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	05/15/2026

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** Based on observation, interview, and record review, the facility failed to ensure three (3) of 3 sampled residents (Residents 3, 23 and 71) reviewed for dignity were treated with respect and dignity in accordance with the facility's policy and procedure (P&P) when: Resident 3's indwelling catheter (a hollow tube inserted into the bladder [a hollow, balloon-shaped muscular organ located in your lower pelvis. Its primary job is to collect and store urine made by your kidneys until it is ready to be released from the body] to drain or collect urine) collection bag (ICCB) was not fully covered with a dignity bag. The dignity bag was covering the top half of the ICCB exposing the urine at the bottom of the ICCB. Resident 71's supra pubic catheter (a flexible tube surgically inserted through a small abdominal incision directly into the bladder to drain urine) bag (SPCB)was not fully covered with the dignity bag exposing the urine on top half of the supra pubic catheter bag.Resident 23 had yellow, dry, crusted substances on both eyes while sitting in his wheelchair in the hallway. These deficient practices have the potential to cause Residents 3, 23 and 71 to have diminished feelings of self-worth and self-esteem. Findings: 1. During a review of Resident 3's admission Record, it indicated the resident was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities) and unstageable (a full-thickness pressure injury [pressure ulcer- localized injuries to the skin and underlying tissue. They are primarily caused by prolonged, unrelieved pressure, friction, or shear on the skin, which restricts blood flow and damages tissues over time] 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) pressure ulcer of sacrum (lower end of the spinal area at the base of the spine). During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool) dated 4/20/2026, the MDS indicated Resident 1 was assessed to have severely impaired cognitive (ability to think and process information) ability. The MDS indicated Resident 3 was dependent (helper does all the effort) for oral hygiene, toileting hygiene, showering, upper/lower body dressing, putting on/taking off footwear, and rolling left and right. During an observation on 5/14/2026 at 2:48 PM, Resident 3's ICCB was not fully covered with a dignity bag. The dignity bag was covering the top half of the ICCB exposing the urine at the bottom of the ICCB. During a concurrent observation in Resident 3's room and interview on 5/14/2026 at 2:54 PM with Licensed Vocational Nurse (LVN) 2, Resident 3's ICCB was observed with a dignity bag covering the top half of the ICCB leaving the collected urine at the bottom of the ICCB exposed. LVN 2 stated the (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dignity bag is not covering the bottom half of the ICCB exposing the urine collected on the top half of the ICCB. LVN 2 stated Resident 3's urine is visible to everyone who passes by, and the purpose of the dignity bag is to maintain the dignity of the resident by covering the urine. LVN 2 stated the resident's dignity is compromised if the dignity bag is not fully covering the ICCB. During a concurrent interview and record review on 5/15/2026 at 10:49 AM with Registered Nurse (RN) 1, the facility's policy and procedure (P&P) titled, dignity, dated 2/2021 was reviewed. 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, and feeling of self-worth and self-esteem. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: helping the resident to keep urinary catheter bags covered. RN 1 stated the policy indicated that a resident's dignity, feelings of self-worth and satisfaction must be maintained and promoted and that ICCB must remain covered with the dignity bag. RN 1 stated a resident is not being treated with dignity if their urine is not covered with the dignity bag because the resident's urine is exposed to everyone to see and it may lessen the resident's sense of worth. 2. During a review of Resident 71's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of urinary tract infection (UTI, an infection of the bladder and urinary system), paraplegia (partial or complete paralysis [loss of voluntary muscle function] of the lower half of the body with involvement of both legs) and type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel). During a review of Resident 71's Care Plan Report initiated on 7/21/2025 and revised on 11/17/2026, the care plan indicated that Resident 71 requires suprapubic catheter due to neurogenic bladder for the diagnosis of paraplegia. The Care plan indicated under intervention to provide privacy bag (dignity bag). During a review of Resident 71 's History and Physical Examination (H&P), dated 11/14/2025, the H&P indicated that, under general appearance, Resident 71's abdomen had a suprapubic catheter. During a review of Resident 71'S MDS dated [DATE], the MDS indicated the resident was cognitively intact with cognitive skills for daily decision making. The MDs also indicated Resident 71 was dependent on toilet hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having bowel movement). During a review of Resident 71's Medication Review Report dated 4/30/2026, it indicated, Suprapubic Catheter French 16 (size) with 10 cubic centimeters (the volume of sterile water, expressed in cubic centimeters [cc] used to inflate the retention balloon of a indwelling catheter to hold it in place inside the bladder) for neurogenic bladder (a disorder causing difficulty or full inability to pass urine without use of a catheter or other method) related to paraplegia. During a concurrent observation outside Resident 71's room and interview on 5/12/2026 at 12:47 PM (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with LVN 5, LVN 5 stated Resident 71's clear yellow urine in the SPCB was visibly seen from the hallway. LVN 5 also stated the SPCB was not fully covered with the dignity bag, the bottom part was exposed. During an interview on 5/14/2026 at 4:08 PM with the Infection Preventionist Nurse (IPN), the IPN stated all SPCB and ICCB were supposed to be fully covered with the dignity bag. The IPN explained residents might feel embarrassed, sad, or even angry because they were not treated with respect and dignity by not ensuring the SPCB or ICCB was not properly covered. 3. During a review of Resident 23 's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses of type 2 diabetes mellitus, hypertension (high blood pressure), and adult failure to thrive (refers to a state where the resident experiences a substantial decline in overall health and functional abilities) . During a review of Resident 23's Care Plan Report initiated on 12/17/2025 and revised on 4/13/2026, the care plan indicated that Resident 23 requires assistance with the Activities of Daily Living (ADLs – activities related to personal care that include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating) related to disease process, limited mobility , impaired balance. During a review of Resident 23 's MDS, dated [DATE], the MDS indicated the resident had severe impairment; cognitive skills for daily decision making were severely impaired. Resident 23 needed supervision and touching assistance (helper provides cues and/or touching assistance as residents complete the activity) for showering/bathing self (the ability to bathe oneself). During a concurrent observation and interview on 5/12/2026 at 12:18 PM in the hallway with the Certified Nursing Assistant (CNA 2), CNA 2 stated Resident 23 was sitting on his wheelchair in the hallway, and Resident 23's had yellow, dry, crusted substance under the resident's eyes. During a concurrent interview and record review on 5/15/2026 at 10:01 AM with the Registered Nurse (RN 2), the facility's Policy and Procedures (P&P) titled Care Plan Baseline, dated 8/25/2021, was reviewed. RN 2 stated the P&P indicated a baseline care plan for each resident, which includes instructions needed to provide effective and person-centered care that meets professional standards of quality care, which should be developed and implemented for each resident. During a concurrent interview and record review on 5/15/2026 at 10:05 AM with RN 2, the facility's Policy and Procedures (P&P) titled Dignity, revised 2/2021, was reviewed. RN 2 stated the P&P indicated residents need to be groomed as they wish to be groomed. RN 2 stated residents need to be checked for their hygiene even if they are independent; they are supposed to be presentable at all times. RN 2 stated, That is why we are here; they need to be taken care of. RN 2 stated that the P&P was not followed.

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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. Based on observation, interview, and record review, the facility failed to accurately measure the shredded Monterey [NAME] Cheese used to prepare Quesadilla served for lunch on 5/14/2026. This deficient practice had the potential to result in meal dissatisfaction, decreased nutritional intake, and weight loss for the six (6) of 6 sampled residents who received the Quesadilla on 5/14/2026.Findings: During an observation in the kitchen on 5/14/2026 at 11:59 AM, Dietary [NAME] (DK 2) was observed using a black - colored scoop (scoop size number 30, capacity of one ounce [oz, unit of measurement]) to measure the Monterey [NAME] shredded cheese used for Quesadilla. During an observation in the kitchen on 5/14/2026 at 12 PM, DK 1 was observed using a yellow-colored scoop (scoop size number 20, capacity of one and five-eighths [1 5/8 oz]) to measure the Monterey [NAME] shredded cheese used for Quesadilla. During an interview on 5/14/2026 at 2:42 PM, DKˆ1 stated that she used the yellow scoop to measure the Monterey [NAME] cheese for preparing the quesadilla. DKˆ1 stated she used the scoop to make one quesadilla and added that the yellow scoop was the correct tool, while the black scoop was not. During an interview on 5/14/2026 at 2:57 PM, DKˆ2 stated that she used the black scoop to measure Monterey [NAME] cheese for preparing the quesadillas. DKˆ2 stated she used the scoop to make five quesadillas. DKˆ2 stated that the yellow scoop and not the black scoop was the correct tool to use to provide proper nutrition for the residents. During a concurrent interview and record review on 5/15/2026 at 10:26 AM with Registered Nurse (RN 2), the Quesadilla recipe dated 2002 was reviewed. RN 2 stated that the menu for quesadillas indicated, under method 2: Place tortillas on the hot griddle and quickly place two oz of cheese on each tortilla. RN 2 stated that 2ˆoz corresponded to the blue scoop as indicated on the facility's Portion Control Chart (a visual reference tool that illustrates appropriate food serving sizes). During a concurrent interview and record review on 5/15/2026 at 10:27 AM with RN 2, the facility's Policy and Procedure (P&P) titled, Menus, revised 10/2022, was reviewed. RN 2 stated that the P&P indicated that menus will be served as written, unless a substitution is provided in response to preference, availability of an item, or special meal.

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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** Based on observation, interview, and record review, the facility failed to follow proper food handling procedures and to maintain the food service area in a clean and sanitary manner in accordance with the facility's policy and procedure (P&P) by failing to ensure: The can opener was free of rust, peeling metal, and food residue.Containers of ground white pepper, oregano, ground black pepper, and onion powder were properly closed or sealed.The Brand 1 blender pitcher did not have a crack and did not have a whitish to yellowish color buildup.The Brand 2 food processor cover was not cracked and did not have a yellowish to whitish calcification buildup.The clear container of food thickener was properly closed.The microwave top and bottom interior was not rusted; the lining was peeled off, chipped and had dry food residue.The resident's refrigerator was kept clean and checked daily for cleaning according to the facility's policies and procedures.Three (3) Brand 3 yogurts were labeled with the resident's name and discarded after the best-by date (expiration or use by date) on 5/2/2026.The resident's freezer door did not have a brown color dripping.The mozzarella cheese container, chocolate ice cream, Brand 4 Maple Griddle, Brand 5 Bowls Mexican Casserole, Brand 6 Lasagna with Meat Sauce, and Cheese Ravioli were dated with when it was [NAME] in by the resident's family or representative and labeled with the resident's name and room number.The [NAME] Style Beef [NAME] was discarded after the best-by date on 4/22/2026.All five conventional oven knobs have temperature settings and were not dirty with grease and food residue buildup. These deficient practices have the potential to result in pathogen (germ) exposure to residents, which could place the residents at risk for developing foodborne illness ([food poisoning] with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever) and can lead to other serious medical complications and hospitalization. Findings: During an observation in the kitchen on 5/12/2026 at 7:48 AM, a can opener was observed to be rusted, with peeling metal and food residue buildup. During an observation in the kitchen on 5/12/2026 at 7:49 AM, containers of ground white pepper, oregano, ground black pepper, and onion powder on the spice rack were not properly closed or sealed. During an observation in the kitchen on 5/12/2026 at 7:50 AM, the Brand 1 blender pitcher was observed to have cracks and whitish to yellowish colored substance buildup During an observation in the kitchen on 5/12/2026 at 7:51 AM, the Brand 2 food processor cover was observed to be cracked and have yellowish to whitish, and brownish substance buildup. During an observation in the kitchen's stock room on 5/12/2026 at 7:57 AM, a clear container of food thickener was not properly closed. During an observation in the kitchen on 5/12/2026 at 7:58 AM, the microwave's interior was rusted, chipped, and had dry food like residue. During a concurrent observation and interview on 5/12/2026 at 8:04 AM at the employee's breakroom with the Dietary Supervisor (DS), the resident's refrigerator was dirty, with dry crusted food debris and accumulation of visible liquid residue. DS stated the resident refrigerator was dirty and the log indicated that resident's refrigerator should have been checked and cleaned every day. During a concurrent observation of resident's refrigerator and interview on 5/12/2026 at 8:05 AM in the employee's break room with the DS, DS stated the Brand 3 Yogurt in the resident's refrigerator was not labeled with the resident's name and room number. Brand 3 yogurt has a best by date of 5/2/2026 (10 days). During the same concurrent observation of the resident's refrigerator and interview on 5/12/2026 at 8:05 AM in the employee breakroom with the DS, the DS stated that the freezer door had visible brown colored substance or chocolate like drippings. The mozzarella cheese, chocolate ice cream, Brand 4 Maple Griddle, Brand 5 Bowls Mexican Casserole, Brand 6 Lasagna with Meat Sauce, and cheese ravioli were not dated with when it was [NAME] in by the resident's family or representative and labeled with resident's name. The DS also stated that the [NAME] Style Beef [NAME]'s best by date was 4/22/2026. During a concurrent observation and interview on 5/14/2026 at 11:00 PM with Dietary District Manager (DDM) (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in the kitchen, DDM stated the conventional oven knobs did not have visible numbers and setting for temperature. DDM asked Dietary [NAME] (DK 1) how they determine the correct temperature when cooking and DK 1 responded that they estimate it. DK 1 also stated the conventional oven has been like that for long time. During an interview on 5/14/2026 at 2:26 PM with Dietary Aid (DA) 1, DA 1 stated the can opener was rusted, with the metal covering peeled off and food residue present. DA 1 also stated, the Brand 1 blender and Brand 2 food processor were cracked and had yellowish to whitish buildup. DA 1 also stated the conventional oven knobs do not have visible numbers or settings for temperature. DA 1 added the knobs were dirty with grease and food residue buildup. DA 1 also stated all food and spices containers should be sealed properly and noted that these conditions or practice were not acceptable and could cause food contamination and sickness. During a concurrent interview and record review on 5/14/2026 at 3:13 PM with DS, the facility's P&P titled Food Brought by Family/Visitors, revised on 3/28/2024, was reviewed. DS stated the P&P indicated that when a food item is intended for later consumption, the responsible staff member will label the food with the resident's name, current date, and use-by date and items will be discarded after 48 hours. DS also stated the P&P indicated that the refrigerator/freezer for storage of food brought in by visitors will be properly maintained and cleaned daily. DS added the P&P was not followed since the resident's refrigerator was not cleaned daily, and the food that was stored in the resident's refrigerator were not labeled with the resident's name and labeled with the use- by date. During a concurrent interview and record review on 5/14/2026 at 3:15 PM with the DS, the facility's P&P titled Food Storage: Cold Foods, revised 2/2023, was reviewed. DS stated the P&P indicated all food must be stored wrapped or in covered containers, labeled and dated, and arranged to prevent cross-contamination (the transfer of harmful substances or disease-causing microorganisms to food by hands, food contact surfaces, sponges, cloth towels, or utensils which are not cleaned after touching raw food, and then touch ready-to-eat foods). DS stated the P&P was not followed. During a concurrent interview and record review on 5/14/2026 at 3:17 PM with the DS, the facility's P&P titled Equipment revised 9/2017 was reviewed. The P&P indicated, all equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. DS stated that all food service equipment such as the resident's refrigerator and conventional oven should be kept clean, sanitary, and maintained in proper working order. DS stated that the P&P was not followed. During a concurrent interview and record review on 5/14/2026 at 3:19 PM with the DS, the facility's P&P titled Receiving revised 2/2023 was reviewed. DS stated that the P&P indicated all non- perishable foods and supplies will be stored appropriately. During an interview on 5/15/2026 at 10:28 AM with the Registered Nurse (RN 2), RN 2 stated that all food containers in the kitchen should be labeled, dated, and closed properly. RN 2 also stated all equipment should be in good condition to prevent food contamination and illnesses such as stomach flu and diarrhea.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a coordination of care between the facility and hospice (care designed to give supportive care to people in the final phase if a terminal illness and focus on comfort and quality of life, rather than cure) staff for two of two sampled residents (Residents 6 and 40) by failing to ensure:Resident 6's hospice medications were reflected on the physician's orders.Resident 40's care plan reflected hospice care and interventions with hospice 1(HSP1).These deficient practices have the potential for Residents 6 and 40 to not receive the hospice care and services necessary to promote comfort and quality of life.Findings: 1. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included unspecified dementia (memory loss and impaired daily functioning), unspecified convulsions (sudden, involuntary muscle contractions or shaking when the exact type of seizure [a sudden and uncontrolled surge of electrical activity in the brain]or its underlying cause remains undetermined), and personal history of pneumonia (history of lung infection). During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool), dated 4/1/2026, the MDS indicated Resident 6 was assessed having moderately impaired (decisions poor; cues/supervision required) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 6 was dependent (helper does all of the effort) with eating, toileting/personal hygiene, upper body dressing, rolling left and right, and sit to lying. The MDS also indicated Resident 6 was in hospice care. During a review of Resident 6's Order Summary Report, dated 5/14/2026, the Order Summary Report indicated a physician order, with a start date of 10/1/2025, for the following: Admit to Hospice (HSP) on routine level of care. HSP to manage care related to Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills and eventually the ability to carry out the simplest tasks). HSP to provide medications related to comfort, symptom control and management of terminal illness. Follow plan of care and collaborate any changes with HSP. During a review of Resident 6's Hospice Medication List, as of 5/8/2026, the Medication List indicated Resident 6 was ordered the following medications: Lorazepam (medication for anxiety) 0.5 milligrams (mg- unit of measurement) 1 tablet sublingually (sl- under the tongue) every four hours as needed for restless behavior or combativeness, with a start date of 4/20/2026 Milk of Magnesia (medication for constipation) 400 mg/5 milliliters (ml- unit of measurement) 30 ml by mouth (po) every 12 hours as needed if no bowel movement (BM) x 3 days, with a start date of 9/30/2025 Ondansetron HCl (medication to prevent and treat nausea and vomiting) 4 mg 1 tablet by mouth every four hours as needed for nausea and vomiting, with a start date of 9/30/2025 (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Phenobarbital (medication for seizures) 120 mg per rectum (PR) as needed for seizure activity then call hospice immediately, with a start date of 3/13/2026 Zinc (a supplement used for wound healing) 50 mg 1 tablet by mouth once daily, with a start date of 9/30/2026 During a concurrent interview and record review on 5/13/2026, at 4:11 PM, with the Director of Nursing (DON), Resident 6's Order Summary Report, dated 5/14/2026 and Hospice Medication List were reviewed. The DON stated Resident 6's Order Summary Report did not include the following medications that were in Resident 6's Hospice Medication List: Lorazepam 0.5 mg 1 tablet sl every four hours as needed for restless behavior or combativeness, with a start date of 4/20/2026 Milk of Magnesia 400 mg/5 ml 30 ml by po every 12 hours as needed if no BM x 3 days, with a start date of 9/30/2025 Ondansetron HCl 4 mg 1 tablet by mouth every four hours as needed for nausea and vomiting, with a start date of 9/30/2025 Phenobarbital 120 mg PR as needed for seizure activity then call hospice immediately, with a start date of 3/13/2026 Zinc 50 mg 1 tablet by mouth once daily, with a start date of 9/30/2026 The DON stated the medications of residents in hospice care were discussed with the hospice coordinator upon admission, quarterly and whenever there was a change in the resident's care. The DON stated it was important that all of Resident 6's hospice medications were reviewed and included in Resident 6's ordered medications to prevent complications especially when there was an exacerbation of Resident 6's symptoms. The DON stated Resident 6 has not been taking zinc because it was not included in Order Summary Report. The DON stated Resident 6 had pressure ulcers (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) and it was important for Resident 6 to take zinc because it was a supplement to promote wound healing. The DON also stated Resident 6's Order Summary Report did not include phenobarbital which was indicated for seizures. During the same concurrent interview and record review on 5/13/2026, at 4:11 PM, with the DON, Resident 6's Hospice Medication List was reviewed. The DON stated Resident 6's Hospice Medication List did not include Naloxone HCl (a life-saving medication that rapidly reverses opioid [strong pain killers that block pain signals in the brain] overdose) 4mg/0.1ml 1 application alternating nostrils as needed for opioid overdose which was included in Resident 6's Order Summary Report. The DON stated it was the responsibility of the hospice staff to ensure that Resident 6's hospice medications matched the medications in the Order Summary Report. The DON stated she was unsure if the hospice staff had access to the list of medications Resident 6 was taking in the facility. The DON stated Resident 6's Hospice Medication List should be reviewed and compared to the list of medications in the Order Summary Report during recap (a routine, usually monthly, administrative review of the Resident's medical chart). The DON stated it was important that the medications in the Hospice Medication List and the Order Summary Report match to ensure that the medications are coordinated and available when needed. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P), titled, Hospice, revised 3/1/2018, the P&P indicated the hospice and Center (facility) must communicate, establish, and agree upon a coordinated plan of care which reflects the hospice philosophy, and is based on an assessment of the patient's needs. During a review of the Hospice and Nursing Facility Service Agreement, signed 9/26/2016, between the facility and HSP, the Hospice and Nursing Facility Service Agreement indicated the under Facility Responsibilities that, Hospice and Facility will communicate pertinent information with each other either verbally or in the patient's medical record at each hospice patient visit or more frequently, whenever needed to ensure that the needs of each hospice patients are met 24 hours per day. Documentation of such communication shall be included in the patient's medical record. 2.During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 40's diagnoses included dementia (a progressive state of decline in mental abilities), atrial fibrillation (AFib, is the most common type of irregular heartbeat), and atrioventricular block (AV block, a malfunction in the heart's electrical wiring) During a review of Resident 40's Order Summary Report, dated 5/14/2026, the Order Summary Report indicated an order to admit Resident 40 to HSP (Hospice) on routine level of care, ordered on 8/19/2025. During a review of Resident 40's Minimum Data Set (MDS – a resident assessment tool), dated 2/16/2026, the MDS indicated Resident 40's cognitive skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 40 required substantial/maximal assistance (helper does more than half the effort) with upper body dressing. The MDS indicated Resident 40 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower, lower body dressing, putting on/off footwear and personal hygiene. The MDS indicated Resident 40 was in hospice care while a resident of the facility. During a concurrent record review and interview on 5/15/2026 at 9:45 AM with Registered Nurse 1 (RN 1), Resident 40's medical records were reviewed. RN 1 stated that Resident 40 was discharged from hospice 2 (HSP 2) on 6/27/2025. RN 1 stated that Resident 40 was admitted to HSP 1 on 8/19/2025RN 1 stated Resident 40 did not have care plan that addressed being under the care of HSP 1. RN 1 stated it was important to have a HSP care plan to determine the coordination of Resident 40's care between HSP 1 and the facility to ensure Resident 40's comfort. RN 1 stated that Resident 40's hospice frequency of visits from HSP 1 was not and should have been in the care plan. RN 1 stated that it was important to reflect hospice frequency of visits on the care plan for coordination of care. During a concurrent record review and interview on 5/15/2026 at 2:25 PM with Registered Nurse 2 (RN 2), Resident 40's medical records and HSP binder were reviewed. RN 2 verified that Resident 40 does not have and should have a care plan regarding care under HSP 1. RN 2 stated this can lead to inconsistency of care that may cause harm to Resident 40. RN 2 stated that the hospice care plan should include all the orders that are indicated in Resident 40's POC summary filed in the hospice binder, like the frequency of hospice staff visits. During a review of the Contract Agreement between HSP and facility, dated 8/26/2019, the Contract Agreement indicated Joint Responsibilities/Mutual Promises between HSP and facility with (continued on next page)

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	055153	A. Building B. Wing	05/15/2026

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	development and implementation of plan of care, Hospice and Facility shall jointly develop and agree upon the Patient's plan of care. The Contract Agreement indicated modification of plan of care/communication protocols, hospice and facility shall jointly coordinate and participate in periodic review and modification of each's patient's plan of care. During a review of facility's Policy and Procedure (P&P) titled, Hospice Program, revised in July 2017, the P&P indicated facility will coordinate with hospice representatives and coordinate facility staff participation in the hospice care planning process for resident receiving these services.

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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** Based on observation, interview, and record review, the facility failed to ensure the call light device (a device used by a resident to signal his or her need for assistance) for one (1) of four (4) sampled residents (Resident 8) reviewed for environment was within reach in accordance with the facility's policy and care plan. This deficient practice had the potential to result in delayed provision of care and services for Resident 8.Findings: During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was initially admitted to the facility on [DATE] with diagnoses that included hypotension (low blood pressure), dementia (progressive brain disorder that slowly destroys memory and thinking skills), muscle weakness. During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 3/5/2026, the MDS indicated Resident 8's cognitive skills (processes of thinking and reasoning) for daily decision making was moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 8 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, oral, toileting and personal hygiene. The MDS also indicated Resident 8 required partial/moderate assistance (helper does less than half the effort) with shower, upper and lower body dressing, and putting on/taking off footwear. During a review of Resident 8's Care Plan, initiated on 5/15/2025, revised on 3/13/2026, indicated Resident 8 is at nutritional risk related to muscle weakness, dementia, dysphagia (difficulty swallowing) and cognitive communication deficit (occurs when a person has difficulty with verbal or nonverbal communication). Resident 8's Care Plan indicated to place call light within reach at all times. During a concurrent observation in Resident 8's room and interview with Resident 8 on 5/12/2026, at 10:09 AM, Resident 8's call light string was observed away from the resident, call light was observed behind Resident 8's bed, and not within Resident 8's reach. Resident 8 stated he could not reach his call light. Resident 8 added that his call light is usually on the left side of the bed where he can easily reach when he needed help. During an interview on 5/14/2026 at 4:06 PM with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated Residentˆ8 is able to use the call light, which is why it is important to ensure the call light is always within the resident's reach. During an interview on 5/14/2026 at 4:11 PM with the Director of Staff Development (DSD), the DSD stated the call light needs to be within the resident's reach at all times so the resident can call for assistance. The DSD added that if the call light is not within reach, the resident cannot call or ask staff for help. During a review of facility's Policy and Procedures titled Accommodation of Needs, revised on November 2025, the P&P indicated the resident has the right to reside and receive services in the facility with reasonable accommodation of their needs and preferences. The P&P also indicated staff are trained and expected to assist the residents in maintaining independence, dignity, and well-being to the extent possible and in accordance with resident's wishes. For example, arranging the call light and personal items so they are in easy reach of the resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a clean and homelike environment for one (1) of 23 sampled residents (Resident 102) by failing to ensure that the trashcan used for disposal of soiled (used) personal protective equipment (PPE-including protective clothing, helmets, gloves, face shields, goggles, face masks, respirators, or other equipment designed to protect the wearer from injury or the spread of infection or illness) in the resident's room(Room A) was not overflowing. This deficient practice created an unsanitary and unsafe environment and had the potential to place residents at risk of infection and injury.Findings: During a review of Resident 102's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of gastrostomy (a surgical procedure for inserting a tube through the abdomen wall and into the stomach used for feeding or drainage), end stage renal disease (advanced stage kidney failure) and muscle weakness. During a review of Resident 102's History and Physical Examination (H&P), dated 5/13/2026, the H&P indicated the resident does not have the capacity to make decisions. During a review of Resident 102's Order Summary Report for the month 5/2026, it indicated on 5/12/2026 an order to place the resident on infection precautions enhanced barrier (EBP, infection control measures used mainly in nursing homes and long term care facilities to help prevent the spread of certain germs, especially multi drug resistant organisms [MDRO, germs usually bacteria that are resistant to multiple antibiotics, making infection harder to treat]) every shift for a gastrostomy tube (G-tube-a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration), and a right upper chest permacath (a soft tube placed into a large vein, usually in the chest, used for dialysis [a lifesaving treatment for residents with kidney failure or end-stage renal disease] or other long-term intravenous treatment [treatment means giving fluids, medicine, blood, or nutrients directly into a vein using a needle or catheter]). During an observation on 5/14/2026 at 10:33 AM, Room A's trashcan was overflowing with PPE. During an interview on 5/14/2026 at 4:13 PM with the IPN, IPN was shown a photo of Room A's trashcan taken on 514/2026 at 10:33 AM, IPN verified that the trashcan in Room A was overflowing with soiled PPE. IPN also stated that Room A was on EBP. During an interview on 5/15/2026 at 2:56 PM with the Registered Nurse (RN 1), RN 1 stated that all trashcans are supposed to be closed all the time to prevent contamination or spread of bacteria, especially the trashcans for soiled PPE. During a review of the facility's Policy and Procedures (P&P) titled Homelike Environment dated 2/2021 was reviewed. The P&P indicated the Residents are provided with safe, clean and comfortable and homelike environment.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two (2) of five (5) sampled residents (Resident 4 and 55) were free from an unnecessary psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) by failing to ensure:Resident 4 had the correct indication for the use of buspirone (a prescription medication primarily used to treat generalized anxiety disorder [GAD, a mental health condition characterized by persistent, excessive, and uncontrollable worry about everyday issues]) as indicated on the facility's policy and procedures (P&P).Resident 55's Ativan (lorazepam, medication used to treat anxiety [persistent and excessive worry that interferes with daily activities) as needed (PRN) order had a documented rationale for extended use, beyond 14 days, in accordance with the facility's P&P.Findings: 1. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE]. It also indicated Resident 4's diagnoses included dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and history of falling. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 3/19/2026, the MDS indicated Resident 4 had severely impaired (never/rarely made decisions) cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 4 had symptoms of little interest or pleasure in doing things, feeling down, depressed, hopeless, feeling tired or having little energy and poor appetite or overeating. The MDS also indicated Resident 4 was dependent (helper does all of the effort) with eating, oral and toileting hygiene, shower, upper and lower body dressing, putting on/off footwear and personal hygiene. It indicated Resident 4 was taking antianxiety (medications that can treat anxiety symptoms) and antidepressant medications (medications primarily used to treat major depressive disorder, anxiety disorders, and chronic pain). During a review of Resident 4's Order Summary Report, dated 5/13/2026, the Order Summary Report indicated buspirone hydrochloride five (5) milligram (mg, unit of measurement), give 1 tablet by mouth, every eight (8) hours for dementia with behavioral disturbance manifested by irritability and striking out to staff during activities of daily living care, ordered on 4/9/2026. During a concurrent record review and interview on 5/15/2026 at 12:36 PM with Registered Nurse 1 (RN 1), Resident 4's buspirone order dated 5/13/2026 was reviewed. RN 1 verified Resident 4 has an order for buspirone for dementia, ordered on 4/9/2026. RN 1 stated the diagnosis of dementia as an indication for the use of buspirone was incorrect because buspirone had previously been given (admission to the facility prior to 3/16/2026) for Resident 4's anxiety. RN 1 stated Resident 4 has another order of Aricept (medication used to treat symptoms of dementia). RN 1 stated it was important to indicate the right diagnosis or use of the medication to know that you are giving the right medication to the right purpose. During a concurrent record review and interview on 5/15/2026 at 2:41 PM with Registered Nurse 2 (RN 2), Resident 4's buspirone order dated 5/13/2026 was reviewed. RN 2 verified Resident 4 has an order for buspirone for dementia, ordered on 4/9/2026. RN 2 stated it was important to have an accurate diagnosis as an indication for use of any medication to ensure the resident receives the correct medication for the correct indication. RN 2 stated psychotropic medication orders should have a resident's diagnosis and the behavior that resident is manifesting, to ensure the medication is necessary for the resident. During a review of Facility's undated P&P titled, Medication Utilization and Prescribing-Clinical Protocol,, the P&P indicated when a medication is prescribed for any reason, the physician and staff will identify the indications, considering the resident's age, medical and psychiatric (mental) conditions, risks, health status and existing medication regimen. 2. During a review of Resident 55's admission Record, the admission Record indicated Resident 55 was originally admitted to the facility on [DATE] and readmitted on [DATE]. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 55's diagnoses included anxiety disorder (a natural human emotion characterized by feelings of worry, nervousness, or unease), claustrophobia (an intense, irrational fear of confined or enclosed spaces) and major depressive disorder. During a review of Resident 55's MDS, dated [DATE], the MDS indicated Resident 55 had modified independence (some difficulty in new situations only) cognitive skills for daily decision making. The MDS indicated Resident 55 has symptoms of feeling down, depressed and hopeless. The MDS indicated Resident 55 required supervision (helper provides verbal cues and/or touching assistance) with eating, oral and personal hygiene. The MDS indicated Resident 55 required substantial/maximal assistance (helper does more than half the effort) with upper body dressing. The MDS indicated Resident 55 was dependent on toileting hygiene, shower, lower body dressing and putting on/off footwear. The MDS indicated Resident 55 was taking antianxiety medication. During a review of Resident 55's Medication Administration Record (MAR) for May 2026, the MAR indicated lorazepam oral tablet 1 mg, give 1 tablet by mouth, every 8 hours as needed for anxiety for 30 days manifested by crying and screaming, with start date of 4/10/2026. During a concurrent record review and interview on 5/15/2026 at 12:21 PM with RN 1, Resident 55's medical records were reviewed. RN 1 verified Resident 55 has an order of lorazepam as needed for anxiety ordered on 4/10/2026, for 30 days. RN 1 stated as needed lorazepam order can be ordered for 30 days if there is documentation from Psychiatrist (a medical practitioner specializing in the diagnosis and treatment of mental illness) as to why lorazepam needs to be extended for more than 14 days. RN 1 stated there was no Psychiatrist documentation prior to Resident 55's lorazepam as needed order for 30 days on 4/10/2026. RN 1 stated Resident 55's lorazepam as needed order should have been limited to 14 days and 30 days. RN 1 added that a reevaluation to include a rationale will be needed to continue for Resident 55 to receive lorazepam beyond 14 days as indicated on the facility policy. During an interview on 5/15/2026 at 2:37 PM with RN 2, RN 2 stated PRN lorazepam order should be limited to 14 days to minimize the unnecessary use of psychotropic medication. RN 2 stated when it comes to psychotropic orders, licensed nurses need to inform the resident's physician or Psychiatrist of the resident's status and behavior. RN 2 added when Psychiatrist decides for PRN psychotropic medication to extend to 30 days, resident evaluation and rationale documentation should be done prior to placing the order. RN 2 stated Resident 2 was not and should have been evaluated prior to PRN lorazepam order on 4/10/2026 for 30 days. RN 2 stated Psychiatrist reevaluation for the use of PRN lorazepam every 14 days was important to check the effectiveness of the medication, and documentation for the need for order adjustment. RN 2 stated there was no documented reason in Resident 55's medical records why Resident 55 can be on as needed lorazepam order for 30 days instead of 14 days. During a review of Facility's undated P&P titled, Medication Utilization and Prescribing-Clinical Protocol,, the P&P indicated as part of the overall review, the physician and staff will evaluate the rationale for existing medications that lack a clear indication or are being used intermittently on a PRN basis. The P&P also indicated the physician will provide and/or document a rationale when the indication, dose, or frequency of a prescribed medication is greater than commonly practice.

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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** Based on interview and record review, the facility failed to ensure accurate assessment of the Minimum Data Set (MDS, a resident assessment tool) to only reflect the resident's active diagnosis for one (1) of 23 sampled residents (Resident 32) in accordance with the facility policy.This deficient practice had the potential for the facility not to develop and implement an individualized care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives, interventions and timeframes to meet a resident's medical, nursing, and mental psychosocial needs).Findings:During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), depressive disorder (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities), and muscle weakness. During a review of Resident 32's Quarterly MDS, dated [DATE], the MDS indicated Resident 32 had moderately impaired (decisions poor, sues/supervision required) cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 32 was independent (Resident completes the activity by themselves with no assistance from a helper) with eating. The MDS indicated Resident 32 required setup or clean-up assistance (helper sets up or cleans up, resident completes activity) with oral and personal hygiene and required partial/moderate assistance (helper does less than half the effort) with toileting hygiene and upper body dressing. The MDS also indicated Resident 32 required substantial/maximal assistance (helper does more than half the effort) with shower, lower body dressing and putting on/taking off footwear. In addition, the MDS indicated Resident 32 has a diagnosis psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a concurrent record review and interview on 5/15/2026 at 8:34 AM with Registered Nurse 1 (RN 1), Resident 32's medical records dated from 3/31/2026 to 5/15/2026 were reviewed. RN 1 stated Resident 32's MDS dated [DATE] indicated a diagnosis of psychosis. RN 1 verified Resident 1 has no diagnosis of psychosis, since it is not part of the medical diagnosis listed in the Resident 32s' admission record. RN 1 also stated there were no other documentation that indicated Resident 32 has psychosis. RN 1 stated Resident 32's recent psychiatric consult notes dated 5/6/2026 did not indicate diagnosis of psychosis. RN 1 stated she does not know why Resident 32's MDS dated [DATE] has a diagnosis of psychosis. During a concurrent record review and interview on 5/15/2026 at 1:55 PM with MDS Assistant (MDSA), Resident 32's medical records dated from 3/31/2026 to 5/15/2026 were reviewed. MDSA verified MDS dated [DATE] has a diagnosis of psychosis. MDSA stated psychosis diagnosis should not have been coded in the MDS since Resident 32 has no active diagnosis of psychosis. MDSA verified Resident 32 is not receiving any medication for psychosis. MDSA stated Resident 32 has no care plan regarding psychosis. MDSA stated that accurate MDS is important for the facility to develop a resident centered care plan. During a review of the facility's Policy and Procedure (P&P) titled, MDS Completion and Submission Timeframes, revised on July 2017, the P&P indicated the facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. During a review of the facility's P&P titled, Certifying Accuracy of the Resident Assessment, revised on November 2019, the P&P indicated any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. The P&P also indicated the information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise the care plan (a formal process that correctly identifies existing needs and recognizes a resident's potential needs or risks to achieve healthcare outcomes) for one (1) of 23 sampled resident (Resident 40) when Resident was discharged from Hospice 2 (hospice, care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure) on 6/27/2025. This deficient practice had the potential to prevent Resident 40 from receiving care that addressed the resident's specific needs, which could negatively affect the residents' overall wellbeing.Findings: During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was initially admitted to the facility on [DATE] and readmitted on [DATE]. It also indicated Resident 40's diagnosis included dementia (a progressive state of decline in mental abilities), atrial fibrillation (often called AFib, is the most common type of irregular heartbeat), and atrioventricular block (AV block, a malfunction in the heart's electrical wiring)During a review of Resident 40's Care Plan (CP) focusing on hospice care due to medical condition and diagnosis of Afib, initiated on 3/13/2024, the CP indicated Resident 40 is under Hospice 2. During a review of Resident 40's Order Summary Report, dated 5/14/2026, the Order Summary Report indicated an order to admit Resident 40 to HSP (Hospice 1) on routine level of care, ordered on 8/19/2025. During a review of Resident 40's Minimum Data Set (MDS - a resident assessment tool), dated 2/16/2026, the MDS indicated Resident 40's cognitive skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 40 required substantial/maximal assistance (helper does more than half the effort) with upper body dressing. The MDS indicated Resident 40 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower, lower body dressing, putting on/off footwear and personal hygiene. The MDS indicated Resident 40 was in hospice care while a resident of the facility. During a concurrent record review and interview on 5/15/2026 at 9:41 AM with Registered Nurse 1 (RN 1), Resident 40's medical records dated from 6/27/2025 to 5/15/2026 were reviewed. RN 1 stated all licensed nurses can initiate and revise care plans. RN 1 stated Resident 40 was discharged from Hospice 2 on 6/27/2025 and Resident 40 was admitted to HSP on 8/19/2025. RN 1 verified Resident 40's care plan focusing on hospice care due to medical condition and diagnosis of Afib, initiated on 3/13/2024 indicated Resident 40 was under the care of Hospice 2 and it did not indicate a discontinue date nor the date Resident 40 was discharged from Hospice 2. RN 1 stated the care plan was not updated to reflect that Resident 40 was under the hospice care of HSP since 8/19/2025. RN 1 stated she does not know the HSP's frequency of visit to Resident 40, which is usually indicated in the hospice care plan. RN 1 stated Resident 40's care plan regarding Hospice 2 was not and should have been completed and discontinued when Resident 40 was discharged to Hospice 2 on 6/27/2025. During a concurrent record review and interview on 5/15/2026 at 2:23 PM with Registered Nurse 2 (RN 2), Resident 40's medical records dated from 6/27/2025 to 5/15/2026 were reviewed. RN 2 verified Resident 40 still has an active care plan initiated on 3/13/2024 regarding Hospice 2 and it was not revised to reflect that Resident 40 was no longer under the care of Hospice 2 since 6/27/2025. RN 2 also stated Resident 40 is under the care of HSP 1 on 8/19/2025. RN 2 stated the care plan regarding Hospice 2 should have been resolved or completed on 6/27/2025. RN 2 emphasized, updating or revising care plans is important to ensure staff members caring for Resident 40 have the necessary knowledge to provide appropriate and resident centered care to the residents. RN 2 added according to Resident 40's order history, Resident 40 was discharged from Hospice 2 on 6/27/2025 and that the resident is not under hospice care until 8/18/2025. RN 2 stated Reisdent 40's care plan should have been removed, discontinued, completed or resolved for staff to know that Resident 40 is not on hospice care. During a record review of Facility's Policy and Procedure (P&P) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled Care Plan Comprehensive, dated 8/25/2021, the P&P indicated assessments of residents are ongoing and care plans are reviewed and revised as information about the resident and the resident's condition change.

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	055153	A. Building B. Wing	05/15/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide grooming services, in accordance with the care plan and facility policy, for one (1) of three sampled residents (Resident 83) when Resident 83 was observed to have long, jagged fingernails and with a yellowish to light brown substance observed on the resident's right palm, left wrist, and fingernails.This deficient practice had the potential for Resident 83 to have injuries and harbor infection.Findings: During a review of Resident 83's admission Record, the admission Record indicated the resident was initially admitted to the facility on (10/14/2025) with diagnoses of hemiplegia (a condition caused by brain damage or spinal cord injury that leads to paralysis [loss of motor function in one or more muscles] on one side of the body) and hemiparesis (weakness on one side of the body), muscle weakness and dementia (progressive brain disorder that slowly destroys memory and thinking skills). During a review of Resident 83's History and Physical Examination (H&P), dated 10/15/2025, the H&P indicated Resident 83 had poor vision. During a review of Resident 83 's Minimum Data Set (MDS-a resident assessment tool), dated 4/10/2026, the MDS indicated that the resident's cognitive skills (ability to think and understand) for daily decision making were moderately impaired. Resident 83 needed setup and clean-up assistance with personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, and washing/drying face and hands). During a review of Resident 83's Care Plan, initiated on 10/15/2025 and revised on 4/13/2026, the care plan indicated Resident 83 requires assistance with ADL care, including bathing, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting. The care plan intervention indicated Resident 83 requires setup assistance from one staff member for personal hygiene care. During a concurrent observation and interview on 5/12/2026 at 12:35 PM with Certified Nursing Assistant (CNA 2), Resident 83 was sitting in a wheelchair in the hallway with a dry whitish substance on the resident's left arm. CNA 2 stated Resident 83 had a cream to white colored puree food on the resident's left arm. During an observation on 5/13/2026 at 10:45 AM, Resident 83 was observed sitting in his wheelchair in the hallway. Resident 83 had a dry brownish to yellowish substance on the resident's right palm and left wrist. Resident 83's fingernails were long and jagged, with a yellowish to brownish-black substance under the resident's fingernails. During a concurrent observation and interview on 5/13/2026 at 10:49 AM with CNA 3, Resident 83 was sitting in a wheelchair in the hallway, and the resident had a dry brownish to yellowish substance on the resident's right palm and left wrist. CNA 3 stated that the brownish substance on the resident right palm left wrist and under his long-jagged nails is dry poop. During an interview on 5/14/2026 at 4:11 PM with the Infection Preventionist Nurse (IPN), the IPN stated, residents can put their dirty hands in their mouths and on their eyes, which can cause illness in both residents and staff. IPN stated this was an issue of infection control (a practice used to prevent the spread of germs and infections in healthcare settings, schools, and the community) and cross-contamination (unintentional transfer of harmful bacteria, viruses, or allergens from one surface, object, or food to another). During a concurrent interview and record review on 5/15/2026 at 10:08 AM with the Registered Nurse (RN 2), the facility's Policy and Procedures (P&P) titled Activities of Daily Living, Supporting, dated 3/2018, was reviewed. RN 2 stated, the P&P indicated residents will be provided with care, treatment, and services as appropriate to maintain or improve the resident's ability to carry out ADLs. The P&P also indicated, appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene, bathing, dressing, grooming, and oral care. RN 2 stated the P&P was not followed. RN 2 also stated Resident 83 should be clean at all times and properly groomed, especially since Resident 83 was blind and personal hygiene needs to be provided. During an interview on 5/15/2026 at 12:16PM with Resident 83, Resident 83 stated, he wants to be clean all the time and needs somebody to help him.

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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** Based on observation, interview, and record review, the facility failed to ensure the low air loss mattress (LALM, designed to distribute the resident's body weight over a broad surface area and help prevent skin breakdown) for one (1) of three (3) sampled residents (Resident 3) reviewed for pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) was at the correct settings in accordance with the facility's policy and procedure (P&P) and the resident's care plan (CP). Resident 3 weighed 152 pounds (lbs, unit of measurement for weight) but the LALM was set to 180 lbs. This deficient practice has placed Resident 3 at risk for deterioration of the resident's current pressure ulcer.Findings: During a review of Resident 3's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities) and unstageable (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) pressure ulcer of sacrum (lower end of the spinal area at the base of the spine). During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool) dated 4/20/2026, the MDS indicated Resident 1 was assessed to have severely impaired cognitive (ability to think and process information) ability. The MDS indicated Resident 3 was dependent (helper does all the effort) for oral hygiene, toileting hygiene, showering, upper/lower body dressing, putting on/taking off footwear, and rolling left and right. The MDS indicated Resident 3 was at risk of developing new pressure ulcers and has two (2) unstageable pressure ulcers. The MDS indicated Resident 3's pressure ulcer treatments included a pressure- reducing device for bed. During a review of Resident 3's Order Summary Report dated 4/17/2026, the order summary report indicated that Resident 3 may use a LALM for wound management. During an observation on 5/12/2026 at 9:27 AM, Resident 3's LALM was set to 180 lbs. During a concurrent observation and interview on 5/12/2026 at 9:31 AM with Licensed Vocational Nurse (LVN) 1, Resident 3's LALM was observed to be set at 180 lbs. LVN 1 stated that Resident 3's LALM was set at 180 lbs. During a concurrent interview and record review on 5/12/2026 at 9:35 AM with LVN 1, Resident 3's weight record dated 5/6/2026 and Resident 3's Medication Review Report (MRR) dated 4/30/2026 was reviewed. Resident 3's weight record indicated Resident 3 weighed 152 on 5/6/2026. Resident 3's MRR indicated Resident 3's LALM's setting were to be accurate based on manufacturer's guidelines. LVN 1 stated that Resident 3 weighs 152 lbs. so the LALM should be set at 150 to 160 lbs. LVN 1 stated the LALM has to be at the correct weight setting in order to properly prevent skin breakdown. LVN 1 stated the LALM will put too much pressure on a wound if it is set above the resident's weight and the resident's wound may get worse. During a concurrent interview and record review on 5/15/2026 at 10:42 AM with Registered Nurse Supervisor (RN) 1, the facility's LALM manufacture's guidelines manual (Brand 1 Manual) was reviewed. The Brand 1 Manual indicated:Brand 1 LALM is indicated for the prevention and treatment of any and all pressure ulcers when used in conjunction with a comprehensive pressure ulcer management program.Determine the patient's weight and set the control knob to that weight setting on the control unit.RN 1 stated the Brand 1 Manual indicated the LALM must be set according to the resident's weight. RN 1 stated the LALM is used to prevent pressure ulcers from getting worse and to prevent any new pressure ulcers. RN 1 stated if a LALM is set at a weight that is higher than the resident's weight, it applies more pressure on a wound and might cause the wound to get worse and might create new pressure ulcers. During a concurrent interview and record review on 5/15/2026 at 10:49 AM with RN 1, 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 this procedure is to provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment and promote healing of all wounds.2. The procedure is to develop comprehensive, interdisciplinary plan of care including prevention and wound treatments as indicated by determining the need for support surface (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for bed. RN 1 stated that the policy indicated pressure ulcers will be managed properly, and healing of pressure ulcers will be promoted. RN 1 stated that if a LALM is not set at the resident's weight, it will add more pressure to a resident's wound and not promote healing. During a concurrent interview and record review on 5/15/2026 at 11:12 AM with RN 1, Resident 3's Care Plan (CP) for LALM for wound management dated 4/30/2026 was reviewed. Resident 3's CP indicated in the interventions that Resident 3's LALM settings are to be monitored for accuracy based on manufacturer's guidelines every shift. RN 1 stated the CP is not followed if the weight settings are not set to the resident's weight on the LALM.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a safe environment by not properly disposing of a used insulin syringe (specialized, single-use medical device used to inject insulin directly into the fatty tissue just beneath the skin) when one used insulin syringe was observed protruding halfway out of one of four sharps container (a specialized, puncture-resistant, and leak-proof bin used to safely dispose of medical instruments that can cut or puncture the skin).This deficient practice resulted in accident hazard and exposed staff and residents to the risk of needleˆstick injuries and potential bloodborne pathogen transmission (infectious microorganisms present in human blood that can cause disease in humans). Findings: During a concurrent observation and interview on 5/13/2026 at 11:57 AM with the Licensed Vocational Nurse (LVN) 5 in the hallway, LVN 5 stated that the Station 1 medication cart had been observed with an insulin syringe not fully placed in the sharp container, with half of it poking out of the sharps' container. LVN 5 also stated that visitors, residents, and staff were passing in the hallway and can get the needle and use it for other purposes. During an interview on 5/15/2026 at 10:22 AM with the Registered Nurse (RN) 2, RN 2 stated the insulin syringe should have been disposed of properly to prevent accidents and ensure the safety of residents, staff, and visitors. RN also stated confused residents might pick up the syringe and play with it. During a concurrent interview and record review of the facility's Policy and Procedures (P&P) on 5/15/2026 at 10:25 AM with RN 2, the P&P titled Sharp Disposal, revised date 1/2012, was reviewed. RN 2 stated according to the P&P, it indicated the facility shall discard contaminated sharps into designated containers. The P&P also indicated that contaminated sharps must be discarded into containers that are closable, puncture-resistant, and leakproof on the sides and bottom. RN 2 also stated that the facility did not follow its P&P because the needle was not correctly disposed in the sharp's container.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary respiratory care services for one (1) of 1 sampled resident (Resident 6) reviewed for oxygen, by failing to ensure Resident 6 who was on oxygen therapy had her head of bed (HOB) elevated in accordance with the physician's order. This deficient practice had the potential to result in respiratory distress and had the potential to negatively impact Resident 6's health and well-being. Findings: During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included unspecified dementia (memory loss and impaired daily functioning), type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and personal history of pneumonia (history of lung infection). During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool), dated 4/1/2026, the MDS indicated Resident 6 was assessed having moderately impaired (decisions poor; cues/supervision required) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 6 was dependent (helper does all of the effort) with eating, toileting/personal hygiene, upper body dressing, rolling left and right, and sit to lying. The MDS also indicated Resident 6 was on oxygen therapy. During a review of Resident 6's Order Summary Report, dated 5/14/2026, the Order Summary Report indicated a physician order, with a start date of 10/1/2025, for oxygen at three (3) liters per minute (LPM) via nasal cannula (n/c- device used to deliver supplemental oxygen placed directly on a resident's nostrils) as needed for shortness of breath. The Order Summary Report also indicated an order, with a start date of 1/18/2026, to keep head of bed elevated to facilitate lung expansion every shift. During a review of Resident 6's Care Plan, dated 1/16/2026, the Care Plan indicated Resident 6 was on oxygen therapy as needed for history of pneumonia, history of acute and chronic respiratory failure with hypoxia (a condition where there is a dangerously low oxygen in the blood with normal or low carbon dioxide levels). The Care Plan interventions included to keep head of bed elevated to facilitate lung expansion every shift and to promote lung expansion and improve air exchange by positioning with proper body alignment (if tolerated) head of bed at 45 degrees. During an observation on 5/12/2026, at 1:24 PM, in Resident 6's room, Resident 6 was awake in bed, receiving 3 LPM of oxygen via nasal cannula. Resident 6's HOB was not elevated, and Resident 6 was flat on her back. During a concurrent observation and interview with Licensed Vocational Nurse 3 (LVN 3) on 5/13/2026, at 10:09 AM, in Resident 6's room, Resident 6 was observed sleeping in bed, receiving 3 LPM of oxygen via nasal cannula. Resident 6 was lying on her back with the HOB in flat position. LVN 3 stated Resident 6's HOB was flat and not elevated to 45 degrees. During a follow-up interview on 5/13/2026, at 12:15 PM with LVN 3, LVN 3 stated Resident 6 was on oxygen therapy and should have her HOB elevated at least 45 degrees to help expand her lungs and help her breath better. LVN 3 stated if Resident 6 does not get enough oxygen, Resident 6 can have trouble breathing and experience shortness of breath. LVN 3 stated it was the responsibility of all Licensed Nurses and Certified Nursing Assistants to ensure Resident 6's HOB was elevated while on oxygen therapy. During an interview on 5/13/2026, at 4:09 PM with the Director of Nursing (DON), the DON stated it was standard practice for facility staff to elevate the HOB to promote lung expansion while receiving oxygen. The DON stated Resident 6's care plan to elevate the HOB was not followed. The DON stated not elevating the HOB can result in Resident 6 not receiving enough oxygen which could lead to complication and hospitalization. During a review of the facility's Policy and Procedure (P&P), titled, Oxygen Administration, dated 1/31/2023, the P&P indicated that the facility will review the physician's orders of facility protocol for oxygen administration and review the resident's care plan to assess for any special needs of the resident.

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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** Based on interview, and record review, the facility failed to ensure one (1) of two (2) sampled residents (Resident 5) reviewed for dialysis (a lifesaving treatment for residents with a kidney failure), who was receiving hemodialysis (process of removing waste products and excess fluid from the body) treatment was provided dialysis care according to the resident's care plan by failing to ensure post dialysis weight was obtained on 4/23/2026. This deficient practice had the potential for complications such as blood pressure drop for unnoticed excessive fluid removed during dialysis and/or fluid overload (occurs when the body retains too much water) if fluid is not properly removed.Findings: During a review of Resident 5's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was re-admitted on [DATE], with diagnosis of end stage renal disease (ESRD, irreversible kidney failure), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and bradycardia (abnormally slow heart rate, typically defined as resting below 60 beats per minute). During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool), dated 3/24/2026, indicated Resident 5's cognitive (ability to think and reason) skills for daily decision making was modified independence (some difficult in new situations only). The MDS indicated Resident 5 required setup or clean up assistance (helper sets up or cleans up, resident completes activity) with eating. The MDS indicated Resident 5 required supervision (helper provides verbal cues) with oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 5 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. The MDS also indicated Resident 5 is on hemodialysis while a resident in the facility. During a review of Resident 5's Care Plan focused on the resident's renal function, risk for complications related to hemodialysis, and renal insufficiency, initiated on 12/22/2025, the Care Plan indicated staff intervention included were to request pre and post weights from dialysis center, send communication book to dialysis and review book upon return. During a review of Resident 5's Order Summary Report dated 5/15/2026, the Order Summary Report indicated hemodialysis, every Tuesday, Thursday, and Saturday, ordered on 1/20/2026. During a concurrent record review and interview on 5/15/2026 at 8:20 AM, with Registered Nurse 1 (RN 1), Resident 5's Hemodialysis Communication Record, dated 4/23/2026, was reviewed. RN 1 stated the Hemodialysis Communication Record dated 4/23/2026 did not reflect Resident 5's post dialysis weight. RN 1 stated the resident's weight should have been completed in the dialysis center. RN 1 added that the Hemodialysis Communication Record on 4/23/2026 was also missing the facility's licensed nurse's signature from the licensed nurse who received Resident 5 from dialysis center. RN 1 stated the licensed nurse who received Resident 5 from dialysis center on 4/23/2026 should have called the dialysis center on 4/23/2026 to request the post dialysis weight. RN 1 stated, it was important to properly assess the residents and complete the Hemodialysis Communication Record to ensure that residents will receive proper care. During a concurrent record review and interview on 5/15/2026 at 2:19 PM with Registered Nurse 2 (RN 2), Resident 5's Hemodialysis Communication Record, dated 4/23/2026, was reviewed. RN 2 stated the Hemodialysis Communication Record for Resident 5 should have been entirely completed by the charge nurse to include the resident's weight and licensed nurse's signature, upon the resident's return from dialysis on 4/23/2206 to know the status of the resident. RN 2 stated obtaining weight after dialysis was important to know how much fluid was removed during dialysis and to avoid complications such as hypotension if too much fluid was removed. During a review of facility's Policy and Procedure (P&P) titled, Dialysis Care, dated 8/25/2021, the P&P indicated the nursing staff, dialysis provider staff, and the attending physician will collaborate on a regular basis concerning the resident's care as follows:Nursing staff will communicate information in writing to the Dialysis staff.The Dialysis (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provider will communicate in writing to the Facility ay problems encountered whole the resident was at the dialysis provider and any ongoing monitoring required.Nursing Staff may use Hemodialysis Communication Record.

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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** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of one (1) of six (6) sampled residents (Resident 38) when Licensed Vocational Nurse 2 (LVN 2) failed to administer Resident 38's potassium tablet (medication to treat or prevent hypokalemia [low blood potassium levels]) with food or full glass of water on 5/14/2026 as indicated on the facility policy and physician's order. This deficient practice had the potential to result in damaging the esophagus (muscular tube that connects the throat to the stomach) and irritating the stomach lining which may cause nausea, cramps, vomiting, or diarrhea (condition of having loose, watery stool at least three or more times in a single day, or more frequently) to Resident 38.Findings: During a review of Resident 38's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE], with diagnosis of muscle weakness, heart failure (a condition where your heart muscle cannot pump enough blood and oxygen to meet the body's need) and acute kidney failure (a sudden and rapid decline in the kidneys' ability to filter waste). During a review of Resident 38's Minimum Data Set (MDS- a resident assessment tool), dated 5/5/2026, the MDS indicated Resident 50 had modified independence (some difficulty in new situations only) with cognitive (ability to think and reason) skills for daily decision making. The MDS indicated Resident 38 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating, and personal hygiene. The MDS indicated Resident 38 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene. The MDS indicated Resident 38 required substantial/maximal assistance (helper does more than half the effort) with upper body dressing. The MDS indicated Resident 38 was dependent on toileting hygiene, shower, lower body dressing, and putting on/taking off footwear. During a review of Resident 38's Order Summary Report, dated 5/13/2026, the Order Summary Report indicated a physician's order, dated 4/24/2026 for potassium oral tablet 10 milliequivalent (mEq, unit of measurement) by mouth, one time a day for supplement. It also indicated to administer with meals/food or full glass of water. During a medication administration observation in Resident 38's room on 5/14/2025 at 8:27 AM, LVN 2 administered Potassium 10 mEq oral tablet to Resident 38 without food or a full glass of water. During an interview on 5/14/2026 at 2:15 PM with LVN 2, LVN 2 stated that he did not administer Resident 38's potassium medication with food and he did not offer Resident 38 a full glass of water to drink with the potassium. LVN 2 stated it was important to administer medication as ordered to get the full benefit of the medication and to prevent stomach upset. During an interview on 5/15/2026 at 10:04 AM with Registered Nurse 1 (RN 1), RN 1 stated medications that were ordered to be given with food should be followed because these medications might cause stomach upset or medication might not be effective. RN 1 stated Resident 38's potassium medication order should have been given with breakfast meal at 8 AM. During a review of Facility's Policy and Procedure (P&P) titled, Administering Medications, revised on April 2019, the P&P indicated medications are administered in a safe and timely manner, and as prescribed. The P&P indicated medications are administered in accordance with prescribe orders, including any required time frame. The P&P also indicated, medication administration times are determined by resident need and benefit, not staff convenience.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an accurate and complete record for two (2) of 23 sampled residents (Residents 32 and 72) as indicated in the facility's policy and procedure when: Resident 32's memantine (Namenda, medication used to treat moderate to severe dementia [progressive state of decline in mental abilities] was incorrectly ordered for supplement instead of for dementia.Resident 72's 24-hour intake and output (I&O- the measurement of all fluids that enter and leave the body) was not tallied as ordered by the physician. This deficient practice had the potential to result in miscommunication, improper delivery of care, and inaccurate information of the care provided to Residents 32 and 72.Findings: 1. During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 32's diagnoses included dementia, depressive disorder (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities), and muscle weakness. During a review of Resident 32's Minimum Data Set (MDS, a resident assessment tool), dated 3/31/2026, the MDS indicated Resident 32 had moderately impaired (decisions poor, sues/supervision required) cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 32 was independent (Resident completes the activity by themselves with no assistance from a helper) with eating. The MDS indicated Resident 32 required setup or clean-up assistance (helper sets up or cleans up, resident completes activity) with oral and personal hygiene. The MDS indicated Resident 32 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene and upper body dressing. The MDS indicated Resident 32 required substantial/maximal assistance (helper does more than half the effort) with shower, lower body dressing and putting on/taking off footwear. The MDS also indicated Resident 32 has a diagnosis of dementia. During a review of Resident 32's Order Listing Report, dated 5/13/2026, timed 2:55 PM, the Order Listing Report indicated memantine hydrochloride extended release (ER) oral capsule 28 milligrams (mg, unit of measurement), give one (1) capsule by mouth one time a day for supplement, ordered on 5/6/2026. During a concurrent record review and interview on 5/13/2026 at 3 PM with Registered Nurse 2 (RN 2), Resident 32's Order Listing Report, dated 5/13/2026, was reviewed. RN 2 stated that Resident 32's current memantine order was not and should have been ordered for dementia. RN 2 stated Resident 32's memantine order for supplement was incorrect because memantine is a medication indicated for dementia. RN 2 stated that the licensed nurse who obtained the memantine hydrochloride ER order on 5/6/2026 documented supplement,' instead of dementia, which Resident 32's previous memantine order had been indicated for. RN 2 stated that this was a human error resulting in the incorrect documentation of the medication's indication. During a concurrent record review and interview on 5/14/2026 at 2:48 PM withident 32's Order Listing Report, dated 5/13/2026, was reviewed. RN 1 stated memantine is never a supplement. RN 1 stated the order was documented incorrectly when the licensed nurse obtained the order on 5/6/2026. RN 1 stated maintaining accurate medical records, including medication orders, is important to avoid confusion. RN 1 further stated that incorrect documentation can lead to wrong treatment, which might (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	05/15/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cause harm to any resident During a follow^up interview on 5/15/2026 at 2:16 PM with RN 2, RN 2 stated accurate documentation of orders is important for the licensed nurse to be aware of the purpose of the medication. RN 2 stated that inaccurate documentation might lead to confusion in the delivery of care. During a review of Facility's Policy and Procedure (P&P) titled, Physician Orders, dated 3/22/2022, the P&P indicated the medical records department will verify that physician orders are compete, accurate and clarified as necessary. 2. During a review of Resident 72's admission Record, the admission Record indicated Resident 72 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included acute kidney failure with tubular necrosis (renal failure- a kidney condition involving damage to the tubule cells of the kidneys which can lead to acute kidney failure), heart failure (when the heart muscle is weakened or stiff and cannot pump blood around the body as well as it should), and dependence on renal dialysis (HD-when a person relies on a medical machine or process to artificially clean their blood). During a review of Resident 72's MDS, dated [DATE], the MDS indicated Resident 72 was assessed having intact cognitive skills for daily decision making. The MDS indicated Resident 72 required setup or clean-up assistance with eating, oral hygiene, and personal hygiene. The MDS indicated Resident 72 was dependent (helper does all of the effort, resident does none of the effort) with toileting hygiene, shower/bathe self, lower body dressing, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. The MDS also indicated Resident 72 was on dialysis. During a review of Resident 72's Order Summary Report, dated 5/14/2026, the Order Summary Report indicated a physician order, with a start date of 4/13/2026 for: Fluid restriction: 1200 milliliters (ml- unit of measurement) per 24 hours Nursing: 600 ml (7AM to 3 PM =300 ml, 3 PM to 11 PM= 200 ml, 11PM to 7AM =100 ml) Dietary: 600 ml (breakfast= 360 ml, lunch= 120 ml, dinner 120 ml Every night shift monitoring I&O tally total intake and output for 24 hours During a review of Resident 72's Care Plan, dated, 1/19/2026, the Care Plan indicated Resident 72 exhibited or was at risk for fluid volume excess as evidenced by renal failure, end stage renal disease (ESRD- the final most severe stage of kidney failure where the kidney can no longer filter waste and excess fluid from the body) on HD. The Care Plan intervention indicated to monitor and tally total intake and output for 24 hours every night shift. During an interview on 5/15/2026, at 8:57 AM, with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated Resident 72 was on dialysis and was on fluid restriction. LVN 4 stated Resident 72's fluid intake was monitored every shift, and the night shift staff added the total fluid intake for the day and documented it in Resident 72's medical record. During a concurrent interview and record review on 5/15/2026, at 9:18 AM, with the Director of (continued on next page)

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	055153	A. Building B. Wing	05/15/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing (DON), Resident 72's Medication Administration Record (MAR), from 5/1/2026 to 5/31/2026 was reviewed. The DON stated the MAR indicated Resident 72's total fluid intake on 5/3/2026, 5/4/2026, 5/9/2026, and 5/10/2026 were zero (0). The DON stated Resident 72's total fluid intake for 24 hours was not tallied and documented correctly because Resident 72's total fluid intake on 5/3/2026 = 580 ml, 5/4/2026 = 380 ml, 5/9/2026 = 580 ml, and 5/10/2026 = 620 ml. The DON stated Resident 72's physician order to tally Resident 72's total fluid intake was not followed. The DON stated it was important to follow and implement Resident 72's fluid restriction order to know how much fluid Resident 72 had in a 24 hour period and to prevent complications such as fluid volume deficit (when the body loses too much water and electrolytes which could lead to organ failure) to fluid overload (too much fluid in the body which could lead to shortness of breath or heart failure) which could result in hospitalization. During a review of the facility's P&P, titled, Charting and Documentation, revised on 7/2017, the P&P indicated: Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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	055153	A. Building B. Wing	05/15/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that Resident 102's gastrostomy tube (G-tube a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration) tip was not placed inside Resident 102's bedside drawer wrapped in tissue paper. This deficient practice had the potential to result in contamination of Resident 102's G-tube and increase the risk for infection.Findings: During a review of Resident 102's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of gastrostomy (a surgical procedure for inserting a tube through the abdomen wall and into the stomach used for feeding or drainage), end stage renal disease (advanced stage kidney failure) and muscle weakness. During a review of Resident 102's History and Physical Examination (H&P), dated 5/13/2026, the H&P indicated that the resident does not have the capacity to make decisions. During a concurrent observation and interview on 5/12/2026 at 12:23 PM with the Licensed Vocational Nurse (LVN 5) in Room A, Resident 102's room, LVN 5 stated that Resident 102's G-tube tip was inside the bedside drawer and was wrapped with tissue paper. During a concurrent interview and record review on 5/13/2026 at 2:20 PM with the Director of Nursing (DON), Resident 102's Order Summary Report was reviewed. The DON stated that the order summary indicated an order dated 5/13/2026 for enteral feeding: Nephro 1.8 calories (high calorie nutrition formula) at 40 milliliters (mL - unit of fluid volume) via G-tube. During an interview on 5/13/2026 at 2:25 PM with the Director of Nursing (DON), the DON stated that as soon as the G-tube is disconnected from the resident, the tip must be recapped and stored properly for infection control (a practice used to prevent the spread of germs and infections in healthcare settings, schools, and the community). The DON stated that it was not specified in the facility's policy and procedure (P&P) for G-tubes, but it was the facility's practice to cap the G-tube tip for infection control. During an interview on 5/14/2026 at 3:59 PM with the Infection Prevention Nurse (IPN), the IPN stated that when the G-tube is not connected to the resident, it must be recapped. The IPN also stated that it should not be wrapped with tissue paper or placed inside the cabinet, as this can possibly cause sickness. During a record review of the G-Tube Protocol lesson plan dated 5/13/2016, the protocol indicated under general guidelines that when feeding equipment is not actively in use, it must be recapped and stored correctly. During a review of the facility's Policy and Procedure (P&P) titled Infection Prevention and Control Program, effective date 9/18/2024, the P&P indicated the infection prevention and control program was established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases (illnesses that can spread from one person, animal, or object to another through germs such as bacteria, viruses, fungi, or parasites) and infection.