities and range of motion (the extent or limit to which a part of the body can be moved around a joint or a fixed point; the totality of movement a joint can do). The DOR stated he thought the nursing staff carried out the RNA recommendation for treatment in 2023 and assumed Resident 114 currently received RNA services (in 2025). The DOR stated residents that typically had a formal PT and OT evaluation performed were residents that had known ADL and physical functional limitations. The DOR stated Resident 114 had known physical limitations and should have had a formal PT and OT evaluation performed sooner. The DOR stated the lack of RNA services and PT and OT evaluation placed Resident 114 at risk for the development of contractures and ADL decline. 47679 2. During a review of Resident 28's Admission Record (Face Sheet), the Face Sheet indicated Resident 28 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included encephalopathy (a disorder or disease of the brain, often affecting its ability to function properly), multiple sclerosis (a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), and a stage four pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) on the right buttock. During a review of Resident 28's History and Physical (H&P), dated 3/11/2024, the H&P indicated Resident 28 could make needs known but could not make medical decisions. During a review of Resident 28's Order Summary Report, dated 4/23/2025, the Order Summary Report indicated to perform a physical and occupational therapy evaluation on 10/3/2024. The Order Summary Report did not indicate Resident 28 was ordered physical or occupational therapy, nor any orders for RNA services. During a review of Resident 28's MDS, dated [DATE], the MDS indicated Resident 28's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 28 had functional limitation impairment on both sides of the upper and lower extremities. The MDS indicated Resident 28 was dependent on staff's assistance with eating, oral hygiene, toileting, bathing, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 28 had a Stage four pressure ulcer. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 28's JMA, dated 4/5/2025, the JMA indicated Resident 28 had severe joint mobility limitations on the shoulders, elbows, wrists, fingers, hips, knees, and ankles. During a concurrent observation and interview on 4/21/2025 at 10:03 a.m. with Resident 28 while in Resident 28's bedroom, Resident 28 was awake, fully dressed, and lying in bed. Both of Resident 28's elbows were bent, and both hands were in a closed fist position. Resident 28 stated he does not receive any therapy with the rehab department nor with the RNAs. During an interview on 4/24/2025 at 8:15 a.m., with the Medical Records Director (MRD), the MRD stated Resident 28 never had PT or an OT evaluation. During an interview on 4/24/2025 at 9:12 a.m., with the DOR, the DOR stated when the resident's physician orders for a PT or OT evaluation, the evaluation would be done within 48 hours. Resident 28's order for a PT or OT evaluation were not done because the Joint Mobility Assessment ([JMA], brief assessment of a resident's range of motion in both arms and both legs) was conducted and presumed the JMA was a sufficient evaluation. The DOR stated the PT and OT evaluation were more extensive and assessed more than just the resident's functional ROM limitations. The DOR stated the PT and OT evaluation should be conducted on residents who have existing ROM limitations, which included Resident 28. The DOR stated Resident 28 should have had a PT and OT evaluation to create a goal and to create a treatment plan to prevent any decline in Resident 28's ROM and ability to participate in ADLs. During a review of the facility's policy and procedure (P&P) titled, Prevention of Decline in Range of Motion revised 1/2025, the P&P indicated, Residents who entered the facility without limited range of motion would not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motion is unavoidable. The P&P indicated, Residents who exhibit limitations in range of motion will be referred to the therapy department for a focused assessment of range of motion. During a review of the facility's P&P titled, Specialized Rehabilitative Services, revised 1/2025, the P&P indicated the facility shall provide or obtain rehabilitative services if required by the resident's comprehensive assessment and care plan. During a review of the facility's P&P titled, Activities of Daily Living revised 2025, the P&P indicated the facility would provide a maintenance and restorative program to assist the resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure infection control measures were implemented and/or maintained for 13 of 158 residents (Residents 58, 8, 87, 17, 84, 48, 114, 28, 22, 215, 90, 82, and 2) when the following occurred: 1. Enhanced barrier precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs, bacteria that are resistant to three or more classes of antimicrobial drugs]) were not implemented for 12 residents (Residents 58, 8, 87, 17, 84, 48, 114, 28, 22, 215, 90, and 82) who met the requirements for EBP. 2. Facility failed to maintain and implement a water management system (the facility's plan and activities for reducing risk of Legionella [a bacteria that can cause illness in the lungs and flu-like illness] and other opportunistic pathogens). 3. Resident 2 ate food from another resident's tray. 4. The Treatment Nurse (TN) did not perform hand hygiene (a way of cleaning one's hands that substantially reduces the potential germs on the hands) while performing Resident 28's wound care. These deficient practices placed all facility residents at risk for infection and illness. Findings: 1. During an interview on 4/23/2025 at 2:52 p.m., with the Infection Preventionist (IP) Nurse, the IP stated the facility was not currently implementing EBP for any facility residents. The IP stated EBP were required for residents with indwelling medical devices (i.e., gastrostomy tubes [GT, a feeding tube placed through the abdomen and into the stomach to deliver nutrition, fluids, or medications], intravenous access [a small tube or catheter placed in a vein to access the bloodstream], open wounds, and MDROs. The IP stated the purpose of implementing EBP was to prevent the spread of infection. a. During a review of Resident 58's Admission Record, the Admission Record indicated Resident 58 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 58's admitting diagnoses included dysphagia (difficulty swallowing), extended spectrum beta lactamase (ESBL, a type of MDRO) resistance. During a review of Resident 58's Minimum Data Set (MDS, a resident assessment tool), dated 1/24/2025, the MDS indicated Resident 58 had a GT. b. During a review of Resident 8's Admission Record, the Admission Record indicated Resident 8 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 8's admitting diagnoses included dysphagia. During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 had a GT. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. During a review of Resident 87's Admission Record, the Admission Record indicated Resident 87 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 87 admitting diagnoses included dysphagia. During a review of Resident 87's MDS, dated [DATE], the MDS indicated Resident 87 had a GT. d. During a review of Resident 17's Admission Record, the Admission Record indicated Resident 17 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 17's admitting diagnoses included dysphagia. During a review of Resident 17's MDS, dated [DATE], the MDS indicated Resident 17 had a GT. e. During a review of Resident 84's Admission Record, the Admission Record indicated Resident 84 was admitted on [DATE] and was most recently readmitted on [DATE]. Resident 84's admitting diagnoses included dysphagia. During a review of Resident 84's MDS, dated [DATE], the MDS indicated Resident 84 had a GT. f. During a review of Resident 48's Admission Record, the Admission Record indicated Resident 48 was admitted on [DATE] and was most recently readmitted on [DATE]. Resident 48's admitting diagnoses included dementia (a progressive state of decline in mental abilities). During a review of Resident 48's MDS, dated [DATE], the MDS indicated Resident 48 had a GT. g. During a review of Resident 114's Admission Record, the Admission Record indicated Resident 114 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 114's admitting diagnoses included dysphagia. During a review of Resident 114's MDS, dated [DATE], the MDS indicated Resident 114 had a GT. h. During a review of Resident 28's Admission Record, the Admission Record indicated Resident 28 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 28's admitting diagnoses included dysphagia and multiple sclerosis (a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord). During a review of Resident 28's MDS, dated [DATE], the MDS indicated Resident 28 had a GT and a Stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). During an observation on 4/21/2025 at 10:03 a.m., outside of Resident 28's room, there was no signage indicating Resident 28 was on EBP. There was no personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) readily accessible. i. During a review of Resident 22's Admission Record, the Admission Record indicated Resident 22 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 22's admitting diagnoses included dysphagia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 22's MDS, dated [DATE], the MDS indicated Resident 22 had a GT. During an observation on 4/21/2025 at 9:59 a.m., outside of Resident 22's room, there was no signage indicating Resident 22 was on EBP. There was no PPE readily accessible. j. During a review of Resident 215's Admission Record, the Admission Record indicated Resident 215 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 215's admitting diagnoses included dysphagia. During a review of Resident 215's MDS, dated [DATE], the MDS indicated Resident 215 had a GT. During an observation on 4/21/2025 at 10:04 a.m., outside of Resident 215's room, there was no signage indicating Resident 215 was on EBP. There was no PPE readily accessible. k. During a review of Resident 90's Admission Record, the Admission Record indicated Resident 90 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 90's admitting diagnoses included dysphagia. During a review of Resident 90's MDS, dated [DATE], the MDS indicated Resident 90 had a GT. During an observation on 4/21/2025 at 10:05 a.m., outside of Resident 90's room, there was no signage indicating Resident 90 was on EBP. There was no PPE readily accessible. l. During a review of Resident 82's Admission Record, the Admission Record indicated Resident 82 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 82's diagnoses included end-stage renal disease (irreversible kidney failure) and dependence on hemodialysis. During an observation on 4/22/2025 at 1:58 p.m., outside of Resident 82's room, there was no signage indicating Resident 82 was on EBP. There was no PPE readily accessible. During a concurrent observation and interview, on 4/21/2025 at 10:47 a.m., with Resident 82, Resident 82 stated he received hemodialysis on Tuesday, Thursday and Saturday. A permacath (a small catheter inserted into a large blood vessel for hemodialysis) was observed on his right upper chest. During a review of the facility's policy and procedure (P&P) titled Enhanced Barrier Precautions, updated 2025, the P&P indicated EBP was an infection control intervention designed to reduce transmission of MDROs. The P&P indicated EBP should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device. 2. During an interview on 4/24/2025 at 12:03 p.m., with the Maintenance Supervisor (MS), the MS stated he was unable to locate any records indicating the implementation of the facility's water management system, including annual review of the water management plan for effectiveness. The MS stated he also did not have any documentation describing the facility's water system. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/24/2025 at 12:13 p.m., with the IP, the IP stated he was aware of the facility's policy and procedure (P&P) titled Water Management Program. The IP stated the P&P indicated he was expected to be a member of the water management team. The IP stated he had not participated in any water management activities, including implementation of the plan or review of the plan's effectiveness. The IP stated the facility housed vulnerable facility residents who were at risk of severe illness in the event of a Legionella, or other opportunistic pathogens (bacteria) and outbreaks from bacteria growth in the facility's water systems. During a review of the facility's P&P titled Water Management Program, undated, the P&P indicated the Maintenance Director was responsible for maintaining documentation the describes the facility's water system. The P&P indicated the water management team was to regularly verify the water management system was being implemented, and the effectiveness of the program was to be evaluated no less than annually. The P&P indicated documentation of all activities related to the water management system were to be maintained for a minimum of three years. 48131 3. During an observation on 4/21/2025 at 12:22 p.m., observed Resident 2 sitting in her wheelchair eating from an unknown resident's partially consumed lunch tray that was left on the food cart in the hallway. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was initially admitted on [DATE] and readmitted on [DATE] with the following diagnoses which included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), schizophrenia (a mental illness that is characterized by disturbances in thought), and dysphagia oropharyngeal (relating to the throat) phase. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 2 could usually be understood and could usually understand others. The MDS indicated Resident 2 required maximal assistance (helper does more than half the effort) for bathing and moderate assistance (helper does less than half the effort) for toileting and personal hygiene. The MDS indicated Resident 2 used a wheelchair for mobility. During a review of Resident 2's Care Plan titled, Potential for Weight Loss, initiated on 1/17/2025, the care plan indicated to observe resident at mealtimes to assess eating patterns. During a concurrent observation and interview on 4/21/2025 at 12:36 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 observed Resident 2 with a dinner roll and opened carton of milk on her bedside table that the resident retrieved from the food cart in the hallway. LVN 2 stated Resident 2 took food off of another resident's dirty lunch tray on the food cart. LVN 2 stated it was unsafe for Resident 2 to eat off of the dirty food tray because she could catch something. LVN 2 stated the food cart should have doors so the residents would not have access to the dirty trays. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 4/23/2025 at 12:36 p.m., with Certified Nursing Assistant (CNA) 4, observed CNA 4 standing outside of Resident 2's room in front of the food cart during lunch. CNA 4 stated he was monitoring the food cart to ensure residents did not take food from the cart. CNA 4 stated the monitoring was done to prevent residents from eating something that was not on their diet and to prevent cross contamination. During an interview on 4/24/2025 at 8:31 a.m., with the IP, the IP stated he observed Resident 2 eating from the plate of another resident while she was in the hallway on 4/21/2025. The IP stated he immediately summoned nursing staff to assist the resident. The IP stated nursing staff should have been watching Resident 2 and redirecting her from the food cart in the hallway. The IP stated Resident 2 could catch germs and become ill due to eating from another resident's tray. During a review of the facility's P&P titled, Standard Precautions Infection Control, updated 2025, the P&P indicated, It is our policy to assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services and therefore our facility applies the Standard Precautions infection control practices. The P&P indicated Standard Precautions represent the infection prevention measures that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where healthcare is delivered. 47679 4. During a review of Resident 28's Admission Record, the Admission Record indicated Resident 28 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included encephalopathy (a disorder or disease of the brain, often affecting its ability to function properly), multiple sclerosis (a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), and a Stage 4 pressure ulcer on the right buttock. During a review of Resident 28's MDS, dated [DATE], the MDS indicated Resident 28's cognition was moderately impaired. The MDS indicated Resident 28 had functional limitation impairment on both sides of the upper and lower extremities (arms, legs). The MDS indicated Resident 28 was dependent on staff's assistance with eating, oral hygiene, toileting, bathing, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 28 had a Stage 4 pressure ulcer. During a review of Resident 28's History and Physical (H&P), dated 3/11/2024, the H&P indicated Resident 28 could make needs known but could not make medical decisions. During a review of Resident 28's Order Summary Report, dated 4/23/2025, the Order Summary Report indicated to cleanse Resident 28's Stage 4 pressure ulcer on the right ischium (area on the lower buttock) with normal saline ([NS], solution made of salt and water), pat dry, pack with gauze soaked with Dakin's solution (used to clean wounds and prevent infection), and cover with a dry dressing daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 4/23/2025 at 8:41 a.m., with the Treatment Nurse (TN) in Resident 28's room, observed the TN explained to Resident 28 that she would be doing his wound treatment. Resident 28 stated he did not have any pain and consented for the TN to begin the wound treatment. The TN prepared her supplies, performed hand hygiene, and applied gloves. The privacy curtain was pulled around Resident 28's bed and Resident 28 was positioned onto his left side with his right buttock exposed. The TN removed the previous dressing and gauze from Resident 28's wound. The TN removed her gloves and immediately applied new gloves. The TN cleansed Resident 28's wound and dried it with gauze. The TN removed her gloves and immediately applied new gloves. The TN packed Resident 28's wound with gauze soaked in Dakin's solution. The TN removed her gloves and immediately applied new gloves. The TN applied a padded dressing over Resident 28's wound and assisted Resident 28 onto his back. During an interview on 4/23/2025 at 8:52 a.m., with the TN, the TN stated hand hygiene was supposed to be performed throughout the wound treatment, especially after taking off gloves and before applying new gloves. The TN stated during Resident 28's wound treatment, she performed hand hygiene at the beginning of the wound treatment, but she did not perform hand hygiene whenever she removed her gloves. The TN stated gloves provided a barrier to help protect the resident from bacteria, however, hand hygiene was necessary to reduce the risk of transmitting bacteria. The TN stated not performing hand hygiene during Resident 28's wound treatment put him at risk of infection due to his open wound. The TN stated an infection could hinder Resident 28's wound from healing and potentially make it worse. During an interview on 4/24/2025 at 8:16 a.m., with the IP, the IP stated the purpose of hand hygiene was to prevent transmission of bacteria and diseases from one person to another. The IP stated during a wound treatment, hand hygiene had to be performed before initiating the treatment, during the treatment when gloves were changed, and once the treatment was completed. The IP stated bacteria could be present on the person's hands and could be transmitted onto the gloves if hand hygiene was not performed. The IP stated this would put the residents at risk of infection, especially for Resident 28 who had a Stage 4 pressure ulcer. The IP stated if Resident 28's wound became infected, the infection could spread to the bone and cause additional health complications. During a review of the facility's P&P titled, Hand Hygiene, revised 2025, the P&P indicated, Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The P&P indicated, The use of gloves does not replace hand washing. Wash hands after removing gloves.

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	04/24/2025

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

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 144) was offered a pneumococcal vaccine (an injection that protects against pneumococcal disease, which is caused by Streptococcus pneumoniae bacteria). This deficient practice had the potential to place Resident 144 at risk for contracting pneumococcal disease (e.g. pneumonia [an infection/inflammation in the lungs]) and suffering potential death. Findings: During a review of Resident 144's Admission Record, the Admission Record indicated Resident 144 was admitted on [DATE] and most recently readmitted on [DATE]. Resident 144's admitting diagnoses included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) and atrial fibrillation (an irregular and often rapid heart rhythm). During a review of Resident 144's Minimum Data Set (MDS, a resident assessment tool), dated 2/14/2025, the MDS indicated Resident 144 had moderately impaired cognition (difficulties with thinking, learning, remembering, and making decisions), and required supervision and/or touch assistance from staff for all ADLs except eating. During an interview on 4/23/2025 at 2:41 p.m., with the Infection Preventionist (IP), the IP stated there was no documentation to indicate Resident 144 was educated about or offered a pneumococcal vaccine. During an interview on 4/23/2025 at 2:50 p.m., with the IP, the IP stated that pneumococcal vaccinations were to be offered to all residents, and stated it was to protect the residents from pneumococcal infections. The IP stated the failure to offer Resident 144 a pneumococcal vaccine placed him at risk for infection. During a review of the facility's policy and procedure (P&P) titled Pneumococcal Vaccine, reviewed 1/2025, the P&P indicated all residents were to be offered a pneumococcal vaccine to aid in preventing pneumococcal infections.

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	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 47286 Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 1 was provided with abuse prevention, identification, and reporting training prior to providing direct care to facility residents. This deficient practice placed facility residents at risk of not having their allegations of suspected abuse being identified and/or reported by LVN 1, as required by the facility's policy and procedure. Findings: During an interview on 4/23/2025 at 1:42 p.m., with the Director of Staff Development (DSD), the DSD stated he could not locate any abuse training records for Licensed Vocational Nurse (LVN) 1. During an interview on 4/23/2025 at 2:18 p.m., with LVN 1, LVN 1 stated she was a registry nurse (a nurse, employed by a nursing agency rather than directly by the healthcare facility, who is typically deployed to fill temporary staffing needs). LVN 1 stated her first shift was in March 2025. LVN 1 stated her nursing agency did not provide abuse training, and stated she did not receive any abuse training from the facility prior to her first shift in March 2025. LVN 1 stated she did not know the abuse reporting requirements of the facility. LVN 1 stated it was important to know the abuse reporting requirements to ensure the safety of the facility residents. During an interview on 4/23/2025 at 3:28 p.m., with the DSD, the DSD stated the facility did not currently ensure abuse training was provided to registry staff prior to their first shift. The DSD stated it was important to ensure all staff received abuse training, including registry staff, to ensure the safety of the facility residents. During an interview on 4/24/2025 at 1:11 p.m., with the Administrator (ADM), the ADM stated there was no current process in place for ensuring registry staff were aware of the facility's abuse policies and procedures (P&Ps), or trained on the facility's abuse P&Ps. The ADM stated they assumed the nursing agency provided abuse training to the registry staff prior to their deployment to a facility. The ADM stated it was important for all staff to be trained in the facility's abuse policies and procedures to ensure the safety of the facility's residents and to ensure any suspected allegations of abuse are reported timely. During a review of the facility P&P titled Abuse, Neglect and Exploitation, updated 1/2025, the P&P indicated residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The P&P indicated new employees were to be educated on abuse, neglect, and exploitation.