STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055141	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Post Acute Center	11900 Ramona Boulevard El Monte, CA 91732

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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 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** Based on interview and record review the facility did not immediately notify the family for one of three sampled residents (Resident 1) regarding Resident 1's fall on 5/4/2026. This failure violated Resident 1's right and had the potential for Resident 1's family member (FM 1) of not being informed of Resident 1's change in condition and not making an informed decision (decision based on facts, relevant information, and clear understanding of potential risks, benefits, and alternatives) regarding Resident 1's fall. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included history of falling, end stage renal disease ESRD (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 1's History and Physical Examination (H&P, physician clinical evaluation and examination of the resident), dated 5/2/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/8/2026, the MDS indicated Resident 1 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for upper body dressing and personal hygiene and was dependent on staff for toileting hygiene and putting on and taking off footwear. During a review of Resident 1's Nursing Progress Notes (NPN), dated 5/4/2026 and timed at 10:40 p.m., the NPN indicated Resident 1 had a fall on 5/4/2026 at 9:45 p.m. The NPN indicated Resident 1 was found (on the floor) in a supine position (flat on the back with face and torso/trunk facing upward) with right leg still on the bed. The NPN indicated Resident 1 had no contact person on file. During a review of Resident 1's Change in Condition Evaluation form (CIC), dated 5/4/2026 and timed at 10:09 p.m., the CIC indicated Resident 1 had a fall on 5/4/2026 during the night. The CIC indicated Resident 1 was observed on the floor while Resident 1's legs were on the bed. The CIC indicated under resident representative notification section Resident 1 had no contact person. During an interview on 5/13/2026 at 9:49 a.m. with Resident 1, Resident 1 stated Resident 1 fell on 5/4/2026. Resident 1 stated Resident 1 was trying to reach for the television remote control and Resident 1 got momentum and fell off the bed. Resident 1 called and informed FM 1 about the fall on 5/4/2026. Resident 1 stated Resident 1 was surprised that no one from the facility notified FM 1 about Resident 1's fall on 5/4/2026. Resident 1 stated FM 1 should have been notified of Resident 1's fall because a fall was important. During an interview on 5/13/2026 at 12:40 p.m. with FM 1, FM 1 stated no one from the facility called FM 1 on 5/4/2026 to inform FM 1 that Resident 1 fell. FM 1 stated on 5/6/2026 FM 1 received a call from Licensed Vocational Nurse (LVN) 1 and LVN 1 informed FM 1 that an X-ray (picture or digital image of the inside of the body) of Resident 1's leg was going to be taken. RP 1 stated LVN 1's call was not to notify FM 1 of Resident 1's fall but to inform FM 1 of the X-ray. FM 1 stated FM 1 was upset that the facility failed to notify FM 1 of something so important to Resident 1 and FM 1. FM 1 stated FM 1 visits Resident 1 every day and could not believe FM 1 was not notified of Resident 1's fall on 5/4/2026 until 5/6/2026. During an interview on 5/13/2026 at 2:42 p.m. with (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 1, LVN 1 stated LVN 1 did not know about Resident 1's fall on 5/4/2026 until 5/5/2026. LVN 1 stated LVN 1 called FM 1 on 5/6/2026 and notified FM 1 of Resident 1's fall on 5/4/2026. LVN 1 stated FM 1 was upset that no one notified FM 1 of the fall when it happened. LVN 1 stated resident representatives and family were required to be notified after a resident (in general) falls out of courtesy and because they had the right to know what was going on with their family members. During an interview on 5/13/2026 at 3:26 p.m. with LVN 2, LVN 2 stated on 5/4/2026 at 10:00 p.m. LVN 2 heard Resident 1 shouting for help. LVN 2 stated when LVN 2 entered Resident 1's room, Resident 1's upper body was on the floor, and the lower part of Resident 1's body was on the bed. LVN 2 stated LVN 2 did not call Resident 1's family because Resident 1 did not have a family phone number listed. LVN 2 stated LVN 2 asked Resident 1 for a phone number for a family member to notify them of the fall but the family member did not answer the phone. LVN 2 stated it was important to notify residents' family members to keep families informed of changes that happen to residents. LVN 2 stated if family members were not informed of falls, they would get upset. During an interview on 5/15/2026 at 3:12 p.m. with the Director of Nursing (DON), the DON stated that after a resident (in general) has a fall their representative and/or family must be notified of the fall. The DON stated resident representative and/or family must be notified because a fall was a significant change in condition for a resident and it was an emergency. The DON stated resident representatives and/or family have the right to be informed of any changes with the residents and it was their right to be informed. The DON stated licensed nurses were responsible for notifying resident representatives and/or families of changes in condition and the DON did not know why FM 1 was not notified of Residents 1's fall. The DON stated the night shift nurse should have followed up and attempted to call FM 1, but they did not. The DON stated after DON was informed of Resident 1's fall, the DON should have called FM 1, but the DON did not. The DON stated no one followed up to call Resident 1's family. During a review of facility's Policy and Procedure (P&P) titled Fall Management System, dated 4/2026, the P&P indicated when a resident sustains a fall, the resident representative would be notified of the fall and the resident status.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one of three sampled residents (Resident 3) received necessary care and services when: 1. Resident 3 did not receive the necessary assistance during mealtimes. 2. Resident 3 had the appropriate call light to request assistance.3. Resident 3 received appropriate care for a skin issue. 4. Resident 3's mobility assessments (a clinical evaluation used to determine how safely and independently a person can move, change positions, and carry out daily tasks) reflected Resident 3's current physical abilities. These failures had the potential for Resident 3 not receiving appropriate and necessary care timely. During an observation on 5/12/2026 at 1:11 p.m. in Resident 3's room, Resident 3's food tray had a full boneless chicken and chopped carrots. Food was untouched. Resident 3's face was extremely dry and flaky and observed skin flakes on Resident 3's shirt. During an observation on 5/13/2026 at 10:06 a.m. in Resident 3's room, Resident 3's food tray had a full pancake, one sausage patty, 1 milk carton and 1 cup of coffee. Food was untouched. Resident 3's face was extremely dry and flaky and observed flakes on Resident 3's sweatshirt. During an observation on 5/13/2026 at 10:25 a.m. in Resident 3's room, Resident 3's call light was clipped to the left side of Resident 3's sweatshirt. Resident 3 pulled the call light, and it pulled Resident 3's sweatshirt down. Resident 3 had trouble reaching the call light with the right hand. Resident 3 had no control over left upper extremity. Resident 3 was unable to push red button on call light system. Resident 3 pulled call light and brought it up to Resident 3's mouth and used Resident 3's teeth to operate the call light. During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included left side hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and dysphagia (difficulty swallowing). During a review of Resident 3's History and Physical Examination (H&P, physician clinical evaluation and examination of the resident), dated 11/1/2025, the H&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 3/26/2026, the MDS indicated Resident 3 required set up assistance for eating. The MDS indicated Resident 3 required maximal assistance (helper does more than half the effort to complete the activity) for oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 3 was dependent on staff for toileting hygiene, shower/bathing, lower body dressing, and putting on/taking off footwear. During a review of Resident 3's Care Plan Report (CPR), with a revision date of 10/3/2025, the CPR indicated Resident 3 needed assistance with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) due to poor balance, unstable gait, and left sided weakness. The CPR interventions included assisting Resident 3 to set up to eat. During a review of Resident 3's Joint Mobility Evaluation (JME, a clinical assessment that measures the flexibility, range of motion, and physical function of joints), dated 3/26/2026, the JME indicated Resident 3's left fingers had 75% to 100% of range intact (a minimum loss of motion). During a review of Resident 3's electronic medical record, there was no care plan regarding Resident 3's flaky skin on the face found in the medical record. During a review of Resident 3's electronic medical record, there was no facial skin assessment found in the medical record. During an interview on 5/13/2026 at 10:10 a.m. with Resident 3, Resident 3 stated Resident 3 had not eaten because Resident 3 was waiting for someone to assist Resident 3 by opening milk carton and to add milk to the oatmeal and coffee. Resident 3 stated Resident 3 asked Certified Nursing Assistant (CNA) 1 to assist with food set up and CNA 1 stated CNA 1 would return to help but CNA 1 did not return to help. Resident 3 stated food was always served in full portions, and staff never cut the food into smaller pieces. Resident 3 stated Resident 3 could not use a knife and a fork at the same time because Resident 3 only had one working arm. Resident 3 stated Resident 3 could not open Resident 3's left hand and Resident 3 was not able to move left wrist up and down. Resident 3 stated Resident 3 did not ask staff to cut Resident 3's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	food because Resident 3 knew staff would not do it because staff did not even want to open the milk carton. Resident 3 stated Resident 3 knew Resident 3's food was cold by now, but Resident 3 would still eat it. Resident 3 stated if staff did not want to help Resident 3 with food set up then Resident 3 would not eat. Resident 3 stated Resident 3 felt mad and sad at the same time because Resident 3 did not receive the support Resident 3 needed. Resident 3 stated Resident 3 felt ignored and not cared for. During an interview on 5/13/2026 at 10:28 a.m. with Resident 3, Resident 3 stated Resident 3 always had a problem using the call light and sometimes Resident 3 did not use the call light because it was too much work. Resident 3 stated Resident 3 struggled to reach the call light and Resident 3 could not push the red button on call light with Resident 3's right fingers. Resident 3 stated Resident 3 could bend right fingers a little but had no strength. Resident 3 stated the only way to push the call light was with Resident 3's teeth. Resident 3 stated Resident 3 wished there was another way to call for assistance, something easier for someone like Resident 3 that had mobility limitations. During an interview on 5/13/2026 at 10:43 a.m. with CNA 1, CNA 1 stated CNA 1 brought breakfast food tray to Resident 3. CNA 1 stated CNA 1 did not set up food or drinks for Resident 3. CNA 1 stated CNA 1 did not cut Resident 3's food into smaller pieces. CNA 1 stated CNA 1 did not return to assist Resident 3 because CNA 1 got busy with other residents. CNA1 stated CNA 1 knew Resident 3 could not use left hand but CNA 1 thought Resident 3 was okay to eat without assistance. CNA 1 stated Resident 3 had appropriate call light because Resident 3 had no problems using the call light. CNA 1 stated CNA 1 did not know what Resident 3 had on face. CNA 1 stated Resident 3's face was always dry and flaky and Resident 3 always scratched it. CNA 1 stated CNA 1 did not know if licensed nurses (in general) applied anything on Resident 3's face to help with the itchiness. During a concurrent interview and record review on 5/15/2026 at 9:39 a.m. with Director of Rehabilitation (DOR), Resident 3's JME, dated 3/26/2026, was reviewed. The JME indicated Resident 3's left fingers had minimal range of motion limitations. The DOR indicated Resident 3 was able to open left fingers with passive range of motion (the movement of a joint or body part that is produced entirely by an external force-such as a physical therapist, a caregiver, or a mechanical machine). The DOR stated all residents got reevaluated quarterly for their joint mobility. The DOR stated during Resident 3's joint mobility reevaluation, the rehabilitation department should have done a thorough assessment and included in the assessment that Resident 3 required more assistance due to not being able to use Resident 3's left hand during mealtimes and using the call light. The DOR stated nursing staff (in general) should have notified rehabilitation department about Resident 3 not being able to hold a fork and a knife at the same time to cut Resident 3's food. During a concurrent observation and interview on 5/15/2026 at 9:52 a.m. with DOR in Resident 3's room, Resident 3 struggled to reach the call light that was clipped to Resident 3's left side of sweatshirt. Resident 3 pulled the call light toward Resident 3 and could not push the red button on call light with Resident 3's right fingers. Resident 3 placed call light to Resident 3's mouth and pushed the call light button with Resident 3's teeth. The DOR stated Resident 3 should have been better assessed by rehabilitation department and the call light given to Resident 3 was not appropriate. The DOR stated the call light was not appropriate for Resident 3 because Resident 3 struggled to use the call light and it took a while for Resident 3 to push call light. The DOR stated this call light was not safe for an emergency. Resident 3 attempted to open left hand and Resident 3's hand mobility was limited. DOR stated Resident 3 had 50 % range of motion. The DOR stated Resident 3 required more assistance during mealtimes. The DOR stated Resident 3's food should be smaller in size because Resident 3 could not cut it. The DOR stated Resident 3's food and drinks should be set up by staff before leaving the room. During an interview on 5/15/2026 at 10:50 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 3 required set up assistance during mealtime because Resident 3 could not use left hand. LVN 1 stated set up assistance is assisting Resident 3 with taking lids off from food and drinks, open milk cartons, remove plastic wrap off food plates, add condiments to food and ask Resident 3 if Resident 3 wanted food cut into smaller pieces. LVN 1 stated staff must notify residents when food has arrived and not leave the room (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because food might get cold. During an interview on 5/15/2026 at 3:00 p.m. with Director of Nursing (DON), the DON stated call lights were used to better assist residents with their needs. The DON stated the facility provided a button call light or a pad call light to residents. The DON stated a pad call light was used by residents that have mobility issues and was contracted. The DON stated Resident 3 was not provided with the correct call light because Resident 3 could not use it the button call light. The DON stated Resident 3 using his mouth to push the call light was not treating Resident 3 with dignity and respect. The DON stated the rehabilitation department was responsible for assessing residents and for recommending the appropriate call light for residents. The DON stated Resident 3 required set up assistance during mealtimes. The DON stated set up assistance was to put food tray at Resident 3's bedside table, open cartons, make utensils accessible, help with food condiments, and cut food. The DON stated it was not acceptable to have residents eat without utensils. The DON stated Resident 3 only had one working hand and Resident 3 did not receive the assistance Resident 3 required. The DON stated Resident 3 could not eat because Resident 3's food was not set up appropriately to meet Resident 3's needs.During an interview on 5/15/2026 at 3:12 p.m. with the DON, the DON stated DON was aware of Resident 3's face dryness and flakiness. The DON stated the DON was not aware if Resident 3 currently received any medication or treatment for the face. The DON stated the DON did not document Resident 3's skin issue, did not notify Resident 3's physician and the DON did not ensure Resident 3 received care for skin issue. The DON stated the DON did not do anything for resident 3's skin issue and DON should have completed a change of condition and referred Resident 3 to see a dermatologist (medical doctor focused on diagnosing, treating, and preventing conditions and diseases affecting skin, hair, nails, and adjacent mucous membranes). During a review of facility's Policy and Procedure (P&P) titled Quality of Care, dated 12/2025, the P&P indicated the facility would ensure each resident received quality of care and services to attain and maintain the highest practicable physical mental and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and care plan. The P&P indicated at any time, it is recognized by any of the team members that a resident condition or care needs have changed, the licensed nurse or nurse supervisor would be made aware, for example when:There's a change in ability or decline in physical function and change in ability to eat or drink. The P&P indicated a nurse would communicate the change to other departments as appropriate and updated communications will be available during morning report. The P&P indicated each department notified will perform their own evaluation and assessments to determine if he change requires further intervention and implement actions accordingly. The P&P indicated the nurse would transcribe the treatment and plan of care relative to the change of condition on the resident electronic medical record. [NAME] a review of facility's P&P titled Call Light, dated 1/2026, the P&P indicated the facility would provide a resident a means of communication with nursing staff. During a review of facility's P&P titled ADL, Services to Carry Out, dated 3/2026, the P&P indicated the facility would provide residents with the appropriate treatment and services to maintain or improve his/her abilities. The P&P indicated residents who are unable to carry out activities of daily living (ADLs) would receive necessary services to maintain good nutrition, grooming, personal hygiene, and oral hygiene.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 2 and LVN 3 administered medications at scheduled medication administration times for two of three sampled residents (Resident 1 and Resident 2). This failure placed Resident 1 and Resident 2 at risk for medication errors and adverse health outcomes. Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included end stage of renal disease ([ESRD] a medical condition in which a person's kidneys cease functioning on a permanent basis) and dependence on renal dialysis (when kidneys no longer function well enough to keep them alive, requiring them to rely on regular, ongoing treatments to filter waste, remove excess fluids, and balance electrolytes from their blood). During a review of Resident 1's History and Physical Examination (H&P, physician clinical evaluation and examination of the resident), dated 5/2/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. 1. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included history of falling, end stage renal disease ESRD (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 1's History and Physical Examination (H&P, physician clinical evaluation and examination of the resident), dated 5/2/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/8/2026, the MDS indicated Resident 1 required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for upper body dressing and personal hygiene and was dependent on staff for toileting hygiene and putting on and taking off footwear. During a review of Resident 1's Order Summary Report (OSR), dated 5/2/2026, the OSR indicated Resident 1 had the following medication orders:1. Atorvastatin (medication to treat high amount of fats, such as cholesterol and triglycerides, in the blood) 20 milligrams (mg, a unit of measure) for hyperlipidemia (high amounts of fats or lipids in the blood), one tablet at bedtime.2. Sevelamer Carbonate (medication to treat high phosphorus level in the blood) 800 mg for ESRD, give three tablets in the evening.3. Carvedilol 25 mg for hypertension (HTN-high blood pressure), give one tablet two times a day.4. Clonidine 0.1 mg for HTN, give one tablet two times a day.5. Levetiracetam 500 mg (medication used to prevent and control seizures [sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), give one tablet two times a day. During a review of Resident 1's Medication Administration Record (MAR), dated 5/1/2026 to 5/13/2026, the MAR indicated Resident 1 was scheduled to receive the following medications:a. Atorvastatin 20 mg was scheduled for 9:00 p.m. b. Sevelamer Carbonate 800 mg three tablets were scheduled for 5:00 p.m.c. Carvedilol 25 mg was scheduled for 9:00 a.m. and for 5:00 p.m.d. Clonidine 0.1 mg was scheduled for 9:00 a.m. and for 5:00 p.m.e. Levetiracetam 500 mg was scheduled for 9:00 a.m. and for 5:00 p.m. During a review of Resident 1's Medication Administration Audit Report (MAAR), dated 5/4/2026, the MAAR indicated LVN 2 did not administer the following medications to Resident 1 as scheduled:a. Atorvastatin 20 mg was administered to Resident 1 at 12:09 a.m. instead of 9:00 p.m.b. Sevelamer Carbonate 800 mg three tablets were administered to Resident 1 at 6:42 p.m. instead of 5:00 p.m.c. Carvedilol 25 mg was administered to Resident 1 at 6:42 p.m. instead of 5:00 p.m.d. Clonidine 0.1 mg was administered to Resident 1at 6:42 p.m. instead of 5:00 p.m.e. Levetiracetam 500 mg was administered to Resident 1at 6:42 p.m. instead of 5:00 p.m. During an interview on 5/12/2026 at 3:39 p.m. with LVN 2, LVN 2 stated on 5/4/2026 LVN 2 administered Resident 1's medications late. LVN 2 stated medications were administered late because LVN 2 got (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	behind during medication administration. LVN 2 stated it was important to administer medications at the scheduled time because residents need the medications and if medication was administered late, it might be too close to the next medication administration time. 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 atrial fibrillation (irregular and often very rapid heart rhythm) and ESRD. During a review of Resident 2's H&P, dated 4/24/2026, the H&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 required maximal assistance (helper does more than half the effort to complete the activity) for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 2's OSR, dated 4/22/2026, the OSR indicated Resident 2 had the following medication orders:a. Renvela 800 mg (medication to treat high phosphorus level in the blood), give one tablet with meals.b. Prednisone 5 mg (medication used to suppress the immune system and reduce inflammation), give one tablet once a day.c. Eliquis 5 mg for atrial fibrillation, give one tablet two times a day.d. Gengraf 25 mg (medication to suppress the immune system), give one capsule every 12 hours.e. Allopurinol 100 mg (medication used to treat gout for gout [painful swelling and redness of the joints]), give one tablet once a day on Monday, Wednesday, Friday.f. Vancomycin 125 mg (medication used to treat infections), give one capsule once a day.g. Tamsulosin 0.4 mg (medication used to treat urinary symptoms caused by an enlarged prostate), give one capsule once a day.h. Lactobacillus capsule (used to restore the natural balance of bacteria in the digestive tract), give one capsule once a day. During a review of Resident 2's MAR, dated 4/23/2026 to 4/27/2026, the MAR indicated Resident 2 was scheduled to receive the following medications:a. Renvela 800 mg was scheduled for 7:15 a.m., 12:15 p.m., and 5:15 p.m.b. Prednisone 5 mg (medication used to suppress the immune system and reduce inflammation) was scheduled for 7:15 a.m.c. Eliquis 5 mg for atrial fibrillation was scheduled for 9:00 a.m. and 5:00 p.m.d. Gengraf 25 mg (medication to suppress the immune system) was scheduled for 9 a.m. and 9 p.m.e. Allopurinol 100 mg (medication used to treat gout for gout [painful swelling and redness of the joints]) was scheduled for 9 am.f. Vancomycin 125 mg (medication used to treat infections0 was scheduled for 9 a.m.g Tamsulosin 0.4 mg (medication used to treat urinary symptoms caused by an enlarged prostate) was scheduled for 9 a.m.h. Lactobacillus capsule (used to restore the natural balance of bacteria in the digestive tract) was scheduled for 9 a.m.During a review of Resident 2's MAAR, dated 4/24/2026, the MAAR indicated LVN 3 did not administer the following medications to Resident 2 as scheduled:a. Renvela 800 mg was given to Resident 2 at 11:13 a.m. instead of at 7:15 a.m.b. Prednisone 5 mg was given to Resident 2 at 11:13 a.m. instead of at 7:15 a.m.c. Eliquis 5 mg for atrial fibrillation was at 11:13 a.m. instead of at 9 a.m.d. Gengraf 25 mg was given to Resident 2 at 11:13 a.m. instead of at 9 a.m.e. Allopurinol 100 mg was given to Resident 2 at 11:13 a.m. instead of at 9 a.m.f. Vancomycin 125 mg was given to Resident 2 at 11:13 a.m. instead of at 9 a.m.g Tamsulosin 0.4 mg was given to Resident 2 at 11:13 a.m. instead of at 9 a.m.h. Lactobacillus capsule was given to Resident 2 at 11:13 a.m. instead of at 9 a.m. During an interview on 5/14/2026 at 1:06 p.m. with LVN 3, LVN 3 stated it was acceptable to administer a medication one hour before or one hour after the scheduled time. LVN 3 stated it was important to administer medications at the scheduled time because residents might have a second dose and it would not be safe to administer medications close together. LVN 3 stated if medications were not administered at the scheduled time, licensed nurses were not following doctor's orders. LVN 3 stated LVN 3 administered medication at the scheduled time. LVN 3 stated LVN 3 did not remember what happened during the medication administration and did the medication administration documentation at a later time. LVN 3 stated LVN 3 did not remember if LVN 3 moved to the next resident medication administration before documenting Resident 2's medication administration. During an interview on 5/14/2026 at 3:36 p.m. with Director of Nursing (DON), the DON stated medications must be administered one hour before or one hour after their scheduled time. The DON stated medications had a therapeutic effect and needed to be administered according to doctor's orders and at the time (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055141	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Post Acute Center	11900 Ramona Boulevard El Monte, CA 91732

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	doctor had scheduled them. The DON stated the risk of administering medications late was it could cause negative side effects. During a review of facility's policy and procedure (P&P) titled Medication Administration, dated 2023, the P&P indicated medications were to be administered within 60 minutes of scheduled time. The P&P indicated the individual who administered the medication dose records the administration on the resident's MAR directly after the medication is given. The P&P indicated Pour-Pass-Chart (refers to the standard, step-by-step medication administration process used by nurses and caregivers. It stands for the three core phases of handling drugs: Pouring (preparing), Passing (administering), and Charting) was the acceptable method for medications preparation, administration, and documentation.