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	04/01/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide supervision, safety measures and monitoring when one (1) of two sampled residents (Resident 1) eloped (exited the facility without the knowledge of facility staff) from the facility on 3/16/2026 around 8 PM and was not returned until 3/16/2026 around 8:45 PM by the police. This failure had the potential to lead to endangerment, accident and injury while outside the facility's premises without supervision from staff.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included diverticulitis of the intestine (inflammation or infection of small, bulging pouches that form in the lining of the lower intestines), other abnormalities of gait (manner of walking) and mobility, and muscle weakness. During a review of Resident 1's Minimum Data Set (MDS- a Resident assessment tool), dated 3/5/2026, 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. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, upper/lower body dressing, sit to lying, sit to stand, toilet transfer and walking 50 feet (ft.- unit of measurement for distance) with two turns. During a review of Resident 1's Progress Note, dated 3/16/2026, at 10:46 PM, the Progress Note indicated at approximately 8 PM, Resident 1 was not in her room nor around the station as observed by the Certified Nursing Assistant (CNA). A Code Pink (an emergency code for elopement) was called. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included essential hypertension (high blood pressure), muscle weakness, and lack of coordination (unsteady movements). During a review of Resident 3's History and Physical Examination (H&P), dated 2/10/2026, the H&P indicated Resident 3 had the capacity to understand and make decisions. During an interview on 4/1/2026, at 11:16 AM, with Resident 3, Resident 3 stated Resident 1 left with her sister in the morning of 3/16/2026 for an appointment and had a taste of the outside. Resident 3 stated Resident 1 always said she wanted to go home. On the evening of 3/16/2026, after Resident 1's sister left, Resident 1 paced back and forth in the room and went to the bathroom that was shared with the next room and exited to the hallway through the other room. During an interview on 4/1/2026, at 1 PM with CNA 1, CNA 1 stated she was assigned to Resident 1 on 3/16/2026. CNA 1 stated she last saw Resident 1 in her room at around 6:10 PM before she went on her break. CNA 1 stated at approximately 8 PM, Resident 1's roommate asked for assistance to go to the bathroom and she observed Resident 1 not on her bed when she turned on the bathroom light. CNA 1 informed Licensed Vocational Nurse 1 and a Code Pink was called. During an interview on 4/1/2026, at 1:24 PM, with Registered Nurse 1 (RN 1), RN 1 stated Resident 1 had unsteady gait and was forgetful. RN 1 stated Resident 1 was noticed missing by CNA 1 after CNA 1 returned from her break. RN 1 stated Resident 1 could only have exited from the door in front of Nurse's Station 1. During an interview on 4/1/2026, at 1:40 PM with the Director of Nursing (DON), DON stated the main door was locked at 6 PM and does not open from the outside. The DON stated the main door could still (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be pushed open from the inside even if it was locked. The DON stated Resident 1 most likely exited the facility through the main door because it was closer to her room. The DON stated the main door was not supervised after 6 PM. The DON stated it was not safe for the main door to not be supervised. During a review of the facility's policy and procedure (P&P), titled, Safety of Residents, dated 6/27/2022, the P&P indicated the facility will provide a safe environment for residents and Facility Staff.