

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/16/2026
NAME OF PROVIDER OR SUPPLIER  Madera Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE  11900 Ramona Boulevard El Monte, CA 91732	

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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to ensure residents' right to privacy for one of three sampled residents (Resident 3) when: 1. Facility staff searched Resident 3's room without Resident 3's consent. This deficient practice had the potential to cause psychosocial harm, loss of dignity and feelings of frustration for Resident 3. Findings: During a review of Resident 3's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and heart failure (progressive heart disease that affects pumping action of the heart muscles, causes fatigue and shortness of breath). During a review of Resident 3's History and Physical (H&amp;P, physician's clinical evaluation and examination of the resident), dated 7/3/2025, the H&amp;P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 2/12/2026, the MDS indicated Resident 3 was unable to complete the interview for cognitive skills. The MDS indicated Resident 3's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was independent (decisions consistent/reasonable). The MDS indicated Resident 3 was independent for eating, oral hygiene, toileting hygiene, dressing, and personal hygiene. The MDS indicated Resident 3 required supervision for shower/bathing and putting on/taking off footwear. During an interview on 3/11/2026 at 10:03 a.m. with Resident 3, Resident 3 stated his room was searched without his consent. Resident 3 stated the administrator (Admin) searched his room for cigarettes and lighters. Resident 3 stated the Admin wanted to search his room because he carried a lighter. Resident 3 stated the facility violated his rights and searched his room without informing him. Resident 3 stated it was not right for staff to walk into residents' room and search through their personal stuff without residents' consent. During an interview on 3/11/2026 at 10:41 a.m. with the Admin, the Admin stated Resident 3 was out on the patio smoking and Resident 3 pulled out a lighter. The Admin stated staff asked Resident 3 to give up lighter and Resident 3 refused. The Admin stated the police department was called and the Admin and police dept went into Residents 3's room to search his room. The Admin stated they were in search for a lighter. The Admin stated the Admin did not notify Resident 3 about the room search and she was to notify him. During an interview on 3/16/2026 at 2:48 p.m. with the Director of Nursing (DON), the DON stated the facility staff could not search a resident's room without residents' permission. The DON stated residents had the right to privacy. During a review of facility's Policy and Procedure (P&amp;P) titled, Resident Rights, dated 1/2026, the P&amp;P indicated a resident had the right to be treated with consideration, respect and full recognition of his or her dignity and individuality.</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to develop a comprehensive care plan with interventions for two of three sampled residents (Resident 1 and 2). 1. Facility did not ensure Resident 1's care plan indicated Resident 1 required two-person assistance during transfers. 2. Facility did not ensure Resident 2's care plan indicated resident 2 had a bile drainage bag. These deficient practices placed Resident 1 at risk of injury and falls during transfers, and placed Resident 2 at risk for a delay in the delivery of necessary care and services. Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses that included absence of left leg above the knee and osteomyelitis (infection and inflammation of the bone or bone marrow, typically caused by bacteria, fungi, or other germs) of right foot and ankle. During a review of Resident 1's care plan for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) dated 1/5/2026, the care plan indicated Resident 1's goal was to improve current level of function in ADLs. The care plan indicated Resident 1's intervention was to transfer (chair/bed to chair transfer, toilet transfer) Resident 1 with staff participation. During a review of Resident 1's History and Physical Examination (H&amp;P, physician's clinical evaluation and examination of the resident), dated 1/8/2026, the H&amp;P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 2/25/2026, the MDS indicated Resident 1's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was moderately impaired. The MDS indicated Resident 1 required set up assistance for eating and oral hygiene. Then MDS indicated Resident 1 required supervision for personal hygiene. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) for upper body dressing. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) for lower body dressing, shower/bathing, and toileting hygiene. The MDS indicated Resident 1 had an impairment on one side of his lower extremity (hip, knee, ankle, foot) that interfered with daily functions or placed resident at risk of injury. During a review of Resident 1's Doctor's progress note, dated 3/11/2026, the progress note indicated Resident 1 had a possible right 5th metatarsal head (little toe) impaction fracture (broken bone ends are forced into each other). The progress note indicated surgery was not indicated and it was expected to heal in six months. During a review of Resident 1's Physical Therapy (PT) Evaluation and Plan of Treatment, dated 3/13/2026, the PT Evaluation and Plan of Treatment form indicated Resident 1 required maximum assistance (2-person assistance) with transfers. During an interview on 3/16/2026 at 10:25 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 required maximum assistance for transfers because his left leg was amputated. CNA 1 stated Resident 1 required maximal assistance for transfers from bed to wheelchair. CNA 1 stated Resident 1 required maximal assistance because Resident 1 had a fracture on Resident 1's right foot. During a concurrent interview and record review on 3/16/2026 at 1:20 p.m. with the Director of Physical Therapy (DOPT), Resident 1's PT Evaluation and Plan of Treatment forms, dated 3/13/2026 was reviewed. The PT Evaluation and Plan of Treatment form indicated Resident 1 required 2-person assistance for transfers. The DOPT stated Resident 1 required 2-person assistance because Resident 1 had an unsteady gate, his mobility level fluctuated and his mental status changed. The DOPT stated it was important to provide the required assistance to residents to prevent injuries and falls. During an interview on 3/14/2026 at 3:01 p.m. with the Director of Nursing (DON), the DON stated Resident 1's care plan should indicate Resident 1 required a 2-person assistance during transfers. The DON stated Resident 1 required 2-person assistance for his safety, The DON stated if it did not get care planned there was a risk for the 2-person assistance for (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>transfers was not practiced. 2. During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm (cancerous, abnormal growth of tissue that invades surrounding tissues and can spread to other body parts) of colon (main part of large intestine) and malignant neoplasm of axilla (armpit) and upper limb lymph nodes (small, bean-shaped organs that filter lymph fluid, removes waste, damaged cells, and germs). During a review of Resident 2's H&amp;P, dated 2/21/2026, the H&amp;P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was intact. The MDS indicated Resident 2 required set up assistance for eating. The MDS indicated Resident 2 required moderate assistance for oral hygiene. The MDS indicated Resident 2 required maximal assistance for upper body dressing. The MDS indicated Resident 2 was dependent on staff for toileting hygiene, shower/bathing and putting on/take off shoes. During a review of Resident 2's Order Recap Report, dated 2/26/2026, the Order Recap Report indicated Resident 2 had an order to flush abdominal biliary drain tube (flexible tube inserted through the skin into the liver or bile ducts to relieve bile duct blockages (a condition where the tubes carrying bile [fluid that aids digestion and is secreted by the liver] from the liver and gallbladder to the small intestine are narrowed or blocked) and drain bile into an external collection bag) with 10 milliliters (ml, metric unit of measurement, used for medication dosage and/or amount) of sterile saline every day and evening shift. During a review of Resident 2's electronic medical record, there was no care plan in Resident 2's electronic medical record to address Resident 2's abdominal biliary drain tube. During an interview on 3/16/2026 at 2:56 p.m. with the DON, the DON stated a care plan was developed to implement goals and interventions for residents' health concerns. The DON stated if care plans do not get developed medical concerns would not get addressed and residents would not receive the care they needed. During an interview on 3/16/2026 at 3:09 p.m. with the DON, the DON stated Resident 2's use of an abdominal biliary drain should be implemented in the care plan. The DON stated Resident 2's Care plan should indicate to monitor drain, check on amount of drainage, monitor signs of infection, and assess for any change of condition and for pain. The DON stated if the use of a biliary drainage bag did not get care planned, there was a risk of not addressing change of Resident 2's condition. During a review of facility's Policy and Procedure (P&amp;P) titled, Comprehensive Person-Centered Care Planning, dated 4/2025, the P&amp;P indicated the facility would develop a comprehensive person-centered care for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing mental and psychosocial needs.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure safe storage for one medication by: 1. Not ensuring medications were stored in a secure and locked manner. 2. Not ensuring medications were discarded after resident was discharged from facility. These deficient practices had the risk of medication theft and diversion of medication (redirection of prescription medication from its intended path (manufacturer to patient) for unauthorized use). Findings: During an observation on 3/11/2026 at 2:22 p.m. in the shed for nursing supplies, there was one box of lidocaine patches (topical, adhesive, local anesthetic products designed to treat pain by numbing specific areas of skin and underlying nerves) five percent (5%). During a concurrent observation and interview on 3/11/2026 at 2:26 p.m. with the Director of Maintenance (DOM) in the shed for nursing supplies, a box of lidocaine patches 5% was on a shelf on top of some diaper boxes. The DOM stated the DOM had never seen that box and the DOM did not know why it was there. The DOM stated medications should not be stored in the nursing supply shed because many people have access to the shed. The DOM stated the DOM did not know how long the medication was in the shed. During an interview on 3/11/2026 at 2:42 p.m. with the Director of Nursing (DON), the DON stated medications are only stored in medication carts and medication storage rooms. The DON stated medications should not be stored in the shed because that was improper medication storage and especially because the medication still had a resident's name on it. The DON stated the medication belonged to a resident that was already discharged from the facility. The DON stated the DON did not know why the medication was in the shed. The DON stated most likely a staff grabbed the medication box and took it to the shed. The DON stated this was an unacceptable practice and it had a risk of medication diversion [redirection of prescription medication from its intended path (manufacturer to patient) for unauthorized use]. During a review of facility's Policy and Procedure (P&amp;P) titled, Medication Storage, dated 2023, the P&amp;P indicated medications and biologicals are stored properly, following manufacturers recommendations or those of the supplier to maintain their integrity and to support safe administration. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medications labeled for individual residents are stored separately from floor stock medications that were not in the medication cart.</p>		

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<p>F 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have policies on smoking.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview, the facility failed to follow their smoking policy and procedure (a structured framework of rules and guidelines that ensure consistency, legal compliance, and operational efficiency within an organization) for one of one sampled resident (Resident 3) by: 1. Not ensuring Resident 3 had a current smoking assessment on medical record. 2. Not reassessing Resident 3's ability to smoke safely quarterly or after a significant change. These deficient practices placed Resident 3 at risk of fire or burn injuries. Findings: During a review of Resident 31's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and heart failure (progressive heart disease that affects pumping action of the heart muscles, causes fatigue and shortness of breath). During a review of Resident 3's History and Physical (H&amp;P, physician's clinical evaluation and examination of the resident), dated 7/3/2025, the H&amp;P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Smoking Evaluation form, dated 11/13/2025, the Smoking Evaluation form was not completely filled out. The Smoking Evaluation form did not indicate Resident 3's smoking frequency, did not address smoking safety, did not address if plan of care was updated to reflect smoking evaluation, if resident was educated on safe smoking practices, if resident was educated on risks of smoking, and if resident was educated on locations of designated smoking areas. During a review of Resident 3's Smoking Evaluation form, dated 2/12/2026, the Smoking Evaluation form was not completely filled out. The Smoking Evaluation form did not indicate Resident 3's smoking frequency, did not address smoking safety, did not address if plan of care was updated to reflect smoking evaluation, if resident was educated on safe smoking practices, if resident was educated on risks of smoking, and if resident was educated on locations of designated smoking areas. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 2/12/2026, the MDS indicated Resident 3 was unable to complete the interview for cognitive skills. The MDS indicated Resident 3's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was independent (decisions consistent/reasonable). The MDS indicated Resident 3 was independent for eating, oral hygiene, toileting hygiene, dressing, and personal hygiene. The MDS indicated Resident 3 required supervision for shower/bathing and putting on/taking off footwear. During a review of Resident 3's care plan for noncompliance with smoking policy, dated 3/10/2026, the care plan indicated Resident 3's intervention was to explain smoking policy and procedures (P&amp;P, a structured framework of rules and guidelines that ensure consistency, legal compliance, and operational efficiency within an organization). During a review of Resident 3's medical record, unable to locate reassessment of smoking evaluation after a change of condition on 3/10/2026. During an interview on 3/12/2026 at 1:16 p.m. with Minimum Data Set Nurse (MDSN), MDSN stated smoking evaluations are completed to identify if a resident is safe to smoke. The MDSN stated smoking evaluations are completed quarterly, annually or when there was a change in condition. The MDSN stated she did not complete the smoking evaluation for Resident 3 and MDSN should have completed the form for it to be valid. During a concurrent interview and record review on 3/12/2026 at 1:22 p.m. with MDSN, Resident 3's Smoking Evaluations forms, dated 11/13/2025 and 2/13/2026 were reviewed. The Smoking evaluations forms indicated Resident 3's smoking frequency, smoking safety, smoking plan of care, education on safe smoking practices, education on risks of smoking, education on locations of designated smoking areas were not addressed. The MDSN stated the Smoking Evaluation form had to be completely filled out for it to be a valid assessment. The MDSN stated if the Smoking Evaluation form was not completely filled out there was a risk Resident 3 was not informed of smoking (P&amp;P). The MDSN stated it was important to evaluate residents on their ability to safely smoke to prevent injuries and to maintain a safe smoking environment for themselves (continued on next page)</p>		

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<p>F 0926</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>and other residents. During an interview on 3/16/2026 at 2:39 p.m. with the Director of Nursing (DON), the DON stated the facility determined if it was safe for a resident to smoke by performing smoking evaluations. The DON stated smoking evaluations are completed quarterly and annually. The DON stated if smoking evaluations are not completed on time, it could potentially create smoking safety issues. The DON stated all sections of the Smoking Evaluation form must be completed, if resident refused participation, the form must indicate why the smoking evaluation form was not completely filled out. During a review of facility's P&amp;P titled, Smoking, dated 7/2025, the P&amp;P indicated the facility would assess all residents to determine if it was safe for them to smoke. The P&amp;P indicated the results of the evaluation would be placed on residents' medical record. The P&amp;P indicated residents' ability to smoke safely would be reassessed quarterly and at any time there was a change of cognition.</p>