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	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montebello Care Center	1035 W Beverly Blvd Montebello, CA 90640

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced dignity and respect in full recognition of the individuality for two (2) of three (3) sampled Residents (Residents 70 and 198) by failing to ensure the residents' urinary collection bag (a medical device used to collect urine that is drained from the bladder, typically via a urinary catheter [a thin, flexible tube {usually made of silicone or plastic} inserted into the bladder to drain urine]) was covered with a privacy bag. This deficient practice violated Resident 70 and 198's right for privacy and had the potential to affect the residents' self-esteem, self-worth, sense of independence, and psychosocial well-being (an individual's mental, emotional, and social health, encompassing aspects like happiness, life satisfaction, self-esteem, social functioning, and a sense of purpose, all of which are interconnected and influence overall functionality). Findings: 1. During a review of the Admission Record, the Admission Record indicated Resident 198 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to end stage renal disease (the kidney is no longer able to perform its main functions, which are to filter the blood to remove any waste and to balance fluids within the body) and chronic kidney disease (a condition where the kidneys are damaged and do not function as well as they should, leading to a gradual loss of kidney function- the ability of the kidneys to perform their vital tasks, which include filtering blood, removing waste and excess fluid, and maintaining a balance of electrolytes and other substances in the body). During a review of Resident 198's Order Summary, dated 3/20/2025, the Order Summary indicated, indwelling catheter: Foley catheter (a type of indwelling urinary catheter, which is a flexible tube inserted through the urethra {or sometimes directly into the bladder through a small incision} to drain urine) French (FR) 16 [NAME] size: 10 cubic centimeters (cc- a unit of volume in the metric system, representing the space occupied by a cube that measures 1 centimeter on each side) change for blockage, leaking, pulled out, excessive sedimentation. Change catheter drainage bag as needed and with every change of indwelling catheter. As needed for Urinary retention. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 198's Minimum Data Set (MDS- a resident assessment tool), dated 3/22/2025, the MDS indicated Resident 198 was moderately impaired with cognitive (the ability to understand and make decisions) skills for daily decision making. Resident 198 needed partial/moderate assistance (helper does less than half the effort) from the staff for the activities of daily living such as toileting, showers and upper and lower body dressing and needed supervision (helper provides verbal cues and resident completes activity) for eating, oral and personal hygiene. During a review of Resident 198's Care Plan initiated on 3/23/2025, the care plan indicated Resident 198 requires indwelling Foley catheter due to urinary retention (the inability to completely empty the bladder when urinating) with Dx (diagnosis) of BPH (Benign prostatic hyperplasia, a condition that causes the prostate gland which produces a fluid that is part of semen to grow larger than normal]). Staff interventions indicated were to provide privacy and comfort and provide a privacy bag. During observation in Resident 198's room on 4/01/25 at 9:07 AM, observed Resident 198 resting in bed. Resident 198's Foley catheter bag was noted to be hanging on the right side of the bed not covered with privacy bag. During an interview with Licensed Vocational Nurse 3 (LVN3) on 4/01/2025 at 9:15 AM, LVN3 stated Resident 198's Foley catheter bag was on the floor and was not covered with a privacy bag. LVN3 stated, the urine bag should be covered with a privacy bag to promote respect and dignity for the resident. During an interview with Registered Nurse 3 (RN3) on 4/01/2025 at 9:20 AM, RN3 stated it is per facility policy to make sure to have all foley catheter bags covered to promote residents' privacy. During an interview with the Director of Nursing (DON) on 4/04/25 at 11:56 AM, the DON stated Resident 198 does use a wheelchair to mobilize and the foley catheter is placed on the side of Resident 198's wheelchair and there must be a privacy bag covering the foley catheter bag for residents' dignity. 42223 2. During a review of Resident 70's Admission Record, the Admission Record indicated resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses of disorder of kidney (filtrates waste and makes urine) and ureter (duct where the urine passes from the kidney to the bladder) and dehydration. During a review of Resident 70's MDS, dated [DATE], the MDS indicated the resident was severely impaired (never/rarely make decisions) with cognitive skills for daily decision making. The MDS also indicated Resident 70 was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 70 had an indwelling catheter (tube that drains urine from the bladder to a drainage bag). During an observation on 4/1/2025 at 8:24 AM, Resident 70's urine collection bag was noted without a privacy bag. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/2/2025 at 1:55 PM, Registered Nurse 3 (RN 3) stated, It is not okay for the urine collection bag to be exposed because that is the resident's dignity. During an interview on 4/2/2025 at 2:36 PM, the Director of Nursing (DON) stated there should be a privacy bag for the urine collection bag to maintain resident's dignity. During a review of the facilities Policy and Procedure (P&P) titled, Quality of life-Dignity, revised 2/2020, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem.11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents. For example: a. Helping the resident to keep urinary catheter bag covered

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on observation, interview, and record review, the facility failed to accommodate the needs of one (1) of 21 sampled residents (Resident 9) in accordance with the facility policy by failing to ensure: 1. Resident 9's call light (device used by residents to call staff for assistance) was within reach. 2. Resident 9 was provided a touch pad call light (device used by residents to call staff for assistance with a gentle touch) appropriate for the resident's condition/needs. This deficient practice has the potential to delay in the provision of Resident 9's necessary care and services, which could negatively affect the overall condition of the resident. Findings: During a review of Resident 9's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with the diagnoses of ptosis (drooping of the eyelid) of left eyelid, cataract (lens of eyes becomes opaque [not letting light through] resulting in blurred vision) of both eyes, and muscle weakness. During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 2/28/2025, the MDS indicated resident was severely impaired with cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 9 was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) in toileting hygiene, shower/bath self and putting on/taking off footwear. Resident 9 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with upper body dressing, lower body dressing and personal hygiene. The MDS also indicated Resident 9 was always incontinent with both urine and bowel. During a review of Resident 9's Care Plan with focus on Risk for falls/injury, revised 12/23/2024, the Care Plan indicated staff intervention to place the call light within reach. During an observation on 4/1/2025 at 8:34 AM in Resident 9's room, Resident 9 was observed with a standard push button call light. Resident was also observed asking for water when Certified Nursing Assistant 2 (CNA 2) stated Resident 9 is blind and would require assistance to get things because she cannot see. During a concurrent observation and interview on 4/2/2025 at 1:57 PM, Resident 9's call light was observed in the middle of the bed. Resident 9 was observed in her wheelchair, on the side toward the foot of the bed, and against the wall. Registered Nurse 3 (RN 3) stated the call light was not within reach of the resident and the call light is not appropriate for Resident 9's needs. RN 3 also stated Resident 9 is blind and would not know where or how to use the call light. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/2025 at 2:29 PM, the Director of Nursing (DON) stated the call light should always be within reach of the resident. The DON also stated a resident who is blind should have a pad call light in order to ask for assistance. During a review of the facility's Policy and Procedure (P&P) titled, Answering the Call Light, revised 9/2022, the P&P indicated to ensure the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. During a review of the facility's P&P titled, Resident Call System, dated 9/2022, the P&P indicated if the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on observation, interview and record review, the facility failed to ensure accurate assessment of resident's functional ability for personal hygiene on the Minimum Data Set (MDS, a resident assessment tool) for one (1) of 1 sampled resident (Resident 9) as indicated on the facility policy. This deficient practice had the potential for the facility to not develop and implement a resident centered care plan for Resident 9 to receive care and services to maximize or improve Resident 9's functional ability in personal hygiene. Findings: During a review of Resident 9's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with the following diagnoses of osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion), muscle weakness, and dementia (a progressive state of decline in mental abilities). During a review of Resident 9's MDS, dated [DATE], the MDS indicated resident was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 9 required partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with oral hygiene and personal hygiene. Resident also required substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with upper body dressing and lower body dressing while was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, shower bath self and putting on/taking off footwear. During a review of Resident 9's Interdisciplinary (a group of health care professionals with various areas of expertise who work together toward the goals of their clients) Care Conference, dated 2/24/2025, indicated Resident 9 required substantial/maximal assistance with personal hygiene. During a review of Resident 9's MDS, dated [DATE], the MDS indicated resident was severely impaired with cognitive skills for daily decision making. The MDS also indicated Resident 9 was dependent with toileting hygiene, shower/bath self and putting on/taking off footwear. Resident 9 required substantial/maximal assistance with upper body dressing, lower body dressing and personal hygiene. During an observation on 4/3/2025 at 10:25 AM, Certified Nursing Assistant 2 (CNA 2) was observed providing Activities of Daily Living (ADL) care to Resident 9. CNA 2 was observed wiping Resident 9's face with maximal assistance from the resident. During an interview on 4/4/2025 at 11:20 AM, the Director of Nursing (DON) stated Resident 9's MDS, dated [DATE], was inaccurately assessed since Resident 9 has always required substantial/maximal assistance for personal hygiene. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/2025 at 11:50 AM, CNA 4 stated Resident 9 has required maximal assistance with personal hygiene for a year and it has not changed. During a concurrent record review of Resident 9's MDS, dated [DATE] and 2/28/2025, and interview on 4/4/2025 at 11:53 AM, the DON and MDS Nurse stated Resident 9's functional ability for personal hygiene was inaccurately assessed on 11/30/24 since it indicated partial/moderate assistance instead of substantial/maximal assistance. The DON and MDS Nurse also stated the MDS, dated [DATE], should have been substantial/maximal assistance and not partial/moderate assistance. The DON and MDS stated it is important to have an accurate MDS because it can affect the residents plan of care. During a review of the facility's Policy and Procedure (P&P) titled, MDS Completion and Submission Timeframes, revised July 2017, the P&P indicated the assessment coordinator, or designee is responsible for ensuring that resident assessments are submitted to CMS in accordance with current federal and state guidelines.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on observation, interview, and record review, the facility failed to develop a care plan for two of 21 sampled residents (Residents 28 and 86) in accordance with the facility policy by failing to ensure a care plan reflected: 1. Resident 28's smoking and refusal to wear a smoker's apron (prevents burns in clothing and keep hot ashes from burning the skin) while smoking. This deficient practice had the potential to place Resident 28 at risk for injury, accidents, and harm. 2. Resident 86's fluid restriction as indicated on the physician's order, dated 3/1/2025. This failure had the potential to place Resident 86 at risk for fluid overload (too much fluid in the body which can raise the blood pressure and force the heart to work harder), edema (swelling caused by too much fluid trapped in the body's tissues), and dehydration (a dangerously loss of body fluid caused by illness, sweating, or inadequate intake). Findings: 1. During a review of Resident 28's Admission Record, the Admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with the diagnoses of dementia (a progressive state of decline in mental abilities) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 28's Minimum Data Set (MDS, a resident assessment tool), dated 1/13/2025, the MDS indicated the resident was severely impaired with cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 28 was dependent with lower body dressing and putting on/taking off footwear. Resident 28 required substantial/maximal assistance (Helper does less than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.) with toileting hygiene and shower/bathe self. During an observation in the smoking area on 4/2/2025 at 9:44 AM with the Admission Assistant (AA), Resident 28 was observed refusing to put on a smoker's apron while smoking. During a concurrent record review of Resident 28's Care Plans, dated 10/17/2024 to 3/5/2025, and interview on 4/3/2025 at 11:28 AM, Director of Nursing (DON) stated the resident does not and should have a plan of care for smoking to address and implement the needs of the resident while smoking such as the use of protective apron to keep the resident safe and prevent accidents. During an interview on 4/4/2025 at 11AM, Activities Director (AD) stated when he would supervise Resident 28, the resident would always refuse to put on a smoker's apron while smoking. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled, Smoking Policy, revised 8/2022, the P&P indicated any smoking related privileges, restrictions, and concerns (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. 48143 2. During a review of Resident 86's Admission Record, the admission record indicated Resident 86 was admitted to the facility on [DATE], with diagnoses that included stage 4 chronic kidney disease (the kidneys are moderately or severely damaged and are not properly filtering waste from the blood), type 2 diabetes (a chronic condition where the body does not use insulin [hormone that helps sugar from food enter cells for energy] effectively or does not produce enough insulin, leading to high blood sugar levels), and acute systolic heart failure, (a sudden and life-threatening condition where the heart's left ventricle struggles to contract and pump blood effectively, leading to reduced blood flow to the body). During a review of the Minimum Data Set (MDS, resident assessment tool), dated 2/10/2025, the MDS indicated Resident 86 had modified independence (some difficulty in new situations) for cognitive skills for daily decision making. Resident 86 need partial or moderate assistance (helper does less than half the effort) with eating, oral, toilet, personal hygiene, upper and lower body dressing, change of position, and transfer. During a review of Resident 86's Physician Orders, dated 3/1/2025, the physician's order indicated Resident 86's fluid restriction of 1200 milliliters (ml, units of measurement) per 24 hours as follows: - Nursing 600 ml: 300 ml for 7AM -3PM (AM shift), 200 ml for 3PM to 11 PM (PM shift), and 100 ml for 11PM to 7AM. (NOC shift) - Dietary 600 ml (for meals): 360 ml for breakfast, 120 ml for lunch and 120 ml for dinner. During a concurrent review of Resident 86's care plan and interview on 4/2/2025 at 12:58 PM with Licensed Vocational Nurse 1(LVN1), LVN 1 stated that there was no care plan to reflect the fluid restriction ordered on 3/1/2025 for Resident 86. During a concurrent review of Resident 86's care plan and interview on 4/2/2025 at 2:26 PM with medical records staff (MR), MR stated there was no care plan for the fluid restriction order on 3/1/2025 for Resident 86. 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 to prevent resident from getting fluid overload which could lead to hospitalization . During a concurrent interview and record review on 4/2/2025 at 2:59 PM, with the Director of Nurses (DON), the DON stated nurses should have implemented a comprehensive care plan for Resident 86's to reflect the interventions to monitor fluid restriction for Resident 86 to prevent fluid overload, edema, dehydration, chest pain, heart attack or other complications which could harm Resident 86. During a record review of the facility's P&P titled, Comprehensive Care Plan, effective 8/25/2021, the policy indicated: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 1. Each resident' s comprehensive care plan is designed to: 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. 2. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes . 4. Assessments of residents are ongoing and care plans are reviewed and revised as information about the resident and the resident 's condition change. 5. The interdisciplinary Team is responsible for evaluation and updating of care plans: a. When there has been a significant change in the resident's condition. b. When the desired outcome is not met. c. When the resident has been readmitted to the facility from a hospital stay; and at least quarterly. During a record review of the facility's P&P titled, Dialysis Care, effective 8/25/2021, the policy indicated the Care Plan, The Interdisciplinary Team (IDT) will ensure that the resident's Care Plan includes documentation of the resident's renal condition and necessary precautions (e.g. fluid restrictions lab draws ., observe for signs and symptoms of infection, etc.). The resident's Care Plan will be updated as needed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903 Based on observation, interview, and record review, the facility failed to set the low air loss mattress (LALM, pressure relieving mattress that operates using a blower based pump that is designed to circulate a constant flow of air through the mattress, commonly used to heal pressure ulcers [wound that occurs as a result of prolonged pressure on a specific area of the body]) at the correct setting for one (1) of six (6) sampled resident's (Resident 51) in accordance with the facility's policy and procedure (P&P) titled, Skin Integrity Management and physician's order. This deficient practice had the potential to result in Resident 51's pressure ulcers to worsen. Findings: During a review of Resident 51's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included pressure ulcer Stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of sacral region (lower back), and diabetes mellitus (DM a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 51's Minimum Data Set (MDS, resident assessment screening tool), dated 2/28/2025, indicated the resident had severe impairment of cognitive (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) skills for daily decision making. Resident 51 was dependent (staff does all the effort in tasks, resident does no effort in task, assistance of two or more helpers is sometimes required to complete a task) on staff for eating, hygiene (oral and physical), toileting, showering, upper/lower body dressing and putting on/taking off footwear. The MDS indicated Resident 51 was admitted with 1 pressure Ulcer Stage 4 and five (5) unstageable pressure ulcers (a full-thickness pressure injury where the base of the ulcer is obscured by dead skin or a dark, dry scab, making it impossible to determine the depth of the tissue damage). The MDS indicated Resident 51 required pressure ulcer care. During a review of Resident 51's Weight Summary, dated 3/25/2025, the Weight Summary indicated Resident 51 weighed 94 lbs (pounds; unit of measurement for weight). During a review of Resident 51's Care Plan titled, Sacro-coccyx (lower end of the spinal area at the base of the spine), pressure ulcer Stage 4, dated 2/7/2025, the care plan indicated staff interventions were to monitor treatment effectives or ineffectiveness, treatment as ordered, and weekly evaluation. During a review of Resident 1's Order Summary Report, dated 3/4/2025, the order summary indicated, Resident 51 was ordered a LALM, and it was to be set based on Resident 51's weight. During a concurrent observation and interview on 4/1/2025 at 9:53 AM with Licensed Vocational Nurse 3 (LVN3), Resident 51's LALM setting was observed set at 160 lbs. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montebello Care Center	1035 W Beverly Blvd Montebello, CA 90640

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 4/1/2025 at 9:58 AM with LVN 3, Resident 51's weight summary was reviewed. The weight summary indicated Resident 51 weighed 94 lbs on 3/25/2025. LVN 3 stated, On 3/25/25 Resident 51 weighed 94 lbs. The purpose of the LALM is to prevent further skin breakdown. If it's set higher than the patient's weight the bed becomes too hard, and it defeats the purpose of the mattress. This can make the patient's wounds worsen. During a concurrent interview and record review on 4/3/2025 at 10:40 AM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Skin Integrity Management, dated 5/26/2021 was reviewed. The P&P indicated: 1. The purpose of the P&P is to provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment and promote healing of all wounds. 2. Nursing staff will observe for any sign of potential or active pressure injury daily while providing nursing care. 3. Implement pressure ulcer prevention for identified risk factors. DON stated, The purpose of the LALM is to relieve the pressure of a resident on bony areas. If the LALM is set higher than the resident's weight, it adds more pressure and the surface becomes harder. A harder surface can be a factor in worsening the condition of wounds.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48143 Based on observation, interview, and record review, the facility failed to provide an environment free from accident (any unexpected or unintentional incident, which results or may result in injury or illness to a resident) hazards for two of two sampled residents (Residents 81 and 198) when: 1. A razor blade was found on the floor in Resident 81's room. This failure had the potential to cause injury to Resident 81. 2. Medication was observed left unattended at Resident 198's bedside table. This deficient practice had the potential for Resident 198 or other residents to get hold of the medication and if ingested (swallowed), had the potential for complications. Findings: 1. During a review of Resident 81's Admission Record, the admission record indicated Resident 81 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included acute on chronic systolic heart failure, (sudden and life-threatening condition, a pre-existing, long-term condition, where the heart's left ventricle struggles to contract and pump blood effectively, leading to reduced blood flow to the body), other abnormalities of gait and mobility, (deviations from the normal pattern of walking or movement, often caused by neurological, musculoskeletal, or other medical conditions, impacting balance, coordination, and overall mobility), and chronic kidney disease (kidneys are moderately to severely damaged, waste products build up in the blood, potentially leading to serious complications). During a review of the Minimum Data Set (MDS- a resident assessment tool), dated 1/16/2025, indicated Resident 81 was severely impaired with cognitive skills (the mental processes that allow people to think, learn, and solve problems) for daily decision making. Resident 81 needed partial or moderate assistance, (helper does less than half the effort) with the eating, oral hygiene and personal hygiene. Resident 81 was dependent, (helper does all of the effort) with the toilet, upper and lower body dressing, change of position, and transfer. During an observation on 4/3/2025 at 11:06 AM in Resident 81's room, observed an unused razor blade on the floor by Resident 81's bed. During a concurrent observation and interview on 4/3/2025 at 11:15 AM with Infection Preventionist Nurse (IPN) in Resident 81's room, IPN verified that there was an unused razor blade on the floor. IPN stated that unattended razor blade can cause injury to resident inside the room and staff who is working with the resident. IPN stated razor blades are not allowed inside the resident's room. IPN stated that it was probably from the (CNA) Certified Nurse Assistant who helped resident to shave in the morning. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/3/2025 at 12:08 PM with Registered Nurse Supervisor 1(RN1), RN 1 stated the razor blade was not supposed to be on the floor or anywhere inside the resident's room. RN 1 stated only staff have access of the storage room where the razor blades were stored. RN1 stated residents cannot keep any razor blade by themselves due to risk for injury. RN1 stated nursing aid may use it to shave the resident in the morning. RN1 stated unattended razor blade inside resident's room can injure residents accidentally. During a record review of the facility's undated policy and procedure titled, Hazardous Areas, Devices and Equipment, the policy indicated: 1. A hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples of environmental hazards include, but are not limited to: a. Equipment and devices that are left unattended. b. sharp objects that are accessible to vulnerable residents. 45523 2. During a review of the Admission Record, the Admission Record indicated Resident 198 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to type 2 diabetes mellitus (DM-a disease in which the blood glucose, or blood sugar, levels are too high), other lack of coordination (a medical condition, often called ataxia, characterized by a loss of muscle coordination, leading to clumsy or jerky movements, unsteady gait, and difficulty with balance and fine motor skills), end stage renal disease (the kidney is no longer able to perform its main functions, which are to filter the blood to remove any waste and to balance fluids within the body),and chronic kidney disease (a condition where the kidneys are damaged and don't function as well as they should, leading to a gradual loss of kidney function) and dysphagia (trouble swallowing). During a review of Resident 198's MDS, dated [DATE], the MDS indicated Resident 198 had moderate impairment with cognitive skills for daily decision making. Resident 198 needed partial/moderate assistance (from the staff for the activities of daily living such as toileting, showers and upper and lower body dressing and needed supervision (helper provides verbal cues and resident completes activity) for eating, oral and personal hygiene. During the initial observation and interview of Resident 198 on 4/01/2025 at 9:15 AM, observed Resident 198 resting in bed watching TV with the bedside table within reach. A medication cup with medication tablets was observed on the bedside table next to Resident 198's breakfast tray. Resident 198 stated, The nurse gave me Tums (used to treat symptoms caused by too much stomach acid such as heartburn, upset stomach, or indigestion) to help me with my heartburn, the nurse left them on the table for me to take when I am ready. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation, interview and record review with Licensed Vocational Nurse 4 (LVN4) on 4/01/2025 at 9:16 AM, LVN4 confirmed that there was medication left on Resident 198's bedside table. LVN4 stated the medication should not have been left on bedside table even though it is an over the counter (medication that can be sold directly to people without a prescription) because it was still considered medication. LVN 4 stated, Leaving medicine at bedside is not something a licensed nurse should do. I did my rounds quickly this morning when I began my shift, it was a mistake on my part not to check. The medicine should not have been left at bedside because it can cause harm to the patient and to others. For example, his roommates may take the medication or the resident could hoard (accumulate or collect) them and take them all at once causing an overdose (take more than the recommended amount of something, often a medicine or drug) or cause an allergic reaction (a reaction that can range from mild, like itching or sneezing, to severe, like anaphylaxis [difficulty breathing], which is a life-threatening condition). If the medicine is left at bedside, anyone could grab it and if taken it can also be considered a medication error. During an interview with Registered Nurse (RN3) on 4/01/2025 at 9:23 AM, RN3 stated it was unacceptable to leave medication at residents' bedside which could cause potential harm to the residents. During an interview and record review with Director of Nursing (DON) on 4/04/25 at 11:56 AM, the DON stated medication should not be left at residents' bedside because it could have potentially caused harm to Resident 198.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903 Based on observation, interview and record review the facility failed to label the enteral feeding (form of nutrition that is directly delivered into the digestive system (a group of organs that work together to digest and absorb nutrients from the food eaten) as a liquid) for one (1) of two (2) sampled resident's (Resident 80) in compliance with the facility's Enteral Feeding policy and procedure. Findings: During a review of Resident 80's Admission Record, the admission record indicated Resident 80 was admitted on [DATE] with diagnosis that included malnutrition (poor nutrition), muscle weakness, and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 80's Minimum Data Set (MDS, resident assessment tool) dated 3/13/2025, the MDS indicated the resident had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 80 required substantial/maximal assistance (helper does more than half the effort) for putting on/taking off footwear and partial/moderate assistance (helper does less than half the effort) for oral hygiene, toileting hygiene, showering, upper/lower body dressing. Resident 80 required set up or clean up assistance (helper sets up or cleans up) for eating and personal hygiene. During a review of Resident 80's Order Summary Report (OSR), dated 3/20/2025, the OSR indicated enteral feeding of Glucerna (a type of enteral feeding) due to failure to thrive (failure to gain weight). During a review of Resident 80's Care Plan (CP) titled, Resident requires tube feeding related to severe malnutrition, initiated on 12/12/2024, the CP indicated the goal was for Resident 80 to maintain adequate nutritional status and stable weight. Staff interventions included were to have the registered dietitian (a credentialed healthcare professional with specialized knowledge and training in nutrition and diet) monitor caloric intake, estimate needs and make recommendations for changes to tube feeding as needed and to administer tube feeding as ordered. During an observation on 4/1/2025 at 11:35 AM in Resident 80's room, Resident 80 was observed lying in bed. Resident 80's enteral feeding attached to the resident's gastrostomy tube was infusing but it did not have a label to indicate the feeding rate, date, and time hung. During a concurrent observation and interview on 4/1/2025 at 9:11 AM in Resident 80's room with Licensed Vocational Nurse 2 (LVN 2), Resident 80's enteral feeding was observed infusing but the tube feeding was unlabeled. LVN 2 stated, the enteral feeding is not labeled, it should be labeled. During a concurrent interview and record review on 4/4/2025 at 12:10 PM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Enteral Feeding, dated 5/26/2021 was reviewed. The P&P indicated: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The purpose of the P&P is to administer tube feeding. 2. Procedure: label the formula with date and time hung. The DON stated, it's important to label the enteral feeding to make sure the correct resident is receiving the correct formula and the correct rate of feed. The feeding rate determines the nutrition and calories the resident is receiving. It's important to make sure the resident is receiving the correct amount of calories and nutrition. If they are not receiving the correct amount of nutrition, they may lose weight and nutritional status. It puts the resident at risk of worsening health condition.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48143 Based on observation, interview, and record review, the facility failed to accurately monitor the fluid intake for one of one sampled resident (Resident 86) who was on fluid restrictions, as indicated on the physician's order. This deficient practice had the potential to place Resident 86 at risk for fluid overload (too much fluid in the body which can raise the blood pressure and force the heart to work harder), edema (swelling caused by too much fluid trapped in the body's tissues), and dehydration (a dangerously loss of body fluid caused by illness, sweating, or inadequate intake). Findings: During a review of Resident 86's Admission Record, the admission record indicated Resident 86 was admitted to the facility on [DATE], with diagnoses that included stage 4 chronic kidney disease (the kidneys are moderately or severely damaged and are not properly filtering waste from the blood), type 2 diabetes (a chronic condition where the body does not use insulin [hormone that helps sugar from food enter cells for energy] effectively or does not produce enough insulin, leading to high blood sugar levels), and acute systolic heart failure, (a sudden and life-threatening condition where the heart's left ventricle struggles to contract and pump blood effectively, leading to reduced blood flow to the body). During a review of the Minimum Data Set (MDS, resident assessment tool), dated 2/10/2025, the MDS indicated Resident 86 had modified independence (some difficulty in new situations) for cognitive skills for daily decision making. Resident 86 need partial or moderate assistance (helper does less than half the effort) with eating, oral, toilet, personal hygiene, upper and lower body dressing, change of position, and transfer. During a review of Resident 86's Physician Orders, dated 3/1/2025, the physician's order indicated Resident 86's fluid restriction of 1200 milliliters (ml, units of measurement) per 24 hours as follows: - Nursing 600 ml: 300 ml for 7AM -3PM (AM shift), 200 ml for 3PM to 11 PM (PM shift), and 100 ml for 11PM to 7AM. (NOC shift) - Dietary 600 ml (for meals): 360 ml for breakfast, 120 ml for lunch and 120 ml for dinner. During an observation on 4/2/2025 at 12:33 PM in Resident 86's room, observed Resident 86 was drinking coffee besides the milk for his lunch. Resident 86 stated that Certified Nursing Assistant (CNA1) gave him the coffee. During an interview on 4/2/2025 at 12:40 PM with, CNA 1 confirmed that she gave the coffee to Resident 86 and stated it was 240 ml. CNA1 stated she knows Resident 86 was on fluid restriction. CNA1 stated she should not have given the 240 ml cup of coffee to the resident which can cause harm or adverse effects to his health because resident is on fluid restriction. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/2025 at 12:58 PM, Licensed Vocational Nurse 1 (LVN1) stated the LVNs put a check mark in the medication administration record (MAR) that Resident 86 is on fluid restriction, but the resident's actual amount of fluid intake is not recorded. During an interview on 4/2/2025 at 1:26 PM with medical record staff (MR), MR confirmed that there was no fluid intake recorded for each shift for Resident 86. During a concurrent interview and record review on 4/2/2025 at 1:45 PM, with the Director of Nursing (DON), the DON stated CNA1 should not have given Resident 86 coffee without verifying with LVN or RN supervisor. The DON stated nurses should have recorded Resident 86's actual amount of fluid intake to ensure implementation of Resident 86's fluid restriction in accordance with the physician's order to prevent fluid overload, edema, dehydration, chest pain, heart attack or other complications which could harm Resident 86. During a review of the facility's Policy and Procedure (P&P) titled, Dialysis Care, effective 8/25/2021, the P&P indicated, Fluid Restrictions: a. Dialysis residents are given fluid based on the fluid restriction as ordered by the physician. b. The Nursing and Dietary Staff will carefully organize the division and distribution of fluid. During a review of the facility's undated P&P titled, Encouraging and Restricting Fluids, indicated the following: General Guidelines: 1. Follow specific instructions concerning fluid intake or restrictions. 2. Be accurate when recording fluid intake. 3. Record fluid intake on the intake side of the intake and output record. Record fluid intake in ml. 4. Substitute other liquids (i.e., tea, broth, soda, gelatin, milk, ice cream, etc.) as permitted by the resident's diet. 5. When a resident has been placed on restricted fluids, remove the water pitcher and cup from the room. If the resident refuses to have the water pitcher removed, notify the supervisor and in turn, the physician. Documentation: The following information should be recorded in the resident's medical record: 1. Any evidence of dehydration such as weight loss, confusion, drowsiness, dry skin, etc. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The amount (in ml) of fluids consumed by the resident during the shift. 3. The type of liquid consumed (i.e., tea, milk, coffee, soup, etc.).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 42223 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures to ensure administering of all drugs and biologicals to meet the needs of one (1) of five (5) sampled residents (Resident 149) in accordance with the facility's policy and procedure (P&P) by failing to completely administer two (2) medications mixed in water to Resident 149. This deficient practice resulted to Resident 149 not receiving the full amount of 2 medications as prescribed by the physician, which could affect the resident's well-being. Findings: During a review of Resident 149's Admission Record, the admission record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the diagnoses of urinary tract infection (UTI, an infection in the bladder/urinary tract) and congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 149's Minimum Data Set (MDS, a resident assessment tool), dated 3/28/2025, the MDS indicated the resident was severely impaired with cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 149 was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 149 was on a feeding tube. During a review of Resident 149's Order Summary, the Order Summary indicated the following: 1. Acetazolamide (a medication for fluid retention [buildup of fluid in the body]) tablet 250 milligrams (mg-a unit of measurement). Give 1 tablet via gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube (G-tube) one time a day for edema. 2. Oyster Shell Calcium/ Vitamin D (a medication to prevent or treat a calcium deficiency) tablet 500-200 mg-unit. Give 1 tablet via G-tube one time a day for supplementation. During an observation on 4/2/2025 at 8:17 AM, Licensed Vocational Nurse 5 (LVN 5) was observed preparing all medications for Resident 149 and was observed using the same G-tube syringe to mix all the individually crushed medications. LVN 5 administered Acetazolamide and Oyster Shell Calcium/ Vitamin D separately to Resident 149 via G-tube. The two medications were not completely administered to Resident 149 due to residue left in the medication cup. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/2025 at 8:45 AM, LVN 5 stated there was still 70% of the Oyster Shell Calcium and 50% of the Acetazolamide left in the medication cup, which was not administered to Resident 149. LVN 5 stated Resident 149 did not get all her medications as ordered which can cause harm to the resident. During an interview on 4/4/2025 at 12pm, Director of Nursing (DON) stated that LVN 5 did not follow doctor's orders since the 2 medications were not entirely administered to Resident 149. During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, revised 4/2019, the P&P indicated medications are administered in accordance with prescriber's orders. The P&P also indicated medication administration is determined by the resident need and benefit that includes preventing potential medication interactions.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903 Based on interview and record review the facility failed to conduct a monthly Medication/Drug Regimen Review (MRR, a monthly thorough evaluation by the consulting pharmacist of a resident's medication regimen, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) in the month of 2/2025 for one (1) of five (5) sampled residents (Resident 47) in accordance with the facility's Medication Regimen Reviews policy and procedure (P&P). This deficient practice had the potential to cause Resident 47 to receive unnecessary medication and to potentially have adverse reactions (harmful effects) from medications. Findings: During a review of Resident 47's Admission Record, the admission record indicated Resident 47 was admitted on [DATE] with diagnosis that included cerebral infarction (loss of blood flow to a part of the brain), unspecified psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with external reality),and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 47's Minimum Data Set (MDS, resident assessment tool), dated 11/1/2024, the MDS indicated the resident had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 47 required substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, showering, lower body dressing and putting on footwear. The MDS indicated Resident 47 required partial/moderate assistance (helper does less than half the effort) for upper body dressing. The MDS indicated Resident 47 required set up or clean up assistance (helper sets up or cleans up) for oral hygiene and personal hygiene. The MDS indicated Resident 47 was independent (resident completes the activity by self) for eating. During a concurrent interview and record review on 4/3/2025 at 7:48 AM with the Director of Nursing (DON), the facility's MRR for 2/1/2025 to 2/28/2025 records were reviewed. The MRR records indicated there was no documented evidence of Resident 47's medications reviewed on the MRR. The DON stated, The resident's (Resident 47) name is not in the MRR list for February 2025. She did not have an MRR done that month. The purpose of the MRR is to ensure necessary dose reduction are done if necessary. It also screens for unnecessary medications. The residents are at risk for adverse effects if the MRR is not done for them. During an interview on 4/4/2025 at 11:51 AM with the facility's Pharmacy Consultant (PC), PC stated, If the resident's name does not appear in the MRR list, the MRR wasn't done. The purpose of the MRR is to discontinue unnecessary medications, check if there are any drug interactions, and adjust medication doses. It is for the patient's safety. During a review of the facility's P&P titled, Medication Regimen Reviews, revised 5/2019, the P&P indicated: (continued on next page)

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Montebello Care Center	1035 W Beverly Blvd Montebello, CA 90640

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The Consultant Pharmacist reviews the medication regimen of each resident at least monthly. 2. The Consultant Pharmacist performs a MRR for every resident in the facility receiving medication. 3. MRR are done upon admission and at least monthly. 4. The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. 5. Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five (5) percent (%). There were two (2) medications errors (the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order/ manufacturer's specifications / accepted professional standards and principles) out of 25 opportunities (observed administered medications) for error, which yielded a facility medication rate of eight (8) % for one of five (5) sampled residents (Resident 149) observed during medication administration. This deficient practice had the potential for harm to Resident 149 due to the resident not receiving the full amount of each medication as prescribed by the physician. Findings: During a review of Resident 149's Admission Record, the admission record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the diagnoses of urinary tract infection (UTI, an infection in the bladder/urinary tract) and congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 149's Minimum Data Set (MDS, a resident assessment tool), dated 3/28/2025, the MDS indicated the resident was severely impaired with cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 149 was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 149 was on a feeding tube. During a review of Resident 149's Order Summary, the Order Summary indicated the following: 1. Acetazolamide (a medication for fluid retention [buildup of fluid in the body) tablet 250 milligrams (mg-a unit of measurement). Give 1 tablet via gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube (G-tube) one time a day for edema. 2. Oyster Shell Calcium/ Vitamin D (a medication to prevent or treat a calcium deficiency) tablet 500-200 mg-unit. Give 1 tablet via G-tube one time a day for supplementation. During an observation on 4/2/2025 at 8:17 AM, Licensed Vocational Nurse 5 (LVN 5) was observed preparing all medications for Resident 149 and was observed using the same G-tube syringe to mix all the individually crushed medications. LVN 5 administered Acetazolamide and Oyster Shell Calcium/ Vitamin D separately to Resident 149 via G-tube. The two medications were not completely administered to Resident 149 due to residue left in the medication cup. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/2025 at 8:45 AM, LVN 5 stated there was still 70% of the Oyster Shell Calcium and 50% of the Acetazolamide left in the medication cup, which was not administered to Resident 149. LVN 5 stated Resident 149 did not get all her medications as ordered which can cause harm to the resident. During an interview on 4/4/2025 at 12pm, Director of Nursing (DON) stated that LVN 5 did not follow doctor's orders since the 2 medications were not entirely administered to Resident 149. During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, revised 4/2019, the P&P indicated medications are administered in accordance with prescriber's orders. The P&P also indicated medication administration is determined by the resident need and benefit that includes preventing potential medication interactions.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on observation, interview and record review the facility failed to ensure safe provision of pharmaceutical services as indicated in the facility policy by failing to: 1. Remove and discard one expired insulin (medication used to regulate blood sugar levels) Humulin R (short-acting insulin) vial, three expired suppositories (medications inserted into the rectum), one expired topical ointment (medication or cream applied directly to the skin), and two expired enemas (liquid to help relieve constipation [infrequent or difficult bowel movements]) from the medication cart. 2. Remove and discard eye drops according to label 3. Store insulin Lispro (short-acting insulin) and insulin Lantus (long-acting insulin) in the refrigerator. 4. Remove and discard three expired Vitamin D bottles from the medication storage room. These deficient practices increased the risk of the residents to be administered medications that have become ineffective or toxic which could result in adverse reactions (any unexpected or dangerous reaction to a drug). Findings: During a concurrent observation of Medication Cart 2 and interview of Licensed Vocational Nurse 6 (LVN 6) on [DATE] at 12:39 PM, the following medications were found stored in a manner contrary to the manufacturer's requirements, and were expired and not discarded in accordance with the facility's policy and procedure: 1. Three expired Bisacodyl (medication to treat constipation) suppositories with expiration date of ,d+[DATE]. 2. Latanoprost (medication to treat increased pressure in the eye) eye drops with an open date of [DATE] and a label which indicated to discard unused portion after 28 days from opening. 3. Dorzolamide and timolol (medication to treat increased pressure in the eye) with an open date of [DATE] and a label which indicated to discard unused portion after 28 days. 4. Triamcinolone Acetonide (topical medication to relieve skin conditions) ointment with a used by date of [DATE]. 5. Unopened Insulin/ Lispro with a label that indicated to refrigerate until used and once in use, store at room temperature. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. One enema with an expiration date of ,d+[DATE]. LVN 6 stated the suppositories are expired and should be discarded. LVN 6 also stated the eye drops should be discarded within 28 days according to the label. LVN 6 stated the topical ointment was expired and should be discarded. LVN 6 also stated the enema was expired and should be discarded as well. LVN 6 stated the unopened insulin should have been kept in the refrigerator until use. LVN 6 stated the medications that were expired and/or not properly stored may not be as potent and can cause harm to the residents. During a concurrent observation of Medication Cart 1 and interview with LVN 7 on [DATE] at 1:06 PM, the following medications were found either stored in a manner contrary to the manufacturer's requirements, and were expired and not discarded in accordance with the facility's policy and procedure: 1. Insulin Humulin (R) with an open date of [DATE]. 2. Unopened Insulin Lantus Solostar with a label which indicated to refrigerate until used and once in use, store at room temperature. 3. One enema with an expiration date of ,d+[DATE] LVN 7 stated unopened insulin should be in the refrigerator until used and should be used within 28 days and discarded after 28 days. LVN 7 also stated the expired enema should be discarded. LVN 7 stated the medications that were not properly stored or expired may not be as potent and can cause harm to the residents. During a concurrent observation and interview with LVN 2 on [DATE] at 1:22PM in the Medication Storage room [ROOM NUMBER], two Vitamin E 180 milligrams (mg, unit of measurement) bottles were found with expiration date of ,d+[DATE]. LVN 2 stated the medications should have been discarded. LVN 2 also stated the expired medication may not be as potent and may cause harm to the residents. During an interview on [DATE] at 12 PM, the Director of Nursing (DON) stated medications should be stored properly and discarded according to manufacturer's instructions. The DON stated multi dose vials should be used within 28 days and then discarded. The DON stated insulin should be kept in the refrigerator until used. The DON added the medications that were expired should not be in the medication cart/medication storage room and should be discarded. During a review of the facility's undated Policy and Procedure (P&P) titled, Medication Labeling and Storage, the P&P indicated if the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. The P&P also indicated the medication label includes but not limited to expiration date. The P&P indicated medications for external use are clearly marked as such and are stored separately from other medications. The P&P also indicated multi-dose vials that have been opened or accessed (needle punctured) are dated and discarded within 28 days. In addition, the P&P indicated medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurse's station or other secured location.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523 Based on observation, interview, and record review, the facility failed to provide menus and nutritional adequacy for three (3) of 3 sampled residents (Residents 198, 84, and 35) in the food care area by failing to: 1. Provide Residents 198, Resident 84 and Resident 35 with a facility meal menu in advance 2. Follow the menu as written for Resident 198 on large and double portion (A large portion refers to a quantity that is bigger than average or standard, while double portion implies a quantity that is twice as large as the original or a standard amount) diets and were served incorrect amounts of food. These deficient practices had the potential to result in weight loss due to inadequate calories in residents who did not receive the correct amount or food items of their choices of their preference. Findings: 1. During a review of the Admission Record, the Admission Record indicated Resident 198 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to type 2 diabetes mellitus (DM-a disease in which your blood glucose, or blood sugar, levels are too high), other lack of coordination (a medical condition, often called ataxia, characterized by a loss of muscle coordination, leading to clumsy or jerky movements, unsteady gait, and difficulty with balance and fine motor skills), end stage renal disease (the kidney is no longer able to perform its main functions, which are to filter the blood to remove any waste and to balance fluids within the body), and chronic kidney disease (is a condition where the kidneys are damaged and don't function as well as they should, leading to a gradual loss of kidney function). During a review of Resident 198's Minimum Data Set (MDS- a resident assessment tool), dated 3/22/2025, the MDS indicated Resident 198 had the mental capacity to understand and make medical decisions. Resident 198 needed partial/moderate assistance (helper does less than half the effort) from the staff for the activities of daily living such as toileting, showers and upper and lower body dressing and needed supervision (helper provides verbal cues and resident completes activity) for eating, oral and personal hygiene. During a review of Resident 198's Care Plan initiated on 3/23/2025, the care plan indicated Resident 198 is at nutritional risk, interventions indicated to provide diet education to resident, honor food preferences within meal plan, monitor for changes in nutritional status (unplanned weight loss) and report to food and nutrition/physician as indicated, monitor intake at all meals, offer alternate choices as needed and alert dietician and physician to any decline in intake. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 198's Order Summary dated 3/28/2025, the Order Summary indicated, carbohydrate controlled (a type of food that provides the body with energy, often called carbs. They are found in foods like bread, fruits, vegetables, and other plant-based item), renal diet (a specialized eating plan designed for people with kidney disease such as lean chicken, turkey, fish, apples, lettuce, wild rice, unsalted popcorn, fresh herbs and spices), soft and bite-sized texture, thin consistency (liquid or watery). Fortified diet (a diet that includes foods with extra nutrients added that wouldn't naturally be present. These added nutrients are usually vitamins and minerals, and the goal is to enhance the nutritional value of the food and benefit health) for all meals with double portion for all meals. During a review of the facility's breakfast menu for 4/1/2025, the following items will be served: scrambled eggs with chorizo and flour tortilla. During initial observation of Resident 198 on 4/1/2025 at 9:07 AM, Resident 198 was resting in bed watching TV. Observed Resident 198's breakfast tray to be on top of bedside table containing, scrambled eggs and flour tortilla, a serving of 4-ounce (oz, unit of measurement) apple sauce and a cup of apple juice. Resident 198 stated, they brought me this breakfast since 7:00 AM, I asked for oatmeal, it is now passed 9:00 AM, it has been more than two hours, and I still have not received my oatmeal. My stomach hurts, my stomach is empty. I cannot even take my medicine because I refuse to take them on an empty stomach. The nurse keeps coming to give me my meds, she keeps asking why she cannot give them to me. I tell her how am I supposed to take them on an empty stomach? Resident 198 also stated, if he knew he was not going to get his oatmeal, he would have called his son to bring him some chilaquiles, that way he would have had breakfast and been able to take his morning meds. During concurrent observation of Resident 198's breakfast tray on 4/01/2025 at 9:10 AM, observed Resident 198's breakfast/ meal ticket to indicate Double portion breakfast, pureed bread, scramble egg portion, 4 oz apple juice, and 3/4 cup of fortified oatmeal. During an observation of License Vocational Nurse (LVN4) on 4/01/2025 at 9:15 AM, observed LVN4 walk into Resident 198's room to manually check the resident's blood pressure. LVN4 informed Resident 198 that LVN4 would be giving Resident 198 the resident's morning medication. Resident 198 informed LVN4 that the resident still had not received the resident's oatmeal and had not had breakfast. Resident 198 told LVN4 I am still waiting for my oatmeal; it has been over two hours. I have an empty stomach; I cannot take my meds. During concurrent observation of Resident 198 on 4/01/25 at 9:31 AM, Observed Dietary Staff (DS1) to visit Resident 198 asking if there was something wrong with his breakfast. Observed Resident 198 tell DS1 about the oatmeal request two hours ago and still did not have oatmeal. DS1 told Resident 198 if he was sure he did not have oatmeal on his tray when he received it in the morning. Resident 198 told DS1, I did not get my oatmeal, that is the reason I have not touched my breakfast, and I am still on an empty stomach, meaning I can't take my morning meds. I would like some oatmeal please. Observed DS1 tell Resident 198 the kitchen did have oatmeal, but it would take a bit to cook it and provide it for him. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with DS1 on 4/01/25 at 9:32 AM, DS1 confirmed Resident 198 should have been served oatmeal but would double check with the Certified Nursing Assistant (CNA) if it was true that Resident 198 did not receive any oatmeal on his tray this morning for breakfast even though Resident 198 stated multiple times, he did not get oatmeal. DS 1 stated, Resident 198 should not have to wait two hours for a serving of oatmeal especially since it was ordered on his meal ticket. DS 1 stated, On the breakfast ticket it does say he should have double portions and a serving of oatmeal. We can make some for him, but it will take a bit since it's already been two hours from breakfast. 2. During a review of the Resident 84's Admission Record, the Admission Record indicated Resident 84 was admitted to the facility on [DATE] with diagnoses that included but not limited to type 2 diabetes mellitus, unspecified fracture of unspecified lumbar vertebra (where the specific bone or injury is not clearly identified or specified of any of the five bones in the back of the human body), subsequent encounter for fracture with routine healing (receiving ongoing care during the healing or recovery phase), muscle weakness, and hyperlipidemia (having too many fats in the blood). During a review of Resident 84's Minimum Data Set (MDS- a resident assessment tool), dated 1/31/2025, the MDS indicated Resident 84 had the mental capacity to understand and make medical decisions. Resident 84 was dependent (helper does all the effort, resident does none of the effort to complete the activity) from the staff for the activities of daily living (ADLs) such as toileting, lower body dressing and putting on/taking off footwear and required substantial/maximal assistance (helper does more than half the effort) for showers and upper body dressing and needed setup or clean-up assistance (helper sets up or cleans up and resident completes activity) for eating, oral and personal hygiene. During a review of Resident 84's Care Plan initiated on 2/01/2025 indicated Resident 84 has nutritional problem or potential nutritional problem related to diet restrictions (limitations or on food consumption, often for reasons of health, religious beliefs, or personal preference), interventions indicated to provide, serve diet as ordered, and monitor intake and record every meal. Also, Registered Dietitian to evaluate and make diet change recommendations as needed. During a review of Resident 84's Care Plan initiated on 2/06/2025 indicated Resident 84 is at nutritional risk due to increased needs for wound healing. Interventions indicated to provide diet education to resident, evaluate for proper consistency diet, honor food preferences within meal plan, monitor meal consumption, monitor weights as ordered and provide diet as ordered. During a review of Resident 84's Order Summary dated 3/01/2025, the Order Summary indicated, carbohydrate controlled (A carb-controlled meal might include a specific amount of carbohydrates, such as a slice of bread or a cup of pasta, alongside other foods like protein and vegetables to help manage sugar levels), renal diet (, regular texture (a surface characteristic or appearance that exhibits a predictable and repeating pattern or arrangement), thin consistency (a dietary modification that allows for regular, unthickened liquids). Fortified diet (a diet in which certain nutrients have been added to foods to increase their nutritional value) for all meals with double portion for all meals. During initial observation and interview with Resident 84 on 4/01/2025 at 9:35 AM, Resident 84 stated, I do not like the food; I do not go to activities it is too hard to go on the wheelchair, it is too hard to mobilize myself to go to the activity room. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During concurrent observation and interview with Resident 84 on 4/01/2025 at 12:52 PM, observed Resident 84 resting in bed. Resident 84 stated he had not had lunch yet and was very hungry. Resident 84 stated, it is late, and I do not even know what they will serve me for lunch. I never get a food menu; I just have the staff come and drop off the tray. Most of the time I do not even eat the food because they pour gravy all over the meals and I just cannot eat that. I wish I knew what meals were being served that way I could tell my brother to bring me food from home instead. During an interview with Resident 84 on 4/02/2025 at 10:37 AM, Resident 84 stated that since he was admitted at the facility, he never gets a menu and does not know what is for lunch or other meals on a daily basis. Per Resident 84 the CNAs do not tell him what the lunch is either, he just gets served the meals and it makes him feel like he is in jail. Resident 84 stated it makes him sad and depressed and stated, I have never been in jail, but I feel like this is worse. Resident 84 stated, at home I was well taken care of. I had hardboiled eggs or eggs over easy in the morning, here I have asked for eggs and all I get is scrambled all the time. Resident 84 stated he will mostly just take a couple of bites of the food but not eat even 25% of what the tray of food has because he does not like it and is never offered a substitution or supplement. Resident 84 stated, the CNA just comes and removes the tray without asking why I did not eat anything. Resident 84 stated he is always hungry. 3. During a review of Resident 35's Admission Record, the Admission Record indicated Resident 35 was admitted to the facility on [DATE] with diagnoses that included but not limited to diabetes mellitus with diabetic neuropathy (nerve damage that can occur in people with diabetes), type 2 diabetes with hyperglycemia (a person has diabetes and their blood sugar levels are excessively high), partial traumatic transmetacarpal amputation of left hand (the partial loss of a finger or fingers due to a traumatic injury, occurring between the finger and the hand), acquired absence of right leg below the knee (the right leg, from the knee joint down, is missing, and this absence was acquired through a process like surgery or trauma, rather than being present at birth), acquired absence of left leg above the knee. During a review of Resident 35's MDS, dated [DATE], the MDS indicated Resident 35 had the mental capacity to understand and make medical decisions. Resident 35 needed supervision or touching assistance (helper provides verbal cues and/or touching steadying and/or contact guard assistance as resident competes activity) from the staff for the activities of daily living such as showers and lower body dressing and needed set up or clean-up assistance (helper sets up or clean up, resident completes activity) for upper body dressing, toileting and personal hygiene. The MDS also indicated Resident 35 was independent (resident completes the activity by themselves with no assistance from a helper) for eating and oral hygiene. During a review of Resident 35's Care Plan initiated 4/04/2023 indicated Resident 35 is at risk for altered nutrition and hydration status related to DM with neuropathy on therapeutic diet. Interventions indicated to honor food preferences within meal plan, monitor intakes of all meals, offer alternate choices as needed, alert dietitian and physician to any decline in intake. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview of the facilities activity room in the presence of Activity Assistant Staff (AAS1) on 4/01/2025 at 12:56 PM, observed the activity room to be empty and staff finishing up collecting chairs and tables from lunch time and putting them away. AAS1 stated the residents that can ambulate or be transferred to the activity room for lunch usually eat their meals inside the activity room at 12:00 PM. AAS1 stated not all residents are able to eat in the activity room during mealtimes because some are bedbound (confined to bed, can't move out of bed) or just do not want to eat their meal in the activity room and prefer to eat in their rooms. AAS1 stated that there is a menu that is placed right outside the activity room door for the residents to see. During interview with the Director of Nursing (DON) on 4/01/2025 at 12:58 PM, the DON stated usually the lunch is served from 12:00 PM to 1:00PM. Per DON, the residents that eat in the activity room usually eat first, at 12:00 PM, and the residents that eat in their rooms get served later. Per DON the residents that eat in their rooms are the ones that prefer to stay in their rooms or are bedbound and cannot go to activity room for meals. The DON confirmed the practice in the was facility to serve the residents in the dining room first and then an hour later serve the residents inside their rooms. During an observation and interview with Resident 35 on 4/01/2025 at 1:05 PM, observed Resident 35 to be sitting on his wheelchair next to side table with lunch tray. Observed Resident 35 with furrowed brows, a glare in his eyes and flared nostrils. Observed Resident 35's diet on meal ticket to indicate it was carbohydrate controlled renal and the lunch tray to contain a plate with a serving size (approximately 3x3inches in size) of vegetable quiche, a small bowl with salsa salad 1/2 cup,1 dinner roll, 1 margarine,1 chocolate ice cream, graham crackers -2 packet (pkt), coffee 6 oz, milk 4oz. Resident 35 stated, this is the food we get? It is ridiculous and it makes me lose my appetite! During concurrent observation and interview with Resident 35 on 4/01/2025 at 1:18 PM, observed Resident 35's lunch tray to be untouched. Observed CNA1 bring Resident 35 a turkey sandwich and handed it to Resident 35 as a substitution for the resident's lunch. Resident 35 stated he might as well eat the dry turkey sandwich he was provided because he was hungry and did not eat his lunch because it did not look appetizing, and it was such a small serving it made the resident so upset. Resident 35 stated, I would eat the lunch if they would serve me a good meal. I cannot even begin to tell you how awful these meals have been. I am so tired of it. The worse part is that I do not even have a menu so I can at least know what the meals are going to be. They say they have a substitution menu, but it is very limited to about 3 different options, for example a cold turkey sandwich, which is basically what I always have to order since I do not eat the meals. Things would be different if I had a menu with the different meal options. At least that way I would know ahead of time if I should order a substitution. I am always hungry. The meals I do eat is because I am very hungry, but I can honestly tell you, I do not enjoy the food. During a concurrent interview with Resident 35 on 4/02/2024 at 10:06 AM, Resident 35 stated he did not know what he was getting for lunch but was not very hopeful of getting something good. Resident 35 stated, I eat not because the food taste good but because I am starving and I know that if I do not eat that meal, I won't eat at all. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montebello Care Center	1035 W Beverly Blvd Montebello, CA 90640

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with DS1 on 4/02/2025 at 10:30 AM, DS1 stated I print out the meal tickets from the computer, their preferences come out on the ticket automatically, this is how we know what meals to serve each resident. The residents have substitution options if they do not like the meals they were served, but they have to give us a two (2) hour in advance notice so we can prepare their substitution. DS1 stated the facility did print out a menu for the month of all the meals the residents were going to be served. DS1 stated, The menu is posted by the activity room and at the front of the facility by the lobby, if there is a last-minute request the residents can ask as well for a substitution. During a concurrent interview with DS1 on 4/03/2025 at 8:33 AM, DS1 confirmed the copy of the menu is posted in the front of the facility and also near the activity room near the kitchen. DS1 confirmed they did not in fact pass out menus to each resident but that the CNAs would inform the residents what the meal was for the day. DS1 stated there is a copy of the meal substitutions with items as cheese quesadillas, deli sandwiches, bean and cheese burrito or tamales and residents were asked to request items at least 2 hours before the meal service. During an interview with Registered Dietitian (RD) on 4/03/25 at 11:54 AM, RD stated the residents are not provided with their own copies of the menu for the month but that the menus are posted near the activity room area and in the front of the facility for the residents to see. RD stated it was not acceptable not to have the menu information for all the residents including the ones that were bedbound or did not leave their rooms. RD stated if a resident is bed bound or does not attend the activity room, they would not be able see the menu. During a concurrent interview with RD on 4/03/2025 at 12:01PM, RD stated that if a resident is not eating the food because they do not like the meals, it can affect the resident's weight, wound healing and possibly the resident will refuse medications because they are on an empty stomach, causing other underlying medical conditions to worsen. RD stated the residents are provided with meal substitution, but it would be hard for the residents to make a meal substitution request if they did not have a menu giving them the information of the daily meals. During a review of the facilities Policy & Procedure titled, Resident Food Preferences, revised 7/2017 indicated, The dietary manager will complete a dietary profile for residents to reflect current food preferences and nutritional needs upon admission, readmission, quarterly, annually or as needed. 1. The Dietary Manager will meet with the resident .to review the following: d. Discuss the resident's food preferences e. The weekly men and location of the posted menu 2. The Dietary Manager will provide residents with meals consistent with their preferences, as indicated on their tray card (diet tray card-printed cards used in facilities like hospitals and nursing homes to provide detailed information about a patient or resident's specific meal requirements)). a. If a preferred item is not available, a suitable substitute should be provided. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facilities Policy & Procedure titled, Quality of life-Dignity, revised 2/2020 indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523 Based on observation, interview, and record review, the facility failed to follow proper food storage handling practices in accordance with its policy and procedure (P&P) by failing to label and discard expired food items stored in the facility's kitchen refrigerators, freezers, and dry storage by failing to ensure: 1. 17 pre-filled orange juice cups and two (2) orange juice pitchers inside refrigerator 3 were labeled with a use by or expiration date. 2. Conventional oven temperature was accurate since its oven knobs have no temperature settings. 3. 18 Large metal baking trays were free of grease build-up 4. Two (2) large food pans were free from dents. 5. One (1) blender used in the preparation of mechanical soft diet (foods that are easy to chew and swallow, requiring minimal chewing, and includes foods that are cooked, shredded, blended, chopped, or ground to a soft consistency stand was clean and free from scratches and cracks. 6. The dishwasher machine was free from dirt, corrosion (the gradual breakdown or eating away of a material, especially metals, due to a reaction with its environment like air, water, or chemicals), and calcification (the formation of calcium deposits or hardened material (like scale) on internal or external surfaces, which can lead to reduced performance, malfunction, or even failure). These deficient practices have the potential to result in pathogen (germ) exposure to 88 residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and can lead hospitalization . Findings: 1.During initial kitchen observation on [DATE] at 7:50 AM, observed inside Refrigerator 3, 17 pre-filled orange juice cups and 2 orange juice pitchers which were not labeled to indicate a use by or expiration date. During a concurrent kitchen observation and interview with Dietary Staff (DS2) on [DATE] at 7:52 AM, DS2 stated the pre-filled orange juice cups and orange juice pitchers were not and should have been labeled with a use by or an expiration date. DS2 stated, this way, staff would know when food items are expiring and when not to serve to the residents. DS2 stated residents could get sick from their stomach and could have vomiting or diarrhea if given expired food, which has a potential to cause harm. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent kitchen observation and interview with DS2 on [DATE] at 7:33 AM, observed ten (10) all the knobs on the conventional oven did not have settings for the temperature. DS2 stated she guesses the temperature setting when cooking using the oven because the settings have been erased over time. Per DS2, If the food is not cooked to correct temperature of at least 165 degrees, like for example if the chicken is cooked and it's raw and it's served to a resident, it can make the resident sick from their stomach and potentially cause harm. During a concurrent observation and interview with DS1 on [DATE] at 7:35 AM, in the kitchen, DS1 stated, We do not know the temperature of the oven, the knob has no settings printed on there. It was difficult to guess, maybe the food does not heat or cook properly and that can be dangerous for the residents if the food does not cook properly. The gas department checked the kitchen, and they did state it wasn't heating to what it should be, so they raised the temperature, and it seems like now it's overheating, possibly overcooking the food. If the cook is not careful to check while it's being cooked and the food is overcooked and served to the residents, the residents might complain that it's too hard to eat or too tough to chew, causing the residents to not eat the food and potentially weight loss, causing the resident potential harm because they need to eat the food to stay healthy. 3. and 4. During a concurrent kitchen observation and interview with DS1 on [DATE] at 7:38 AM, observed multiple eighteen (18) metal baking trays piled up on top of each other. The edges were visibly crusted with dry caked grease. Also observed two large metal food pans stored under the stove to be old and dented. Per DS1, using trays inside the oven with dry caked on grease could potentially be a fire hazard. 5. During a concurrent kitchen observation and interview with DS1 on [DATE] at 7:40 AM, observed plastic blender used for mechanical soft diet have small cracks at the bottom. The blender stand was dirty, dusty, and DS1 stated it was a new blender but since it was made out of plastic, it looked so old. DS1 stated it was important for the blender used for the residents pureed diet to be in good condition to make sure the food will be pureed perfectly for the residents' meals. 6. During a concurrent kitchen observation and interview with DS1 on [DATE] at 7:43 AM, observed the dishwashing machine to have visible calcification (the build-up of calcium deposits, often salts of calcium, within the machine's components. This hardening process can lead to various issues, including reduced functionality, increased maintenance needs, and potential damage), corrosion and discoloration. DS1 stated the same dishwashing machine has been in the facility for a very long time, since before he began to work there. DS1 stated that the dishwashing machine gets serviced once a year and it's tested by dishwasher staff three (3) times a day, once before every meal, breakfast, lunch, and dinner. DS1 stated the machine was recently serviced by a technician only to replace some bolts but that it would it be advisable to consult a qualified technician for any further repairs or maintenance regarding the corrosion since per the warning label, it could be a potential for electrical hazards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with DS3 on [DATE] at 8:00am, DS3 stated that if the dishwashing machine is not working properly due to the corrosion, it can also lead to reduced performance, malfunction, or even failure of the machine causing the dishes to not be washed or sanitized properly. DS3 stated if the dishwasher is not sanitizing dishes properly, there is a risk of leaving behind food particles (bits of food left on dishes) behind and bacteria (microscopic living organisms that have only one cell. Most bacteria are not harmful, but certain types can make people sick), which potentially could spread germs to the residents causing them to get sick from their stomach and experience nausea, vomiting or diarrhea. During a review of the facility's P&P titled, Food Receiving and Storage, revised ,d+[DATE], the P&P indicated, Food shall be received and stored in a manner that complies with safe food handling practices 7. Refrigerated foods are labeled and dated. During a review of the facility's P&P titled, Sanitization, revised ,d+[DATE], indicated, The food service area is maintained in a clean and sanitary manner . 2. All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use of proper cleaning .12. Plastic ware, China and glassware that cannot be sanitized or are hazardous because of chips, cracks or loss of glaze are discarded. Damaged or broken equipment that cannot be repaired is discarded. During a review of the facility's P&P titled, Preventing Foodborne Illness-Food Handling, revised ,d+[DATE] indicated, Food will be stored, prepared, handled, and served so that the risk of foodborne illness is minimized . This facility recognizes that the critical factors implicated in foodborne illness are: . b. Inadequate cooking and improper holding temperatures c. Contaminated equipment

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 45523 Based on observation, interview, and record review, the facility failed to properly contain waste and cover two (2) of 2 large trash bins with lids as indicated on the facility policy. This deficient practice had the potential to attract vermin (animals that are believed to be harmful, carry diseases such as rodents, parasitic worms, or insects), pests (any living thing that has a negative effect on humans), and wildlife (undomesticated animal species) that could potentially infiltrate the facility, affect the resident care areas, and pose a disease threat to the residents and staff of the facility. Findings: During initial visit on 4/01/2025 at 8:01 AM, observed two large trash bins in the facility parking lot area with open lids and there was also visible trash on the floor surrounding the parking lot area. During an observation and interview with Dietary Staff 1 (DS1) on 4/01/2025 at 8:03 AM, DS1 confirmed both trash bins were open and not covered with a lid. DS1 stated the trash bins are picked up weekly but the trash lids should be closed to prevent any type of contamination or pest infestation (a situation where a large number of unwanted pests, such as insects, rodents [any of various small mammals with large, sharp front teeth, such as mice and rats, or other organisms, invade and establish themselves in a particular area]). During an observation of the same trash bins in the facility parking lot area on 4/02/2025 at 7:32 AM, observed the 2 trash bins to be overfilled with trash bags and the lids were not closed. During an interview with the Director of Nursing (DON) on 4/03/2025 at 2 PM, the DON stated the trash bin lids should be closed at all times because if the trash bin lids are open, it can attract vermin or other animals. The DON also stated it's not sanitary to have open trash lids near the resident's activity room which is located inside the facility near the parking lot area where the trash bins are located. During an interview with Maintenance Supervisor (MS) on 4/03/2025 at 2:10 PM, MS stated the trash bins are emptied by a private company but there is not an exact time of when they get picked up. MS stated the trash lids should remain closed at all times for sanitary purposes. Per MS, Central supply, the kitchen and housekeeping staff are responsible for throwing out the trash. MS stated, If any staff throws out the trash and leaves the trash bins lids open, it can attract rodents like mice and also cockroaches. It's not sanitary to leave the lids open or to have trash on the floor in the surrounding areas. During an interview with Infection Preventionist (IP) nurse on 4/03/25 at 2:20 PM, IP stated trash bins should always be covered with a lid to prevent any type of rodents being attracted to the facility area. IP stated, It is not sanitary and also, it's not acceptable for staff to leave the trash bin lids open. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facilities Policy & Procedure (P&P) titled, Sanitization, revised on 11/2022, the P&P indicated . 14. Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters/compactors with lids (or otherwise covered). 15. Areas used for garbage disposal are free from odors and waste fats and maintained to prevent pests. During a review of the facilities undated P&Ps titled, Food-Related Garbage and Reuse Disposal, the P&P indicated Food-related garbage and refuse are disposed of in accordance with current state laws 2. All garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or no in continuous use . 5. Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests . 7. Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42223 Based on observation, interview, and record review, the facility failed to follow infection control practices according to facility's policy and procedure for four (4) of five (5) sampled residents (Residents 70, 9, 198, and 248) by failing to ensure: 1. Facility staff doff (take off) Personal Protective Equipment (PPE, protective clothing, goggles, or other garments to prevent or minimize exposure to and spread of infection or illness) and perform hand hygiene (cleaning hands to prevent germs) after providing peri-care (cleaning the genitals and anal area) and during wound care for Resident 70. 2. Facility staff did not touch Resident 9's straw after touching another resident's surface. Facility staff also failed to doff PPE and perform hand hygiene after providing peri-care for Resident 9. 3. Resident 198's indwelling urinary catheter was not touching the floor. 4. Resident 248's respiratory treatment mask and nasal cannular (NC) were stored inside a clean bag with the resident's name and date to prevent equipment contamination and infection. These deficient practices have the potential to spread infection to staff and residents. Findings: 1. During a review of Resident 70's Admission Record, the Admission Record indicated resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the diagnoses of sepsis (a life-threatening blood infection), cellulitis (a skin infection that causes swelling and redness), and dementia (a progressive state of decline in mental abilities). During a review of Resident 70's Minimum Data Set (MDS, a resident assessment tool), dated 1/31/2025, the MDS indicated the resident was severely impaired (never/rarely make decisions) with cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 70 was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 70 had an indwelling catheter (tube that drains urine from the bladder to a drainage bag) and was always incontinent with bowel. During a review of Resident 70's Care Plan with focus on Patient at risk for Multidrug-resistant Organisms (MDRO, bacteria that are resistant to three or more classes of antimicrobial drugs) colonization (presence of microorganisms in a host that multiplies without interaction between host and organism), revised 3/12/2025, the Care Plan indicated enhanced standard precaution (EBP - gown and glove use during high contact care activities) to use gown and gloves when performing high contact activities such as changing briefs or assisting with toileting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/3/2025 at 9:28 AM in Resident 70's room (EBP), Certified Nursing Assistant 2 (CNA 2) was observed not wearing a gown and was providing incontinent care (cleaning the residents perineal [genital and anal area] area of urine and feces) to Resident 70. After providing incontinent care, CNA 2 was observed using the same gloves, touching resident's hands and bed side rail. CNA 2 stated she did not and should have worn a gown when providing care to Resident 70. CNA2 also stated she did not and should have taken off her gloves and performed hand hygiene prior to touching the resident's hands and surfaces. During a review of Resident 70's physician orders, dated 3/14/2025, the physician orders indicated to apply collagenase powder (medication to improve the functionality of cells) to sacrococcyx (tail bone area) topically every day for pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) for 30 days. Cleanse with normal saline (mixture of sodium chloride and water), pat dry and apply to affected area with calcium alginate (topical cream for wounds) and cover with super absorbent dressing. During an observation and interview on 4/3/2025 at 9:50 AM, Treatment Nurse 1 (TN 1) was observed performing wound care for Resident 70. TN 1 was observed with gloves on. TN 1 removed Resident 70's dirty dressing off and with the same gloves, continued with treatment application and applied a clean dressing over the wound. TN 1 stated she did not and should have changed her gloves and performed hand hygiene prior to continuing Resident 70's wound treatment and prior to applying the dressing. During an interview on 4/3/2025 at 11:07 AM, IPN stated gloves should be one time use. IPN also stated the treatment nurse should change gloves and perform hand hygiene prior to continuing treatment and applying the clean dressing. 2. During a review of Resident 9's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with the diagnoses of urinary tract infection (UTI - an infection in the bladder/urinary tract), and dementia. During a review of Resident 9's MDS, dated [DATE], the MDS indicated resident was severely impaired with cognitive skills for daily decision making. The MDS also indicated Resident 9 was dependent with toileting hygiene, shower/bath self and putting on/taking off footwear. Resident 9 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with upper body dressing, lower body dressing and personal hygiene. The MDS also indicated Resident 9 was always incontinent with both urine and bowel. During a concurrent observation and interview on 4/1/2025 at 8:34 AM, CNA 2 was observed touching Resident 9's roommate's surfaces and proceeded to grabbing Resident 9's cup while touching the straw. CNA 2 stated she should have performed hand hygiene in between resident care because that can spread infection. During an interview on 4/2/2025 at 2:25 PM, IPN stated the CNA should have changed gloves and performed hand hygiene in between resident care to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/3/2025 at 10:25 AM, CNA 2 was observed with gloves while providing incontinent care to Resident 9. CNA 2 was observed with the same gloves, touching resident's hand and bed side rail after providing incontinent care to Resident 9. CNA stated she was supposed to change her gloves and perform hand hygiene prior to touching the resident's hands and surfaces to prevent the spread of infection. During an interview on 4/3/2025 at 11:07 AM, the Infection Prevention Nurse (IPN) stated the CNA should put on a gown prior to entering an EBP room. IPN also stated the CNA should have doff the gloves and perform hand hygiene prior to touching the resident's hand and surfaces because that can spread infection. 45523 3. During a review of the Admission Record, the Admission Record indicated Resident 198 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), other lack of coordination (a medical condition, often called ataxia, characterized by a loss of muscle coordination, leading to clumsy or jerky movements, unsteady gait, and difficulty with balance and fine motor skills), end stage renal disease (the kidney is no longer able to perform its main functions, which are to filter the blood to remove any waste and to balance fluids within the body), chronic kidney disease (is a condition where the kidneys are damaged and don't function as well as they should, leading to a gradual loss of kidney function). During a review of Resident 198's MDS, dated [DATE], the MDS indicated Resident 198 was moderately impaired with cognitive skills for daily decision making. Resident 198 needed partial/moderate assistance (helper does less than half the effort) from the staff for the activities of daily living such as toileting, showers and upper and lower body dressing and needed supervision (helper provides verbal cues and resident completes activity) for eating, oral and personal hygiene. During a review of Resident 198's Order Summary, dated 3/20/2025, the Order Summary indicated, indwelling catheter: Foley catheter (a type of indwelling urinary catheter, which is a flexible tube inserted through the urethra {or sometimes directly into the bladder through a small incision} to drain urine) French (FR) 16 balloon size: 10 cubic centimeters (cc- a unit of volume in the metric system, representing the space occupied by a cube that measures 1 centimeter on each side) change for blockage, leaking, pulled out, excessive sedimentation. Change catheter drainage bag as needed and with every change of indwelling catheter as needed for Urinary retention (the inability to completely empty the bladder when urinating). During a review of Resident 198's Care Plan initiated on 3/23/2025, the care plan indicated Resident 198 requires indwelling Foley catheter due to urinary retention with Dx (diagnosis) of BPH (Benign prostatic hyperplasia, a condition that causes the prostate gland which produces a fluid that is part of semen to grow larger than normal]). Staff intervention included was to keep foley catheter (a type of indwelling urinary catheter, to collect urine drained from the bladder) off the floor During observation in Resident 198's room on 4/01/25 at 9:07 AM, observed Resident 198 resting in bed, with the Foley catheter bag (a collection bag that attaches to a Foley catheter) noted to be on the right side of the bed touching the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Licensed Vocational Nurse 3 (LVN3) on 4/01/2025 at 9:15 AM, LVN3 confirmed Resident 198's Foley catheter bag was on the floor and was not covered with a privacy bag. LVN3 stated, the urine bag should not be touching the floor to prevent any type of bacteria from entering the bag possibly causing infection to the resident. During an interview with Registered Nurse 3 (RN3) on 4/01/2025 at 9:20 AM, RN3 stated it's per facility policy to make sure all foley catheters are off the floor to prevent any type of infection to the resident. During an interview with the Director of Nursing (DON) on 4/04/25 at 11:56 AM, the DON stated Resident 198 uses a wheelchair to mobilize and the foley catheter is placed on side of wheelchair and the staff must make sure it's not touching the floor to prevent any type of bacteria introduced into the catheter or to prevent backflow (urine flowing backwards from the drainage bag or tubing into the bladder, potentially leading to infection). 48143 4. During a review of Resident 248's Admission Record, the admission record indicated Resident 248 was admitted to the facility on [DATE] with diagnosis that included chronic obstructive pulmonary disease (COPD, a progressive lung disease characterized by persistent airflow limitation and difficulty breathing due to narrowed or damaged airways). During a review of the MDS, dated [DATE], indicated Resident 248 had modified independence (some difficulty in new situations) for cognitive skills for daily decision making. Resident 284 need partial or moderate assistance with the eating, oral hygiene and personal hygiene. Resident 284 was dependent with the toilet, upper and lower body dressing, change of position, and transfer. During a review of Resident 284's Physician Orders, dated 3/14/2025, the physician's orders indicated the following: 1. Oxygen at 2 liters per minute (2L/min) via nasal canular (NC, a device that delivers extra oxygen through a tube and into the nose continuously) to keep oxygen level above 92%. 2. Ipratropium-albuterol solution 0.5-2.5 (3) milligrams (mg, a unit of measurement) /3 milliliters (ml, a unit of measure for the capacity of an item) inhale orally three times a day for asthma. During an observation on 4/1/2025 at 9:28 AM in Resident 284's room, observed Resident 284's breathing treatment mask and nasal cannula laying on top of an undated and unlabeled plastic bag on top of the night. During an observation on 4/3/2025 at 10:41 AM in Resident 284's room, observed Resident 284's breathing treatment mask and nasal cannula laying on top of an undated and unlabeled plastic bag on top of the night. During an interview on 4/3/2025 at 11:05 AM with Licensed Vocational Nurse (LVN1), LVN 1 stated that the breathing treatment mask and nasal cannula were supposed to be inside a clean bag labeled with a date and resident's name on it to prevent infection and cross contamination. (continued on next page)

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	04/04/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/2/2025 at 11:14 AM with Infection Preventionist Nurse (IP), IP nurse confirmed that the breathing treatment mask and nasal cannula were supposed to be stored in a clean, dated and named bag to prevent infection, cross contamination. During a review of the Facility's Policy and Procedure (P&P) titled, Standard Precautions, revised September 2022, the P&P indicated hand hygiene is performed with alcohol-based hand rub (ABHR) or soap and water: 1. Before and after contact with the resident 2. Before moving from work on a soiled body site to a clean body site on the same resident 3. After contact with items in the resident's room 4. And after removing gloves The P&P also indicated standard precautions apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. The P&P also indicated resident-care equipment soiled with blood, body fluids, secretions, and excretions are handled in a manner that prevents skin and mucous membrane exposure, contamination of clothing, and transfer of microorganisms to other residents and environments. During a review of the Facility's P&P titled, Handwashing/Hand Hygiene, dated 9/18/2023, the P&P indicated to consider hand hygiene the primary means to prevent the spread of infection. The P&P also indicated the use of ABHR before and after contact with the resident, after contact with blood/body fluids, or after contact with objects in the resident's room. The P&P indicated single use disposable gloves when in contact with blood or body fluids and gloves does not replace hand washing/hand hygiene.