STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055153	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montebello Care Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

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 07/18/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 6) received treatment and care in accordance with professional standards of practice (guidelines and expectations that define competent and ethical conduct within specific profession) by failing to complete medication reconciliation (the process of verifying and updating a patient's medication list during the transition from hospital to home or another care setting) of Resident 6's Discharge Medication List from General Acute Care Hospital (GACH 2) to administer the resident's Terazosin (a medication used in men to treat symptoms of benign prostatic hyperplasia [BPH-also known as an enlarged prostate], which include difficulty urinating, painful urination, and urinary frequency and urgency) once a day to start on 1/28/2025 at 9 PM. This failure could lead to worsening of the Resident 6's BPH and hospitalization.Findings: During a review of Resident 6's admission Record, the admission Record indicated the facility admitted Resident 6 on 1/28/2025, with diagnoses including but not limited to urinary retention (the inability to completely or partially empty the bladder) and BPH. During a review of Resident 6's Minimum Data Set (MDS-a resident assessment tool), dated 1/31/2025, it indicated Resident 6 had intact cognitive skills (ability to think, understand and reason) for daily decision making. The MDS also indicated Resident 6 required set up or clean up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with eating, oral and personal hygiene. The MDS indicated Resident 6 also required substantial or maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with shower/bathing self and upper body dressing and dependent (Helper does all the effort. Resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) with toileting hygiene, lower body dressing, and putting on/taking off footwear. During a concurrent interview and record review on 7/17/2025 at 5:14 PM with the Director of Nursing (DON), the External Facility Discharge Medication List from General Acute Care Hospital (GACH 2) dated 1/26/2025, Resident 6's Medication Administration Record (MAR) from the facility dated January 2025, and Resident 6's Order Summary Report from the facility dated1/28/2025 to 4/30/2025 were reviewed. The External Facility Discharge Medication List from GACH 2 dated 1/26/2025 indicated terazosin 5 mg (milligram-a unit of mass or weight equal to one thousandth of a gram) orally once a day, next dose on 1/28/2025 at 9 PM. Resident 6's MAR and Order Summary Report for January 2025 to April 2025, did not indicate there was an order for terazosin nor it was given to Resident 6 from 1/28/2025 to 4/24/2025 The DON stated the terazosin order that was in Resident 6's External Facility Discharge Medication List from GACH 2 was not reconciled in the physician's order when the resident was admitted at the facility on 1/28/2025. The DON stated that since it was not reconciled, it would not be in the order summary and MAR and Resident 6 did not receive the terazosin during the resident's stay in the facility from 1/28/2025 to 4/24/2025. During an interview on 7/17/20265 at 5:25 PM with the DON, the DON stated, Resident 6's missing medication that was not reconciled from the discharge medication list was not acceptable as it will affect the residents' health and safety and residents are put at risk for experiencing complications for not having received the medications. Resident 6's BPH symptoms could end up getting worse and affect Resident 6's overall health. The DON stated RN 1 could not explain why the terazosin order was not reconciled in Resident 6's Order Summary. The DON stated there were 87 doses of Terazosin that was not given to Resident 6, from 1/28/2025 to 4/24/2025 because the resident's discharge medication list for GACH 2 was not reconciled correctly. During a concurrent interview and record review on 7/18/2025 at 10 AM with Resident 6's attending physician (MD), the External Facility Discharge Medication List from GACH 2 was reviewed. The discharge medication list from GACH 2 reflected order for terazosin to give once a day. The MD validated that terazosin was not reconciled and was not given to Resident 6 during the resident's stay in the facility from 1/28/2025 to 4/24/2025. The MD stated the terazosin was for Resident 6's BPH and resident did not receive this medication. During a review of the facility's Policy and Procedure (P&P), titled Reconciliation of Medication on Admission, revised 1/5/2025, the P&P indicated the purpose of the P&P is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility. The P&P also indicated, medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process. In addition, the P&P indicated, medication reconciliation helps to ensure that

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent accidents to one of four (Resident 1) sampled residents who was identified at risk for falls and had a history of falls in accordance with the facility's policy and procedure (P&P) titled, Fall Management by failing to:1. Ensure adequate supervision of Resident 1 was provided to prevent accidents and injury on 7/16/2025.2. Create a comprehensive resident - centered care plan (a care plan developed and implemented to meet his or her preferences and goals, and addressed the resident's medical, physical, mental, and psychosocial needs) for Resident 1's long term care plan with focus on Resident 1's risk for fall/injury which includes intervention to supervise the resident every hour from 4/1/2025 to 7/16/2025. This deficient practice resulted in Resident 1 found on the floor near the Nurse's Station and the resident lying on her right side next to her on 7/16/2025 at 4:45 AM. Resident 1 was noted to have a small skin tear on the right temple (the area on the side of the head, just above the cheekbone and below the hairline) with minimal bleeding.Findings: During a review of Resident 1's admission Record, the admission Record, the admission Record indicated Resident 1 was initially admitted on [DATE] and was readmitted on [DATE] with diagnoses that included unspecified dementia (a brain disorder that results in memory loss, poor judgment, and confusion), muscle weakness, and history of falling. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 6/19/2025, the MDS indicated Resident 1 was assessed having severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 1 required substantial/maximal assistance (helper does more than half the effort) with eating, oral/personal hygiene, and upper/lower body dressing. Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with roll left and right, sit to lying, lying to sitting on side of bed, and chair/bed-to-chair transfer. During a review of Resident 1's Nursing Documentation Evaluation, dated 3/23/2025, the Nursing Documentation Evaluation form indicated Resident 1's Fall Risk factor included disorientation, confusion, and visual impairment. Resident 1's Nursing Documentation Evaluation form indicated fall risk indicators were identified for Resident 1. During a review of Resident 1's Interdisciplinary Care Conference (IDT- a meeting where healthcare professionals from different disciplines collaborate to develop or review a resident's care plan), dated 7/16/2025, the IDT indicated, on 7/16/2025 at 4:45 AM, Resident is observed on right side lying position next to her wheelchair. A small skin tear is noted to the right temple with minimal bleeding observed. During an interview, on 7/18/2025, at 11:27 AM, with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 1 was at risk for falls because the resident always tried to jump and move out of bed. CNA 1 stated CNA 1 did not know if Resident 1 had a history of falls in the facility. During an interview, on 7/18/2025, at 12:04 PM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated he was assigned to Resident 1 the morning of 7/16/2025 when Resident 1 had a fall. LVN 1 stated Resident 1 was a fall risk and had a history of falls. LVN 1 stated, at around 4 AM, on 7/16/2025, Resident 1 woke up and was restless and anxious in bed. LVN 1 stated CNA 2 placed Resident 1 on the resident wheelchair and wheeled Resident 1 to the Nurse's Station. LVN 1 stated, at around 4:45 AM, LVN 1 was notified by Housekeeping 1 (HSK 1) that HSK 1 found Resident 1 on the floor in the Nurse's Station. LVN 1 stated Resident 1 was found lying on her right side in the Nurse's Station. LVN 1 stated Resident 1 had discoloration and skin tear on the resident's right temporal area. During an interview, on 7/18/2025, at 12:24 PM, with HSK 1, HSK 1 stated, on 7/16/2025 at around 4:30 AM, HSK 1 passed by the Nurse's Station to get the broom and saw Resident 1 sitting on her wheelchair with CNA 2 and when she returned back to the Nurse's Station, she observed Resident 1 leaning towards the right side of the resident wheelchair and did not see CNA 2 or other facility staff at the Nurse's Station. HSK 1 stated HSK 1 informed LVN 1 to check on Resident 1 because the resident could fall and when HSK1 returned to the Nurse's Station, HSK1 found Resident 1 on the floor. HSK 1 stated Resident 1 was alone in the Nurse's Station when HSK1 found Resident 1 on the floor. During a concurrent interview and record review, on 7/18/2025, at 1:01 PM, with the Director of Nursing (DON), Resident 1's long term care plan with focus on Resident 1's risk for falls with risk factors including the resident's physical behavior observed by staff of scooting (sliding in a sitting position) from her low bed onto the fall mat, revised on 3/23/2025, was reviewed. The DON stated Resident 1's care plan intervention for resident safety check every hour for proper positioning, and to address and anticipate resident's needs was cancelled on 3/23/2025. During the same concurrent interview and record review, on 7/18/2025, at 1:01 PM, with the