

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  04/23/2026
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to promptly respond to call lights (a device used by a resident to signal his or her need for assistance from staff) and/or promptly respond to a resident's request for toileting assistance for two of four sampled residents (Residents 6 and 11). This failure placed Resident 6 and Resident 11 at risk for a delayed emergency response, accidents, or prolonged incontinence (lack of voluntary control over urination or defecation/bowel movement) and had the potential to result in Resident 6 and Resident 11 feeling like their concerns were unheard and to feel frustrated.a. During a review of Resident 6's Face Sheet (FS, front page of the chart that contains a summary of basic information about the resident), the FS indicated the facility admitted Resident 6 on 12/12/2025 with diagnoses which included cellulitis (an infection of the skin and deep underlying tissues) of right lower limb, type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and dysphagia (difficulty swallowing foods or liquids).</p> <p>During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 3/20/2026, the MDS indicated Resident 6 had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated Resident 6 required supervision or touch assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from staff for bathing, lower body dressing, and putting on/taking off footwear.</p> <p>During an interview on 4/22/2026 at 2:15 PM with Resident 6, Resident 6 stated that sometimes Resident 6 waited a long time for facility staff (in general) to answer Resident 6's call light. Resident 6 stated Resident 6 would wait 30 minutes for staff (in general) to answer the call light. Resident 6 stated the weekend was the time it took staff (in general) a long time to answer Resident 6's call light.</p> <p>b. During a review of Resident 11's FS, the FS indicated Resident 11 was originally admitted to the facility on [DATE] with diagnoses which included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) , type 2 diabetes mellitus, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial weakness or impaired movement on one side of the body).</p> <p>During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11 showed no evidence of acute change in mental status and cognitive pattern (the way a person thinks, learns, remembers, and processes information). The MDS indicated Resident 11 was dependent on staff (helpers do all the effort to complete the activity) for toileting, lower body dressing, and with putting on/taking off footwear.</p> <p>During an interview on 4/22/2026 at 12:55 PM with Resident 11, Resident 11 stated the facility staff's (in general) call light responses were delayed with waiting times of approximately 30 minutes. (continued on next page)</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 11 also stated call light response delays increased during the night, which was frustrating for Resident 11 whenever Resident 11 needed to be cleaned.</p> <p>During an interview on 4/23/2026 at 12:35 PM with the Director of Nursing (DON), DON stated answering the call lights promptly at all times was essential to attending to residents' needs especially when residents were dependent on staff for care.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Dignity and Respect, undated, the P&amp;P indicated, All residents shall be treated with kindness, dignity and respect. The staff shall display respect for residents when speaking with, caring for or talking about them, as constant affirmation of their individuality and dignity as human beings .</p> <p>During a review of the facility's P&amp;P titled, Call Light, with review date of 6/2025, the P&amp;P indicated, Answer the light/bell within a reasonable time.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interview and record review, the facility failed to promptly notify one of three sampled residents' (Resident 8's) doctor of Resident 8's fever and complaint of pain when urinating. This failure had the potential for Resident 8 to not receive timely treatment for Resident 8's pain and fever. (Cross Reference F842) During a review of Resident 8's Face Sheet, (FS, front page of the chart that contains a summary of basic information about the resident), the FS indicated the facility admitted Resident 8 on 10/8/2020 and readmitted Resident 8 on 4/1/2026 with diagnoses including pancytopenia (having low levels of red blood cells, white blood cells and platelets), muscle weakness, and acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood). During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 3/27/2026, the MDS indicated Resident 8's cognitive skills (ability to make daily decisions) were intact. The MDS indicated Resident 8 was dependent (helper does all the effort to complete the activity) on staff for toileting hygiene. The MDS indicated Resident 8 required substantial/maximal assistance (helper does more than half the effort to complete the activity) from staff for bathing and lower body dressing. The MDS indicated Resident 8 required partial/moderate (helper does less than half the effort to complete the activity) assistance from staff for upper body dressing and personal hygiene. During an interview on 4/23/2026 at 10:05 AM with Resident 8, Resident 8 stated Resident 8 had a fever the previous evening on 4/22/2026. Resident 8 stated Resident 8 thought Resident 8 presently had another fever. Resident 8 stated Resident 8 felt a burning pain whenever Resident 8 urinated, since the previous evening on 4/22/2026. During an interview on 4/23/2026 at 10:10 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated LVN 1 received report from the previous shift nurse (unidentified) that the nurse gave Resident 8 Tylenol (medication used to treat fevers and mild pain) for Resident 8's fever. LVN 1 stated the nurse on the previous shift should have contacted Resident 8's doctor regarding Resident 8's complaint of pain and fever. During a concurrent interview and record review on 4/23/2026 at 10:26 AM with Registered Nurse (RN) 1, Resident 8's eINTERACT Change in Condition Evaluation (CIC), dated 4/22/2026, was reviewed. The CIC indicated Resident 8 had a fever and complained of pain and a burning sensation when urinating on 4/22/2026. The CIC indicated Resident 8's doctor was notified but that the nurses were still waiting for orders from Resident 8's doctor. RN 1 stated the facility staff normally communicated with Resident 8's doctor via text from a facility cell phone. RN 1 stated the facility staff should have called the facility's Medical Director when Resident 8's doctor did not reply with orders to address Resident 8's complaints of pain and a fever. During a concurrent telephone interview and record review on 4/29/2026 at 12:11 PM with LVN 2, Resident 8's CIC, dated 4/22/2026, was reviewed. The CIC indicated Resident 8 had a fever and complained of pain and a burning sensation when urinating on 4/22/2026. The CIC indicated Resident 8's doctor (MD 1) was notified but that the nurses were still waiting for orders from MD 1. LVN 2 stated LVN 2 texted MD 1 around 6:30 pm on 4/22/2026 but did not receive a reply from MD 1. LVN 2 stated LVN 2 texted MD 1 twice during the shift but did not receive a reply from MD 1. LVN 2 stated LVN 2 should have reached out to the Medical Director when LVN 2 could not get ahold of MD 1. LVN 2 stated the CIC was incorrect when LVN 2 documented that LVN 2 notified MD 1 of Resident 8's change in condition since MD 1 did not reply to LVN 2's text messages. During a concurrent interview and record review on 4/23/2026 at 2:14 PM with the Director of Nursing (DON), the DON presented a document showing screen shots of the text messages sent to MD 1 on 4/22/2026 regarding Resident 8's changes in condition. The screen shots indicated a text message was sent to MD 1 on 4/22/26 at 7:02 pm and again at 10:28 pm. The screen shot indicated MD 1 did not reply to both messages sent. The DON stated the facility staff should have reached out to the Medical Director when MD 1 did not respond to the text messages. The DON stated the way staff verified if MD 1 was notified of Resident 8's change in condition was if MD 1 replied to the text message. The (continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>DON confirmed MD 1 did not respond to the text messages sent on 4/2/2026. The DON confirmed MD 1 was not notified of Resident 8's change in condition on 4/22/2026. During a telephone interview on 4/23/2025 at 3:12 PM with Nurse Practitioner (NP) 1, NP 1 stated NP 1 worked with MD 1. NP 1 stated neither MD 1 nor NP 1 were made aware of Resident 8's fever and pain on 4/22/2026. During a review of the facility's policy and procedure (P&amp;P) titled, Change in Condition, revised 4/2025, the P&amp;P indicated, .There will be certain circumstances where immediate attention will be warranted, and nursing will be responsible for notifying the appropriate department for evaluation. The nurse shall use his/her clinical judgment and shall contact the physician based on the urgency of the situation. The Medical Director shall be notified in the event that the Attending Physician or on-call Physician cannot be reached.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</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 implement the care plan to prevent a resident from falling for one of 11 sampled residents (Resident 10). This failure had the potential to increase the risk of serious injury to Resident 10 after a fall. During a review of Resident 10's Face Sheet (FS, front page of the chart that contains a summary of basic information about the resident), the FS indicated Resident 10 was originally admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing); major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and fracture (a partial or complete break in the bone) of unspecified part of neck of left femur (upper part of left thigh bone). During a review of Resident 10's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated Resident 10 showed no evidence of acute change in mental status and cognitive pattern (the way a person thinks, learns, remembers, and processes information). The MDS also indicated Resident 10 was dependent (helper does all of the effort to complete the activity) on staff for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 10's Change In Condition Evaluation (CIC), dated [DATE], the CIC indicated Resident 10 was found sitting on the floor on the right side of Resident 10's bed and Resident 10's back was against the wall. During a review of Resident 10's Care Plan Report (CPR), initiated on [DATE], the CPR indicated Resident 10's bed should be in the lowest position to minimize the risk of injury. During an observation on [DATE] at 10:40 AM inside Resident 10's room, Resident 10 was lying in bed which was not in the lowest position. Resident 10's bed frame was not lowered close to the floor. During a concurrent observation and interview on [DATE] at 10:05 AM with Certified Nursing Assistant (CNA) 3 inside Resident 10's room, Resident 10's bed was not in the lowest position. CNA 3 stated Resident 10 needed supervision to sit up and lay in bed, and to transfer in and out of bed/wheelchair. CNA 3 stated Resident 10's bed was not in the lowest position but should be kept in the lowest position to reduce the risk of falls. During an interview on [DATE] at 10:18 AM with Resident 10, Resident 10 stated on [DATE] Resident 10 fell as Resident 10 was trying to go back to bed from the wheelchair because Resident 10's wheelchair was too far from the bed. Resident 10 stated when Resident 10 fell on [DATE] Resident 10's bed was not in the lowest position. During an interview on [DATE] at 12:35 PM with the DON (Director of Nursing), DON stated Resident 10 was found on the floor and had been at a high risk of falling. DON stated staff should have supervised Resident 10, Resident 10's bed must be in the lowest position, and call light must be within reach for Resident 10's safety as stated in the facility's P&amp;P. During a review of the facility's policy and procedure (P&amp;P) titled, Fall Management System, dated 4/2025, the P&amp;P indicated The facility provides an environment that remains as free of accident hazards as possible and to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs .</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on observation, interview and record review, the facility failed to maintain a complete and accurate medical record for one of three sampled residents (Resident 8) when Licensed Vocational Nurse (LVN) 2 documented inaccurately in Resident 8's medical record that Resident 8's doctor (MD 1) was notified of Resident 8's fever and pain on 4/22/2026. This failure resulted in Resident 8's medical record containing inaccurate information. (Cross Reference F580) During a review of Resident 8's Face Sheet, (FS, front page of the chart that contains a summary of basic information about the resident), the FS indicated the facility admitted Resident 8 on 10/8/2020 and readmitted Resident 8 on 4/1/2026 with diagnoses including pancytopenia (having low levels of red blood cells, white blood cells and platelets), muscle weakness, and acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood). During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 3/27/2026, the MDS indicated Resident 8's cognitive skills (ability to make daily decisions) were intact. The MDS indicated Resident 8 was dependent (helper does all the effort to complete the activity) on staff for toileting hygiene. The MDS indicated Resident 8 required substantial/maximal assistance (helper does more than half the effort to complete the activity) from staff for bathing and lower body dressing. The MDS indicated Resident 8 required partial/moderate (helper does less than half the effort to complete the activity) assistance from staff for upper body dressing and personal hygiene. During an interview on 4/23/2026 at 10:05 AM with Resident 8, Resident 8 stated Resident 8 had a fever the previous evening on 4/22/2026. Resident 8 stated Resident 8 thought Resident 8 presently had another fever. Resident 8 stated Resident 8 felt a burning pain whenever Resident 8 urinated, since the previous evening on 4/22/2026. During an interview on 4/23/2026 at 10:10 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated LVN 1 received report from the previous shift nurse (unidentified) that the nurse gave Resident 8 Tylenol (medication used to treat fevers and mild pain) for Resident 8's fever. LVN 1 stated the nurse on the previous shift should have contacted Resident 8's doctor regarding Resident 8's complaint of pain and fever. During a concurrent interview and record review on 4/23/2026 at 10:26 AM with Registered Nurse (RN) 1, Resident 8's eINTERACT Change in Condition Evaluation (CIC), dated 4/22/2026, was reviewed. The CIC indicated Resident 8 had a fever and complained of pain and a burning sensation when urinating on 4/22/2026. The CIC indicated Resident 8's doctor was notified but that the nurses were still waiting for orders from Resident 8's doctor. RN 1 stated the facility staff normally communicated with Resident 8's doctor via text from a facility cell phone. RN 1 stated the facility staff should have called the facility's Medical Director when Resident 8's doctor did not reply with orders to address Resident 8's complaints of pain and a fever. During a concurrent telephone interview and record review on 4/29/2026 at 12:11 PM with LVN 2, Resident 8's CIC, dated 4/22/2026, was reviewed. The CIC indicated Resident 8 had a fever and complained of pain and a burning sensation when urinating on 4/22/2026. The CIC indicated Resident 8's doctor (MD 1) was notified but that the nurses were still waiting for orders from MD 1. LVN 2 stated LVN 2 texted MD 1 around 6:30 pm on 4/22/2026 but did not receive a reply from MD 1. LVN 2 stated LVN 2 texted MD 1 twice during the shift but did not receive a reply from MD 1. LVN 2 stated LVN 2 should have reached out to the Medical Director when LVN 2 could not get ahold of MD 1. LVN 2 stated the CIC was incorrect when LVN 2 documented that LVN 2 notified MD 1 of Resident 8's change in condition since MD 1 did not reply to LVN 2's text messages. During a concurrent interview and record review on 4/23/2026 at 2:14 PM with the Director of Nursing (DON), the DON presented a document showing screen shots of the text messages sent to MD 1 on 4/22/2026 regarding Resident 8's changes in condition. The screen shots indicated a text message was sent to MD 1 on 4/22/26 at 7:02 pm and again at 10:28 pm. The screen shot indicated MD 1 did not reply to both messages sent. The DON stated the facility staff should have reached out to the Medical Director when MD 1 did not respond to (continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>the text messages. The DON stated the way staff verified if MD 1 was notified of Resident 8's change in condition was if MD 1 replied to the text message. The DON confirmed MD 1 did not respond to the text messages sent on 4/2/2026. The DON confirmed MD 1 was not notified of Resident 8's change in condition on 4/22/2026. During a review of the facility's Policy and Procedure (P&amp;P) titled, Charting and Documentation, reviewed 2/2026, the P&amp;P indicated, .The purpose of this procedure is to provide. A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., as well as the progress of the resident's care.</p>