

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2025
NAME OF PROVIDER OR SUPPLIER Montebello Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1035 W Beverly Blvd Montebello, CA 90640	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48143</p> <p>Based on observation, interview, and record review, the facility failed to develop/implement comprehensive care plan for Resident 1's Foley catheter care which was order physician on [DATE].</p> <p>This failure had the potential to negatively affect the provisions of care and services for Residents 1 and had the potential to place Resident 1 at risk for left buttock pressure ulcer wound become worse, cause urine blockage, and risk of urinary tract infection.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included fracture of unspecified part of neck of left femur (a break in the bone at the base of the left thigh bone, specifically in the neck region, but the exact location of the fracture within that area isn't specified. It's a hip fracture), presence of left artificial hip joint (a person has undergone a hip replacement surgery on the left side of their body, where the natural hip joint has been replaced with a prosthetic implant) and unspecified fall (descend freely by the force of gravity where the specific cause or circumstances are not known or documented).</p> <p>During a review of the Minimum Data Set (MDS- a resident assessment tool) dated [DATE], indicated Resident 1 had severely impaired (never/ rarely made decisions) for cognitive skills (the mental processes that allow people to think, learn, and solve problems) for daily decision making. Resident 1 is dependent, (helper does all of the effort) with the eating, oral hygiene and personal hygiene, toileting, upper and lower body dressing, change of position, and transfer, shower/bathe self.</p> <p>During a review of the Resident 1's Medication Administration Record (MAR) for the month of [DATE], the MAR indicated D/C Foley catheter monitoring:</p> <p>Monitor urine output q shift (every shift) monitor urine output every shift started on [DATE] which started from [DATE] to [DATE] for D/C Foley catheter.</p> <p>During a review of the Resident 1's Order Summary Report for the month of [DATE], the report indicated physician's order for indwelling catheter:</p> <p>(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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Indwelling Catheter. Foley catheter size:16 FR balloon size:10 CC (a fluid measuring unit) change for blockage, leaking, pulled out, excessive sedimentation. Change catheter drainage bag as needed and every change of indwelling catheter. as needed for urinary retention start date on [DATE].</p> <p>During a review of the Resident 1's Care Plan Report (CPR) for the month of [DATE], there was no care plan developed or implemented for the Foley catheter care.</p> <p>During a concurrent interview and record review on [DATE] at 12:56 PM with LVN 2, LVN 2 stated there was no care plan has been developed to monitor resident's urine output for Foley catheter discharge. Nursing supervisor and charge nurse should have developed the care plan for Foley catheter care when Resident 1 admitted to the facility and update or revised plan of care when there is a change in resident's condition and when there is a new order from physician.</p> <p>During an interview on [DATE] at 2:36 PM with medical record (MR), MR confirmed that there was no care plan for the [DATE] Foley catheter monitor and discharge foley catheter urine output monitoring for Resident 1. MR stated nurses should have developed the plan of care every time there is a new physician order or change of resident's condition to update the nursing interventions and provide better care and the appropriate monitoring of Resident 1's foley catheter care and urine output monitoring for discontinue of foley catheter.</p> <p>During a concurrent interview and record review on [DATE] at 4:49 PM, with the Director of Nurses (DON), DON stated nurses should have implemented a comprehensive care plan for Resident 1 to reflect the update interventions of monitoring.</p> <p>During a record review of the facility's policy and procedure titled, Care Plan Comprehensive, effective date [DATE], the policy indicated:</p> <p>The facility's interdisciplinary team, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, physical, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>1. Each resident' s comprehensive care plan is designed to:</p> <ol style="list-style-type: none"> a. Incorporate identified problem areas. b. Incorporate risk and contributing factors associated with identified problems. c. Build on the resident's individualized needs, strengths, preferences. d. Reflect treatment goals, timetables, and objectives in measurable outcomes. e. Identify the professional services that are responsible for each element of care. f. Aid in preventing or reducing declines in the resident's functional status and/or functional levels. <p>(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 - Few</p>	<p>2. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes.</p> <p>3. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS).</p> <p>4. Assessments of residents are ongoing and care plans are reviewed and revised as information about the resident and the resident 's condition change.</p> <p>5. The interdisciplinary Team is responsible for evaluation and updating of care plans:</p> <p>a. When there has been a significant change in the resident's condition.</p> <p>b. When the desired outcome is not met.</p> <p>c. When the resident has been readmitted to the facility from a hospital stay; and at least quarterly.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48143</p> <p>Based on observation, interview, and record review, the facility failed to ensure concise, and accurate document what happened on 4/17/2025 on Weekly Summary Documentation for one (1) of two (2) sampled residents (Resident 1).</p> <p>This deficient practice had the potential to cause delay of precaution and care for pressure ulcer and potentially cause worsening of wounds.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included fracture of unspecified part of neck of left femur (a break in the bone at the base of the left thigh bone, specifically in the neck region, but the exact location of the fracture within that area isn't specified. It's a hip fracture), presence of left artificial hip joint (a person has undergone a hip replacement surgery on the left side of their body, where the natural hip joint has been replaced with a prosthetic implant) and unspecified fall (descend freely by the force of gravity where the specific cause or circumstances are not known or documented).</p> <p>During a review of the Minimum Data Set (MDS- a mandated resident assessment tool) dated 4/7/2025, indicated Resident 1 had severely impaired (never/ rarely made decisions) for cognitive skills (the mental processes that allow people to think, learn, and solve problems) for daily decision making. Resident 1 is dependent, (helper does all of the effort) with the eating, oral hygiene and personal hygiene, toile personal hygiene, toileting, upper and lower body dressing, change of position, and transfer, shower/bathe self.</p> <p>During a review of the Change in Condition Evaluation (CCE) dated 4/13/2025 indicated Resident 1 had a new onset Grade 2 or higher pressure ulcer/injury, or progression of pressure ulcer/injury despite interventions at site # 32 left buttock with pressure injury stage 3 size 2 x 2 cm. Site # 49 for right heel DTI 4 x 5 cm, and site # 50 for left heel DTI 2 x 2 cm, family and physician had been notified, and signed by Unit Manager Registered Nurse (RN).</p> <p>During a review of the Resident 1's Treatment Administration Record (TAR) for the month of April 2025, the TAR indicated a wound treatment</p> <p>L heel DTI:</p> <p>Betadine swab sticks external swab 10 % (Povidone-Iodine) apply to left heel topically every day shift for DEEP TISSUE INJURY for 21 days paint with betadine, cover with gauze, and wrap with kerlex roll which started from 4/14/2025 to 4/30/2025.</p> <p>R heel DTI:</p> <p>(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>Betadine swab sticks external swab 10 % (Povidone-Iodine) apply to right heel topically every day shift for DEEP TISSUE INJURY for 21 days paint with betadine, cover with gauze, and wrap with kerlex roll which started from 4/14/2025 to 4/24/2025.</p> <p>Left Buttock pressure injury stage 2,</p> <p>cleanse with normal saline (NS), pat dry, cover with form dressing every day for 21 days which started from 4/14/2025 to 4/17/2025.</p> <p>During a review of the Weekly Summary Documentation (WSD) dated 4/17/2025, section p for skin integrity indicated Resident 1 has no skin issues and signed by LVN 1.</p> <p>During a review of the Weekly Wound Assessment (WWA) provided by wound care doctor dated 4/17/2025 indicated left heel wound size is L:5 cm x W: 6 cm x D: UTD (Unstageable Full Thickness Skin or Tissue Loss - Depth Unknown), right heel wound size is L: 4 cm x W: 4 cm x D: UTD, left buttock wound size is L: 3 cm x W: 3 cm x D: 0.4 cm.</p> <p>During a telephone interview on 5/16/2025 at 12:26 PM with LVN 1, LVN 1 stated she did her assessment on the WSD dated 4/17/2025, but she had checked section p of skin integrity by mistake to indicate Resident 1 has no skin issues. LVN 1 stated she should have marked section p to indicate Resident 1 has skin problems to ensure documentation accuracy, and nurses can provide treatment and skin monitoring to prevent Resident 1's skin integrity worsening.</p> <p>During a concurrent interview and record review on 5/16/2025 at 3:13 PM with DON, DON stated WSD date 4/17/2025 was not consistent with what skin condition/ wound Resident 1 had in accordance with the wound care doctor's weekly wound assessment and TAR. DON stated nurses should have to ensure documentation accuracy in order to provide monitoring and prevent worsening of Resident 1's skin integrity and wounds on her left, right heel and left buttock area. DON stated precise documentation ensure consistent communication and provide a high-level overview of the week's progress for all residents' care.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled Nursing Documentation, dated 6/27/2022, indicated,</p> <p>I. PURPOSE</p> <p>To communicate patient's status and provide complete, comprehensive, and accessible accounting of care and monitoring provided.</p> <p>II. POLICY</p> <p>Nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate based on the resident's/patient's (hereinafter patient) condition, situation, and complexity.</p> <p>III. PROCEDURE</p> <p>(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>a. Documentation includes information about the patient's status, nursing assessment and interventions, expected outcomes, evaluation of the patient's outcomes, and responses to nursing care.</p> <p>b. Timely entry of documentation must occur as soon as possible after the provision of care and in conformance with time frames for completion as outlined by other policies and procedures.</p> <p>c. The patient's record specifies what nursing interventions were performed by whom, when, and where.</p>		