STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555195	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Del Rosa Villa	2018 N Del Rosa Ave. San Bernardino, CA 92404

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50754 Based on interview, and record review, the facility failed to ensure a copy of the notice of transfer or discharge were sent to the Ombudsman for one (1) of three (3) sampled residents (Resident 63) reviewed for hospitalization s when: 1. Resident 63 was sent to the hospital on February 16, 2024, and there was no copy of notice of transfer or discharge sent to the Ombudsman. 2. Resident 63 was sent to the hospital on July 6, 2024, and there was no copy of notice of transfer or discharge sent to the Ombudsman. This failure had the potential for Resident 63 to be inappropriately transferred or discharged . Findings: 1. A review of Resident 63's clinical record, the Admission Record (a document that gives a summary of resident's information), indicated Resident 63 was admitted to the facility on [DATE], with diagnoses of Hemiplegia and Hemiparesis (weakness or unable to move one side of the body) following cerebral infarction affecting left non-dominant side (parts of the brain dies when the blood flow is reduced) and dysphagia (difficulty swallowing). During a review of Resident 63's physician order (a set of instructions written by a doctor for the care of a resident), dated February 19, 2024, it indicated, May be sent out to hospital for further evaluation. May have 7-day bed hold. During a subsequent review of Resident 63's hospitalization paperwork, dated February 16, 2024, there was no record of the notice of transfer or discharge sent to the Ombudsman found. During an interview on January 24,2025, at 4:20 PM, with the Social Worker (SW), the SW stated, I cannot find the notice of transfer or discharge sent to the Ombudsman. It was not sent. 2. During a review of Resident 63's physician order, dated July 6, 2024, at 2:18 PM indicated, May go to acute care with a 7-day bed hold. (continued on next page)

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a subsequent review of Resident 63's hospitalization paperwork, dated July 5, 2024, there was no record of the notice of transfer or discharge sent to the Ombudsman found. During an interview on January 24, 2025, at 4:45 PM here, with the SW, the SW stated, I cannot find the notice of transfer or discharge sent to the Ombudsman for this hospitalization date. It was not sent. During a concurrent interview and record review on January 24, 2025, at 5:25 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Transfer or Discharge notice, dated March 2024, was reviewed. The P&P indicated .4. Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge: d. An immediate transfer or discharge is required by the resident's urgent medical needs; and/or e. The resident has not resided in the facility for thirty (30) days . 6. For Facility-Initiated discharges, a copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative . The DON stated the P&P was not followed and further stated the Ombudsman should have been notified and was not.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50754 Based on observation, interview, and record review, the facility failed to ensure medications were administered according to the facility's policy and procedure (P&P) for one (1) of 92 residents (Resident 75) when five tablets were found in a medication cup, on the bedside table, unattended by staff. This failure had the potential to cause ineffective drug therapy, significant side effects, and adversely affect the health and safety of Resident 75. Findings: During a review of Resident 75's clinical records, the Admission Record (contains demographic and medical information) indicated, Resident 75 was admitted to the facility on [DATE], with diagnoses of traumatic subarachnoid hemorrhage without loss of consciousness (bleeding in the brain without passing out), and displaced fracture of body of right talus subsequent encounter for fracture (a break of the bone that connects the ankle to the foot, and the neck area). During a concurrent observation and interview on January 21, 2025, at 12:42 PM, with Resident 75, inside Resident 75's room, five medication tablets were found in a medication cup, on-top of the beside table next to the lunch meal tray. Resident 75 stated, These are the morning medications, and I haven't gotten around to taking it yet. Resident 75 proceeded to grab the medication cup and swallowed the tablets. During a concurrent interview and record review on January 21, 2025, at 1:01 PM with the Licensed Vocational Nurse 2 (LVN 2), LVN 2 went inside Resident 75's room and Resident 75 confirmed LVN 2 was the nurse who gave him the medication in the morning. LVN 2 reviewed the picture taken of the five tablets in the medication cup and she stated she was not sure if that was Resident 75's morning medications. LVN 2 stated she did not remember seeing if Resident 75 took his medication this morning at 9:00 AM but verified she was the nurse who gave his morning medications. LVN 2 further stated it was important to make sure medications are taken by the resident at the time of the prescribed time and to make sure the residents swallow the medications handed to them. During a concurrent interview and record review on January 21, 2025, at 2:34 PM, with the Director of Nursing (DON), the facility's P&P titled, Administering Medications, dated April 2019, was reviewed. The P&P indicated, .Medications are administered in a safe and timely manner, and as prescribed. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified . The DON stated that the P&P was not followed and further stated it was important to make sure medication tablets are not laying around unattended and that residents are medicated as prescribed by the physician.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 50631 Based on observation, interview, and record review, the facility failed to follow the menu when: 1. six (6) of six (6) Residents on pureed diet (a diet of smooth, blended foods that require no chewing) was served 2/3 cup of pureed Jambalaya instead of one cup that the menu called for during lunch on January 21, 2025. 2. 33 of 33 Residents on regular carbohydrate controlled (CCHO-consistent, constant, or controlled carbohydrate [sugars, starches and fiber]) diet, were served one whole slice of garlic bread instead of half a slice the menu called for during lunch on January 21, 2025. This failure had the potential to compromise residents' nutritional status when menus were not followed for 39 of 39 Residents on a Pureed and CCHO diet. Findings: 1. During tray line (when cook serves food on plates for each resident according to the menu) observation on January 21, 2025, at 11:50 AM in the kitchen, the Dietary [NAME] served a pureed Chicken Jambalaya using a 2/3 cup scoop to Resident 4 receiving a pureed diet, instead of one cup as indicated on the facility approved menu. During an interviewed with the cook on January 21, 2025, at 3:05 PM, the cook acknowledged that during the tray line she was not aware of the portion size listed on the menu and served only 2/3 cup instead of one cup of pureed Jambalaya for lunch on January 21, 2025, to all residents on pureed diet. The cook further acknowledged that the cook's spreadsheet winter menu dated January 21, 2025, indicates pureed Chicken Jambalaya one cup. During a review of the facility's document titled, Cooks Spreadsheet Winter Menu, dated January 21, 2025, the Winter Menu indicated, Chicken Jambalaya one cup for pureed diet and half a slice garlic bread for regular CCHO diet. 2. During tray line observation on January 21, 2025, at 11:50 AM in the kitchen, the Dietary [NAME] served one whole slice of garlic bread to Resident 548 and Resident 2 receiving regular CCHO diet, instead of a half slice of garlic bread as indicated on the facility approved menu. During an interviewed with the cook on January 21, 2025, at 3:05 PM, the cook acknowledged that during the tray line she was not aware of the portion size listed on the menu and served one whole slice of garlic bread instead of half a slice for lunch to all residents on a regular CCHO diet. The cook further acknowledged that the cook's spreadsheet winter menu dated January 21, 2025, indicates Garlic Bread: 1/2 (half) slice (small), 1/2 slice (regular), and 1 (one) Slice (large). During an interview with the Registered Dietician Nutritionist (RDN) on January 21, 2025, at 3:20 PM, the RDN stated the recipe, and the cook spreadsheet winter menu should be followed. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure (P&P) titled, Menu Planning, dated 2023, the P&P indicated, .the menus are planned to meet nutritional needs of residents in accordance with established national guidelines .

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50631 Based on observation, interview, and record review, the facility failed to store residents' food according to professional standards for food service safety when a dark brownish-reddish frozen spill was found on the bottom part of the freezer of the residents' refrigerator on January 21, 2025. This failure had the potential for bacteria to growth and to cause foodborne illness in residents who store food in the the residents' refrigerator. Findings: During an observation of the residents' refrigerator on January 21, 2025, at 10:55 AM, a dark brownish-reddish frozen spill was on the bottom part of the freezer. During an interview with the Registered Nurse 1 (RN 1) on January 21, 2025, at 10:57 AM, RN 1 stated that usually the Licensed Vocational Nurse on duty or the housekeeping is responsible for cleaning the residents' refrigerator and does not know why the freezer is dirty. During an interview with the Dietary Supervisor (DS), on January 23, 2025, at 10:49 AM, the DS stated his expectation is that the residents' refrigerator is clean with no frozen spills. The DS stated he wasn't aware the freezer was dirty and that he should have checked it for cleanliness. During a concurrent Interview and record review with the Director of Nursing (DON) on January 24, 2025, at 2:09 PM, the facility's P&P titled, Facility Resident Refrigerators was reviewed. The P&P states, this facility will ensure safe refrigerator maintenance, temperatures, and sanitation, and will observe food expiration guidelines .Weekly cleaning and maintenance on refrigerator Refrigerators will be kept clean and maintained with a disinfectant . When asked if this P&P was followed, the DON stated, If someone would have told housekeeping about the frozen spill, they would have cleaned it. During a review of the FDA Federal Food Code, dated 2022, 4-601.11 indicated (C) Non-food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris . in addition, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51269 Based on observation, interview, and record review, the facility failed to ensure Enhanced Barrier Precautions (EBP-are a set of infection control practices that use gowns and gloves to reduce the spread of multidrug-resistant organisms [MDROs- germs that resist treatment with more than one antibiotic]) were maintained for one (1) of five (5) sampled residents (Resident 97) when one Certified Nurse Assistant (CNA 1) did not wear a gown when providing incontinence care. This failure had the potential to result in an increased risk of cross-contamination (the transfer of harmful bacteria) to 92 highly vulnerable residents whose health conditions are already compromised. Finding: During an observation on January 22, 2025, at 9:50 AM, in Residents 97's room, there was a sign outside the room indicating Resident 97 was on EBP precautions. Resident 97 was lying in bed while CNA 1 was changing the incontinence brief without wearing a gown. During an interview on January 22, 2025, at 9:55 AM, with CNA 1, CNA 1 stated she should have worn a gown for a resident on EBP. CNA 1 stated, I forgot to wear a gown. I should have worn one to prevent the risk of spreading disease, but I was in a rush because other residents also needed assistance. During a review of Active orders dated January 21, 2025, for Resident 97, the order indicated, enhanced barrier precautions [EBP] during high contact resident care activities secondary to wound to right leg. During a review of Resident 97's clinical record, the Admission Record (contains demographic and medical information and the admitted), the Admission Record indicated Resident 97 was admitted to the facility on [DATE], with diagnoses of Leukocytoclastic Vasculitis (LCV- a disease that causes inflammation of small blood vessels), Cellulitis (a skin infection that usually appears as a red, inflamed area of skin) of right and left lower limbs, and non-pressure chronic ulcer (sores that develop on the skin and take a long time to heal) of unspecified part of left lower leg. During a concurrent interview and record review on January 22, 2025, at 11:30 AM with the Director of Nursing (DON), the facility's Policy and Procedure (P&P) titled, Isolation - Transmission-Based Precautions & Enhanced Barrier Precautions, dated September 2022, was reviewed. The P&P indicated, Enhanced Standard Precautions .wear gowns and gloves while performing the following high-contact tasks .Any care where close contact with the resident is expected to occur such as bathing, peri-care, assisting with toileting, changing incontinence briefs, respiratory care . The DON stated CNA 1 did not show compliance with the P&P and should have due to risk of resident's safety throughout the facility.