STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055162	A. Building B. Wing	07/02/2026

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Monterey Park Conv Hosp	416 N Garfield Ave Monterey Park, CA 91754

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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 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. 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) when: The clear container of mashed potatoes was not closed properly.The food blender (Blender 1) pitcher had a lingering vegetable smell, and the top cover was peeling off and with food residue.The classic peanut butter jar had peanut butter smeared on the outside of the jar's red lid.The can opener had dry crusted food residue.A bag containing beef patties, cinnamon rolls, and chocolate chip cookies was torn, exposing its contents and the label on the bag was unreadable.The food grater had dry food residue.Blender 2 with a gray plastic insert paddle was chipped, calcified, and had dried food residue. 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 a concurrent observation and interview on 06/29/2026 at 7:37 AM in the kitchen with the Dietary [NAME] (DC1), a clear container of mashed potato was not closed sealed off. DC1 stated the clear container of mashed potatoes was not closed properly. During a concurrent observation and interview on 06/29/2026 at 7:38 AM in the kitchen with DC1, Blender 1 has lingering vegetable smell, and the top cover was peeling off and with food residue. DC1 stated Blender 1 pitcher smelled like vegetables from the pureed food. DC1 also stated they used Blender 1 for breakfast, lunch, and dinner. DC1 also stated the top cover of Blender 1 was peeling off and had dry food residue. During a concurrent observation and interview on 06/29/2026 at 7:39 AM in the kitchen with DC1, classic peanut butter jar had peanut butter smeared on the outside of the jar's red lid. DC1 stated the classic peanut butter jar had peanut butter smeared on the outside of the jar's red lid. During a concurrent observation and interview on 06/29/2026 at 7:40 AM in the kitchen with DC1 can opener had dry crusted food residue. DC1 confirmed the can opener had dry, crusted food residue. During a concurrent observation and interview on 06/29/2026 at 7:45 AM to 7:50 AM in the kitchen with DC1, plastic bag containing beef patties, a plastic bag containing cinnamon rolls and chocolate chip cookies in the freezer was torn, exposing the beef patties. DC1 stated the plastic bag containing beef patties, cinnamon rolls and chocolate chip cookies in the freezer were torn, exposing the food items. DC1 stated the label on the plastic bag containing 8 patties in the freezer was not readable whether it is the food item name or the use by date. During a concurrent observation and interview on 06/29/2026 at 8:00 AM in the kitchen with DC1, food grater had dry food residue. DC1 stated confirmed, the food grater inside the kitchen drawer had dry food residue on it. During a concurrent observation and interview on 06/29/2026 at 8:02 AM in the kitchen with DC1, Blender 2 with a gray plastic insert paddle was chipped, calcified, and had dried food residue. DC1 stated Blender 2 gray plastic paddle was chipped, calcified, and had dry food residue. During an interview on 07/01/2026 at 2:14 PM with the Dietary Aide (DA1), DA1 stated all food containers in the kitchen should be labeled and properly closed. DA1 also stated the blenders (Blenders 1 and 2) should not have any smell and should be in good condition, with no peeled off, chipped off part or calcification. DA 1 added the can (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	opener should not have any dry food residue, and food containers should be clean with no food residue to prevent food contamination, which can cause sickness such as diarrhea. During a concurrent interview and record review on 7/1/2026 at 2:41 PM with the Dietary Supervisor (DS), the facility's P&P titled Date Marking for Food Safety, revised on 12/19/2022, was reviewed. DS stated the P&P indicated that the food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. During a concurrent interview and record review on 07/01/2026 at 2:42 PM with the DS, the facility's P&P titled Food Safety and Food Storage, revised on 12/19/2022, was reviewed. DS stated the P&P indicated that food should be stored, prepared, distributed, and served in accordance with professional standards for food service safety. DS also stated the P&P indicated that labeling, dating, and monitoring refrigerated food, including but not limited to leftovers, must be done so it can be used by its use-by date or frozen/discarded, and that foods should be kept covered or in tightly sealed containers. DS stated the P&P indicated all equipment used in the handling of food must be cleaned and sanitized and handled in a manner to prevent contamination. DS further stated the P&P was not followed, and that the P&P was supposed to be followed to prevent food contamination that can possibly cause foodborne illness such as stomachache and diarrhea.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to observe infection control measures for two (2) of 2 sampled residents (Residents 9 and 13), reviewed for bowel and bladder, as indicated on the facility policy by failing to ensure:1. Certified Nursing Assistant 7 (CNA 7) performed hand hygiene (cleaning hands to prevent germs) after doffing (take off) gloves when providing incontinence (incontinent- a person is unable to voluntarily control their bladder or bowels) care for Resident 9 and before repositioning the resident and touching clean bed sheets.2. CNA 8 doff gloves and performed hand hygiene after providing incontinent care to Resident 13 and before repositioning Resident 13 and touching clean bed sheets.These failures had the potential to result in an increased risk for the spread of bacteria, viruses and pathogens (harmful microorganisms) to the residents, visitors and staff.Findings:1. During a review of Resident 9's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted to the facility on [DATE] with the diagnoses that included gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) status, gastro-esophageal reflux disease (a chronic digestive condition where stomach acid repeatedly flows back into the tube connecting your mouth and stomach [esophagus]), interstitial pulmonary disease (a large group of disorders that cause progressive inflammation and scarring of the tissue between the air sacs in the lungs) and dementia (a progressive state of decline in mental abilities). During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 3/30/26, the MDS indicated the resident is severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated, the resident is dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated the resident is always incontinent in both bladder and bowel. During a concurrent observation in Resident 9's room and interview on 7/1/2026 at 9:20 AM, CNA 7 was observed providing incontinent care for Resident 9. CNA 7 was observed cleaning feces off Resident 9 and then doff gloves while touching the outside of the dirty gloves. CNA 7 was then observed putting on a new set of gloves without performing hand hygiene. CNA 7 was later observed touching Resident 9's when repositioning the resident and then touching the clean bed sheets. CNA 7 stated she should have performed hand hygiene after doffing gloves and before putting on a new set of gloves. CNA 7 also stated it is for infection control. 2. During a review of Resident 13's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of benign prostatic hyperplasia (enlarged prostate) and encounter for palliative care (relieving physical pain, stress, and other symptoms to improve your overall quality of life). During a review of Resident 13's MDS, dated [DATE], the MDS indicated the resident is severely impaired in cognitive skills for daily decision making. The MDS also indicated the resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with eating, oral hygiene, upper body dressing and personal hygiene but is dependent with toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear. During a concurrent observation in Resident 13's room and interview on 7/1/2026 at 11 AM, CNA 8 was observed providing incontinent care for Resident 13. CNA 8 was observed using the same gloves after providing incontinent care for Resident 13 and touching the resident when repositioning and then touching the resident's bed sheets and side rails (safety/assist guards attached to beds). CNA 8 stated she should have changed her gloves and performed hand hygiene after incontinent care and before repositioning for infection control reasons. During an interview on 7/2/2026 at 3:12 PM, the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Infection Preventionist Nurse (IP) stated the CNA is supposed to perform hand hygiene after the removal of gloves and before putting on a new set of gloves because that is cross contamination and infection control. IP also stated after incontinence care, the CNA should change gloves and perform hand hygiene for infection control reasons. During an interview on 7/2/2026 at 3 PM, the Director of Nursing (DON) stated the CNAs should change glove and perform hand hygiene after providing incontinent care to a resident. The DON also stated it is to prevent the spread of infection. During a review of the facility's Policy and Procedure (P&P) titled Personal Protective Equipment, revised 12/19/2022, the P&P indicated perform hand hygiene before donning gloves and after removal. The P&P also indicated gloves are not a substitute for hand hygiene. During a review of the facility's P&P titled Hand Washing, revised 12/19/2022, the P&P indicated the staff must wash their hands before and after patient care as well as before application of gloves after removal of gloves.

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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 that the call light device (one of the major communication technologies that link nursing home staff to the needs of residents) was within reach (an arm's length) of one (1) of 1 sampled resident (Resident 78) reviewed for call devices under the environment care area . This failure had the potential to cause a delay in care for Resident 78 and prevent the resident from receiving the necessary care and services, which could lead to illness or serious injury.Findings: During a review of Resident 78 's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] 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), hemiparesis (weakness on one side of the body), contracture(permanent tightening or shortening of muscles, tendons, skin, or other tissues that causes joints to become stiff and restricts normal movement) of the left shoulder, 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 78 's Minimum Data Set (MDS-a resident assessment tool), dated 4/13/2026, the MDS indicated the resident had moderate cognition (ability to think, remember, and reason) with cognitive skills for daily decision making. Resident 78 needed partial moderate assistance (helper does less than half the effort) on eating, dependent (helper does all the effort) on personal hygiene (the ability to maintain personal hygiene), roll left and right (the ability to roll from lying on back to left side and right side and return to lying position). During a review of Resident 78's Care Plan, revised on 4/5/2025, the Care Plan indicated Resident 78 has an alteration in musculoskeletal status (current health, strength, and functional capability of the body's movement system, which includes muscles, bones, joints, ligaments, and tendons) related to left knee contractures, left shoulder internal rotator contracture, and degenerative changes of the thoracic spine (middle part of the backbone). The care plan indicated staff interventions were to anticipate and meet needs, ensure the call light is within reach, and respond promptly to all requests for assistance. During a concurrent observation and interview on 6/29/2026 at 10:03 AM with the Certified Nursing Assistant 4 (CNA4) in Resident 78's room, Resident 78's call light was coiled on the left side of the resident's bed rails (adjustable metal or rigid plastic bars attached to the sides of a medical or home-care bed) and hanging facing towards the floor. CNA 4 stated the call light was on the contracted side of Resident 78, and the resident is not able to reach the call light and use it to call for staff when assistance is needed. During an interview on 1/23/2026 at 5:07 PM with the Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 78's call light should be on the resident's right side, the dominant side of the resident (refer to the side of the body a person naturally uses more often and has better control, strength, or coordination with), where the resident can reach the call light so the resident can use it to call or to ask for help. LVN 1 also stated the call light is for the safety and needs of the residents and the resident might feel helpless if unable to access or use the call light. During a concurrent interview and record review on 7/1/2026 at 10:51 AM with the Registered Nurse 2 (RN 2), the facility's Policy and Procedures (P&P) titled, Call Lights: Accessibility and Timely Response, revised on 12/19/2026, was reviewed. RN 2 stated the policy indicated that the purpose of the policy is to ensure the facility is adequately equipped with call lights. RN 2 also stated, the P&P indicated staff are required to ensure the call light is within reach of the resident and secure as needed. RN 2 stated that the P&P was not followed and the call light should be within the resident's reach at all times for safety.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to inform the physician for one (1) of two (2) sampled residents (Resident 71) reviewed for behavior, when Resident 71 had a change of condition (COC - a sudden, clinically important deviation form a resident's baseline in physical, cognitive, behavioral, or functional domains) on 6/29/2026.This deficient practice had the potential to result in a delay in the necessary care and services for Resident 71.Findings:During a review of Resident 71's admission Record, the admission Record indicated the resident was admitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and depression (a serious mood disorder that causes persistent sadness, loss of interest in activities, and a lack of energy). During a review of Resident 71's Minimum Data Set (MDS - a resident assessment tool), dated 6/15/2026, the MDS indicated the resident is moderately impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with eating, oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene but is dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with shower/bathe self. The MDS indicated Resident 71 behavior status, care rejection or wandering is worse compared to prior assessment. During an observation on 6/29/2026 at 11:40AM, Surveyor 1 attempted to interview Resident 71. Resident 71 was observed pinching the surveyor on the surveyor's left arm. During a concurrent observation Resident 71's room and interview on 6/29/2026 at 11:47AM, Resident 71 was observed grabbing Activities Director's (AD) left arm. AD stated this is the first time Resident 71 has done this and it is a new behavior of the resident. During a concurrent observation in the facility's dining room and interview on 6/29/2026 at 12:15 PM, Speech Therapist (ST) was observed being pinched by Resident 71, while ST was feeding Resident 71. ST stated a Certified Nursing Assistant (CNA) was feeding Resident 71 initially, but CNA got scared when Resident 71 started grabbing/pinching the CNA, so ST took over to assist Resident 71 with feeding. During an interview on 7/1/2026 at 2 PM, Registered Nurse 2 (RN 2) stated Resident 71 behavior of pinching/grabbing behavior is a new behavior and considered a significant COC. RN 2 also stated the behavior requires a doctor to be notified but the doctor was not notified when it was noted on 6/29/2026. RN 2 further stated Resident 71 behavior can get worse and can affect other residents/staff who are around Resident 71if it was not addressed promptly. During an observation on 7/2/2026 at 1:30 PM, Resident 71 was observed lying in bed. Resident 71 was also observed attempting to grab/pinch the surveyor. During an interview on 7/2/2026 at 2:49 PM, the Director of Nursing (DON) stated Resident 71's pinching/grabbing behavior is a significant COC. The DON also stated a COC form should have been done as well as monitoring the resident's behavior and calling the physician of the new COC. The DON further stated staff need to inform the licensed nurse when there is a COC so the nurses can address it. During a review of the facility's Policy and Procedure (P&P) titled Notification of Changes, revised 12/19/2022, the P&P indicated to ensure the facility promptly consults the resident's physician and the resident representative when there is a change requiring notification. The P&P also indicated significant change in the resident's physical, mental, or psychological (anything relating to the human mind, mental processes, or behavior) condition such as deterioration in health, mental or psychosocial (the intersection between psychological processes [thoughts, emotions, behavior] and the social environment [relationships, cultural norms, community structures]) status.

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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 one (1) of five (5) sampled residents (Resident 12) reviewed for unnecessary medications (medication prescribed or consumed without a valid clinical indication for an excessive duration, at too high a dose, or when their potential risks outweigh the benefits) had a specific indication for the use of Buspirone (a medication used to treat anxiety disorder [a group of mental health conditions characterized by persistent, excessive, and uncontrollable fear, worry, or dread that interferes with daily life]), in accordance with the facility's Policy and Procedure (P&P) titled, Use of Psychotropic Medications (drugs that affect a person's mind, emotions, or behavior).This deficient practice had the potential to increase Resident 12's risk to experience adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to psychotropic medication (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior), possibly leading to impairment or decline in the resident's mental, functional, or psychosocial (the dynamic intersection between psychological processes [internal thoughts, emotions, and behaviors] and the social environment [relationships, cultural norms, and community structures]) status. Findings:During a review of Resident 12's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with the following but not limited to diagnoses of anxiety and depression (a common and serious mood disorder that causes persistent feelings of sadness, hopelessness, and a loss of interest in activities). During a review of Resident 12's Physician Orders, dated 6/2/2026, the Physician Order indicated Buspirone Hydrochloride (HCL) Oral Tablet 15 milligrams (mg - unit of measure) to give 1 tablet by mouth two times a day for anxiety as manifested by restlessness/inability to relax. The order did not indicate specific behavior of the resident's restlessness/ inability to relax. During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool), dated 6/5/2026, the MDS indicated the resident is moderately impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs and provides more than half the effort) with eating, oral hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated, the residents have anxiety and depression. During an interview on 7/2/2026 at 8:31 AM, Registered Nurse 2 (RN 2) stated Resident 12 restlessness would be pacing and asking about appointments. During an interview on 7/2/2026 at 8:46 AM, RN 1 stated Resident 12 restlessness is complaining of pain and inability to sleep. During an interview on 7/2/2026 at 8:51 AM, Licensed Vocational Nurse 1 (LVN 1) stated Resident 12's restlessness would be walking around and asking for pain medication. During an interview on 7/2/2026 at 8:56 AM, Certified Nursing Assistant 2 (CNA 2) stated she does not know Resident 12's signs and symptoms of restlessness. During an interview on 7/2/2026 at 9:48 AM, RN 2 stated on 6/30/2026 Resident 12's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) should have reflected Resident 12's anxiety level but it does not. During an interview on 7/2/2026 at 9:50 AM, Resident 12's Responsible Party 1 (RP 1) stated Resident 12's sign of restlessness is isolating himself. RP also stated, on 6/30/2026, Resident 12 kept texting RP and stating he (Resident 12) was having an anxiety. RP further stated Resident 12 was texting her from 10:30 AM until 7 PM on 6/30/2026. During a concurrent interview on 7/2/2026 at 10:17AM with the Director of Nursing (DON) Resident 12's MAR, dated 6/2026, was reviewed. The Director of Nursing (DON) stated Resident 12's MAR is not accurate because everyone has a different aspect or behavior of what restlessness is. The DON also stated the staff do not have the same idea of what Resident 12's specific behavior or signs and symptoms of (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restlessness are. The DON further stated Resident 12 should have the correct manifestation of resident's anxiety, and it should have been reflected in the physician's order and the resident's MAR. In addition, the DON stated the indications for Buspirone need to be more specific such as indicated for anxiety as manifested by resident whether it is isolating himself or pacing so the staff can be consistent on how to monitor the resident properly. During a review of the facility's Policy and Procedure (P&P) titled, Use of Psychotropic Medication(s), revised 3/17/2025, the P&P indicated psychotropic medications are to be used only when a practitioner determines that the medication is appropriate to treat the resident's specific, diagnosed, and documented condition. The P&P also indicated adequate indications for use refers to the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop an individualized resident-centered care plan (a care plan that prioritizes the unique health needs and desired outcomes of the resident) with measurable objectives, timeframe, and interventions to meet the resident's impaired hearing needs for one (1) of 1 sampled residents (Resident 33) reviewed for hearing/vision. This deficient practice has the potential to delay in the necessary care and services for Resident 33's impaired hearing which can result in ineffective communication.Findings:During a review of Resident 33's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with the following but not limited to diagnoses of dementia (a progressive state of decline in mental abilities), muscle weakness and abnormality in gait and mobility. During a review of Resident 33's History and Physical (H&P), dated 5/9/2026, the H&P indicated the resident has a history of hard of hearing. During a review of Resident 33's Minimum Data Set (MDS - a resident assessment tool), dated 6/5/2026, the MDS indicated the resident is moderately impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides less than half the effort) with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing and putting on/taking off footwear but required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with eating. The MDS indicated the residents have minimal difficulty in hearing. During a concurrent observation in the resident's room and interview on 6/29/2026 at 9:07 AM, Resident 33 was observed lying in bed. Resident 33 stated he cannot hear the surveyor during a normal conversation. Resident 33 also stated he is hard of hearing and he refuses to use his hearing aid. During an interview on 6/30/2026 at 2:55 PM, Social Service Director (SSD) stated Resident 33 does have difficulty hearing and the resident refuses to use his hearing aid. SSD also stated there is no care plan initiated for Resident 33's impaired hearing. During an interview on 7/1/2026 at 12:46 PM, Resident 33's care plans, dated 5/12/2026 to 6/30/2026, were reviewed. Registered Nurse 2 (RN 2) stated there is no care plan for Resident 33's impaired hearing and there should be one. RN 2 stated Resident 33 needs a care plan to address the resident's impaired hearing and refusal to use the resident's hearing aid, so the resident is able to communicate effectively during care. During an interview on 7/2/2026 at 2:54 PM, the Director of Nursing (DON) stated a resident with impaired hearing would need to be care planned according to the facility's policy. The DON also stated if hearing impairment was triggered in the MDS, then it would need to be care planned. The DON further stated it is important to have a care plan for the resident's hearing impairment including resident's refusal to use the resident's hearing aid so the staff can communicate with the resident effectively. During a review of the facility's Policy and Procedure (P&P) titled Hearing and Vision Services, revised 12/19/2022, the P&P indicated the facility will utilize the comprehensive assessment process for identifying and assessing a resident's hearing ability in order to provide person-centered care which includes care plan development and implementation. During a review of the facility's P&P titled Comprehensive Care, revised 12/19/2022, the P&P indicated to develop and implement a comprehensive person-centered care plan for each resident. The P&P indicated the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial (the intersection between psychological processes [thoughts, emotions, behavior] and the social environment [relationships, cultural norms, community structures]) well-being.

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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 interview and record review, the facility failed to revise the care plan for risk for fall for (one) 1 of two (2) sampled residents (Resident 41) reviewed for falls after the resident had an actual fall on 6/7/2026. This deficient practice has the potential for Resident 41 to have further falls, which could result in harm and/ or death.Findings:During a review of Resident 41's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with the following but not limited to diagnoses of repeated falls, dementia (a progressive state of decline in mental abilities), muscle weakness and difficulty in walking. During a review of Resident 41's Care Plan with focus Risk for falls, date initiated 3/12/2025 and revised 2/24/2026, the care plan did not indicate it was revised after the fall on 6/7/2026. The care plan did not indicate interventions such as frequent visual check were added after 6/8/2026. During a review of Resident 41's Minimum Data Set (MDS - a resident assessment tool), dated 5/13/2026, the MDS indicated the resident is severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts, holds, or supports trunk or limbs and provides more than half the effort) with oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/ taking off footwear and personal hygiene but is dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with shower/bathe self. During a review of Resident 41's Change in Condition (COC - an alteration in an individual's physical, mental, or functional baseline) Evaluation, dated 6/7/2026, the COC indicated Resident 41 had a fall and was crying intermittently. During a review of Resident 41's Progress Notes, dated 6/7/2026 at 6:20AM, the Progress Notes indicated Resident 41 was on the floor and was witnessed by Certified Nursing Assistant (CNA) at 6:10 AM. During a review of Resident 41's Interdisciplinary Team (IDT; a group of healthcare professionals from complementary fields who work in tandem to treat a resident) fall incident care conference, dated 6/8/2026 at 9:33 AM, the IDT care conference indicated Resident 41 had a fall in the resident's room where the resident slide off her bed due to poor safety awareness. The IDT care conference also indicated that the resident is confused and recommend the following but not limited to frequent visual checks, and assist the resident in maintaining her position in bed. During an interview on 7/2/2026 at 8:23 AM, Resident 41's Care Plans, dated 6/7/2026 to 6/19/2026, were reviewed. RN 2 stated whenever there is a COC such as the fall on 6/7/2026, the risk for fall care plan should be revised. RN 2 also stated there is no care plan created nor revised for the resident's fall on 6/7/2026. RN 2 further stated it is important to revise the care plan because of the need to implement new interventions to help prevent further falls for the resident. During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Care Plans, revised 12/19/2022, the P&P indicated all care assessment areas triggered by the MDS will be considered in developing the plan of care and other factors identified by the IDT team, will also be addressed in the plan of care. During a review of the facility's P&P titled, Fall Prevention Program, revised 4/20/2026, the P&P indicated each resident risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care:a. Interventions will be monitored for effectiveness b. The plan of care will be revised as needed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide assistance with toileting and perineal care (gentle cleaning of the genitals which involves washing, rinsing, and drying the perineum to maintain hygiene, prevent infection, and protect skin integrity) for one (1) of two (2) sampled residents (Resident 1) reviewed for Activities of Daily Living (ADL - activities such as bathing, dressing and toileting a person performs daily) in accordance with the facility's policy. This deficient practice had the potential to result in skin breakdown, incontinence-associated dermatitis (IAD, skin irritation and damage caused by long-term contact with urine or stool, which makes the skin red, sore, and weakened, and can lead to infection), urinary tract infection, and affect resident's self-esteem.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of generalized muscle weakness and other signs and symptoms involving the musculoskeletal system (the combined network of bones, muscles, and joints that gives the body its shape and allows it to stand, walk, and perform daily physical tasks). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 3/28/2026, the MDS indicated Resident 1 had a moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 1 was dependent (helper does all the effort) with toileting hygiene, shower, lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with oral hygiene, and upper body dressing and required partial/moderate assistance (helper does less than half the effort) with eating and personal hygiene. During a review of Resident 1's Care Plan revised on 3/28/26, the Care Plan indicated Resident 1 has Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily) self-care deficit and a proposed plan requiring the resident 1 staff extensive assistance with personal hygiene. During a concurrent observation and interview on 6/29/2026 at 8:59 AM, Resident 1 was observed lying in bed and stated that one of the Certified Nursing Assistants (CNAs) (resident did not know the staff member's name) told her on Thursday night (6/25/2026) not to use the call light and to just pee on her diaper because she has a lot of things to do when Resident 1 attempted to call for assistance to use the restroom. Resident 1 also stated that the same CNA did not clean on the night of 6/29/2026 or the morning of 6/30/2026 before placing a new diaper on her. During an interview on 6/29/2026 at 9 AM, Resident 1's roommate (Resident 48) stated she heard her roommate (Resident 1) on Thursday night close to 12 midnight (MN) pressing the call light multiple times. Resident 48 also stated the CNA told Resident 1 not to use and turn on the call light because she has other things to do and for Resident 1 to wait. Resident 48 stated when the CNA finally removed Resident 1's wet diaper, Resident 1 asked the CNA if she was going to wipe her, but the CNA said no because she was too busy. Resident 48 also stated that close to 10 minutes before 7 AM the next morning, which is Friday 6/30/2026 Resident 1's diaper was changed by the same CNA and Resident 1 asked the CNA again if she was going to clean her, but she did not. During an interview on 7/1/2026 at 9:31 AM, CNA 5 stated Resident 1 required assistance to go to the restroom. CNA 5 also stated the CNA staff should assist residents to go to the restroom to ensure residents do not have an accident themselves and to keep them comfortable. CNA 5 also stated Resident 1's wet diaper should have been changed and cleaned to remove the traces of urine from the resident before putting a clean diaper to prevent the resident from developing rashes and skin breakdown. During an interview on 7/1/2026 at 9:45 AM, the Director of Nursing (DON) stated CNA staff should assist the residents to ensure the residents' needs are met. The DON also stated the CNA staff should have offered to bring Resident 1 to the restroom and not tell the resident to urinate on her diaper to maintain the resident's dignity. The DON further stated Resident 1 had the right to be treated with dignity and respect. During an interview on 7/2/2026 at 10:44 AM, Licensed (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Vocational Nurse 2 (LVN 2) stated Resident 1 required assistance to use the restroom and the CNA staff should have assisted the resident to use the restroom to prevent the resident from wetting herself in her diaper. LVN 2 also stated Resident 1 had the right to be treated with respect and should not have been told by the CNA to urinate on her diaper because the CNA was busy. During a review of the facility's P&P titled, Activities of Daily Living (ADL), revised 12/19/2022, the P&P indicated that the facility's care and services on activities of daily living included toileting. The P&P also indicated a resident who is unable to carry out ADL will receive the necessary services to maintain good personal hygiene. During a review of the facility's P&P titled, Promoting/Maintaining Resident Dignity, revised 12/19/2022, the P&P indicated that it is the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the facility was free from accident hazards when the facility failed to ensure:1. Proper disposal of a used vacutainer needle (a specialized, double-ended medical needle used for multi-sample blood collection) when the vacutainer was observed not fully placed into the sharp's container.This deficient practice had the potential to result in accidental needlestick injuries (accidental skin punctures caused by used needles or sharp medical instruments) and possible exposure to bloodborne pathogens (infectious microorganisms present in human blood that can cause disease in humans).2. The wheelchair of one (1) of five (5) sampled residents (Residents 85) reviewed for accidents was locked while the resident was left seated in it and left unattended in the hallway.This deficient practice placed Resident 85 at risk of injury and serious harm. Findings: 1. During a concurrent observation and interview on 6/29/2026 at 9:45 AM with the Licensed Vocational Nurse 1 (LVN 1) in the hallway, LVN 1 stated that a vacutainer was not fully inserted into the sharps container attached to the Medication Cart (Medication Cart A, a mobile storage unit used in hospitals, nursing homes, and clinics to securely organize, store, and transport medications and supplies) located in the hallway in front of Room A. LVN 1 stated that the clear tubing contained blood residue. LVN 1 also stated that staff, residents, and visitors were passing through the hallway. During an interview on 7/2/2026 at 8:13 AM with LVN 1, LVN 1 stated that the vacutainer should have been disposed of properly to prevent accidents and ensure the safety of residents, staff, and visitors. During a concurrent interview and record review of the facility's Policy and Procedures (P&P) on 7/2/2026 at 2:51 PM with Registered Nurse (RN1), the P&P titled Bloodborne Pathogens/Contaminated Sharps Occupational Exposure, revised on 12/19/2022, was reviewed. RN 1 stated that the P&P indicated it is the policy of this facility to outline procedures in the event of occupational exposure to body fluids or contaminated sharps, in accordance with federal, state, and local guidelines as well as the facility's exposure control plan. The P&P also indicated that universal precautions will be observed to prevent contact with blood or other potentially infectious materials. During a concurrent interview and record review of the facility's P&P on 7/2/2026 at 2:55 PM with RN1, the P&P titled, Standard Precautions Infection Control, revised on 12/19/2022, was reviewed. RN1 stated that the P&P indicated for injection and medication safety, licensed staff who administer injection medications must do so in a safe manner to prevent sharps injuries and contamination of medications and injection equipment. Recommended practices include proper disposal of injection equipment in a sharp container. RN1 stated that the vacutainer should have been fully inserted into the sharp container for the safety of the residents, to prevent needlestick injuries that can possibly cause illness. 2. During a review of Resident 85's admission Record, the admission Record indicated Resident 85 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included history of falling, Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 85's Fall Risk Assessment (a nursing tool that uses a scoring system to evaluate resident's risk of fall), dated 2/1/2025, the Fall Risk Assessment indicated Resident 85's was at risk for fall due to intermittent confusion and use of assistive device such as wheelchair. During a review of Resident 85's Minimum Data Set (MDS- a resident assessment tool), dated 5/4/2026, the MDS indicated Resident 85 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 85 normally used wheelchair in the last seven (7) days and was dependent (helper does all the effort) with shower and putting/taking off footwear. The MDS further indicated Resident 85 required substantial/maximal assistance (helper does more than half the effort) with oral, toileting and personal hygiene and lower body dressing and required partial/moderate assistance (helper does less than half the effort) with upper body dressing and required supervision (helper provides cues) with eating. During an observation on 6/29/2026 at 8:04 AM, Resident 85 was observed sitting on the wheelchair, unattended in the hallway. Resident 85's wheelchair was observed unlocked. During an interview on 7/1/2026 at 12:32 PM, Licensed Vocational Nurse 2 (LVN 2) stated Resident 85's wheelchair brakes should be locked on both sides as safety precautions to prevent fall and injury to the resident. LVN 2 also stated Resident 85 was at risk for fall. During an interview on 7/1/2026 at 12:40 PM, the Director of Nursing (DON) stated Resident 85's wheelchair brakes should be on locked position to keep the wheelchair steady and not roll in case Resident 85 stands up, preventing a fall incident. During a review of the facility's P&P titled, Accidents and Supervision, revised 12/19/2022, the P&P indicated the resident environment will remain as free of accident hazards as is possible which included implementing interventions to reduce hazards and risks.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (1) of 1 sampled Resident (Resident 9) reviewed for tube feeding (medical device used to provide liquid nourishment, fluids, and medications by bypassing oral intake) received appropriate gastrostomy tube (GT, tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) care by failing to confirm GT placement when Licensed Vocational Nurse 5 (LVN 5) did not check the resident's gastric residual volume (GRV, the amount of fluid that remains in the stomach and can be withdrawn through a feeding tube before giving additional feedings or medications. It helps determine how well the stomach is emptying and whether the resident is tolerating tube feedings) prior to medication administration on 7/1/2026. This deficient practice placed Resident 9 at risk of aspiration (feeding could enter the windpipe and lungs) that could lead to lung problems such as pneumonia (an infection/inflammation of the lungs).Findings: During a review of Resident 9's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted to the facility on [DATE] with the following but not limited to diagnoses of gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) status, gastro-esophageal reflux disease (a chronic digestive condition where stomach acid repeatedly flows back into the tube connecting your mouth and stomach [esophagus]), interstitial pulmonary disease (a large group of disorders that cause progressive inflammation and scarring of the tissue between the air sacs in the lungs) and dementia (a progressive state of decline in mental abilities).During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 3/30/26, the MDS indicated the resident was severely impaired with cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 9 was dependent (helper does all of the effort. Residents do none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 9 has a feeding tube and was receiving a therapeutic diet (a personalized meal plan prescribed by a healthcare provider or dietitian to treat a specific medical condition). During a review of Resident 9's Physician Orders, dated 2/21/2026, the Physician Orders indicated enteral feeding (a medical method used to deliver liquid nutrition directly into the stomach) for every shift continuously: Jevity (liquid, fiber-fortified nutritional formula, designed for oral or tube feeding when a person cannot meet their nutritional needs via regular food) 1.2 at 40 milliliters (ml - unit of measure)/hour for 20 hours via GT to provide 800 ml/960 kilocalorie (Kcal - the amount of energy food provides to your body)/24 hours. Start between 11 AM to 12PM and continue until total volume is infused. During a concurrent observation and interview of a medication administration on 7/1/2026 at 9:51AM, LVN 5 was observed preparing and administering medications to Resident 9. LVN 5 did not confirm Resident 9's GT placement prior to medication administration. LVN 5 stated she did not but should have confirmed Resident 9's GT placement by checking residuals prior to administering resident's medications. LVN 5 stated this was important to prevent aspiration. During an interview on 7/1/2026 at 1:14PM, the facility's Policy and Procedure (P&P) titled Medication Administration via Enteral Tube, revised 12/19/2022, was reviewed. Registered Nurse 2 (RN 2) stated prior to medication administration GT placement and residuals should be checked. RN 2 also stated GRV should be checked to prevent aspiration. RN 2 stated checking GRV prior to medication administration was not but should be in the policy.During an interview on 7/2/2026 at 1:02PM, the facility's Policy and Procedure (P&P) titled, Medication Administration via Enteral Tube, revised 12/19/2022, was reviewed. The P&P indicated that it is the facility's policy to ensure safe (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and effective administration of medications via enteral feeding tubes by utilizing best practice guidelines. It also indicated to verify tube placement prior to administering any fluids or medications. The Director of Nursing (DON) stated checking GT residuals prior to medication administration is not but should be in the policy. The DON also stated it is important to check GT residuals to prevent aspiration and ensure the residents are tolerating their medications and tube feedings.

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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 ensure oxygen was administered for one (1) of 1 sampled resident (Resident 44) reviewed for respiratory care in accordance with the physician's order and facility policy. This deficient practice placed Resident 44 at risk for hypoxia (a condition that occurs when the lungs cannot get enough oxygen to the blood) causing serious harm. Findings: During a review of Resident 44's admission Record, the admission Record indicated Resident 44 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure (a sudden, life threatening emergency where the lungs cannot get enough oxygen into the blood, or they cannot remove enough carbon dioxide from the body) with hypoxia and encephalopathy (a brain disease, disorder, or damage that affects brain function). During a review of Resident 44's Minimum Data Set (MDS- a resident assessment tool), dated 5/28/2026, the MDS indicated Resident 44 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 44 was on oxygen therapy while in the facility. The MDS further stated Resident 44 was dependent (helper does all the effort) with eating, oral, toileting and personal hygiene, shower, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 44's Physicians Order, dated 6/4/2026 at 5:05 PM, the Physicians Order indicated oxygen via nasal cannula (NC, a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) at two (2) to five (5) liters per minute (LPM - unit of flow rate) to maintain oxygen saturation (the amount of oxygen circulating in the blood) greater or equal to 95 percent (%) every shift. During a review of Resident 44's Care Plan. revised on 6/4/2026, the Care Plan indicated the resident was on oxygen therapy related to acute respiratory failure with hypoxia and interventions included humidified (moistened) oxygen via NC at 2 to 5 LPM to maintain oxygen saturation greater or equal to 95 % every shift. During a concurrent observation in Resident 44's room with Registered Nurse 3 (RN 3) on 6/29/2026 at 10:33 AM, Resident 44 was lying in bed with the NC on the left side of the resident's face while the oxygen concentrator (a medical device that gives extra oxygen by taking and filtering air from the surroundings) was set at 2.5 LPM. During an interview on 7/1/2026 at 11:19 AM, RN 3 stated Resident 44's oxygen NC should be placed correctly in the resident's nose for the resident to receive oxygen to prevent oxygen desaturation (blood oxygen level had dropped below normal). During an interview on 7/1/2026 at 11:26 AM, the Director of Nursing (DON) stated Resident 44's oxygen NC should always be in the resident's nose to help maintain the resident's oxygen saturation at 95 % and above to prevent respiratory distress (trouble breathing). During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised 5/20/2024, the P&P indicated oxygen is administered to residents who need it, consistent with professional standards of practice and comprehensive person-centered care plans. The P&P also indicated oxygen is administered under orders of the physician.

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	055162	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monterey Park Conv Hosp	416 N Garfield Ave Monterey Park, CA 91754

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 clinical record in accordance with the facility's policy by failing to accurately document the meal percentage on 6/29/2026 for one (1) of two (2) sampled residents (Resident 41).This deficient practice had the potential to affect Resident 41's nutritional assessment, care planning, monitoring of intake trends, and timely identification of nutritional risks or decline. Findings: During a review of Resident 41's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with the following but not limited to diagnoses of repeated falls, dementia (a progressive state of decline in mental abilities), muscle weakness and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 41's Minimum Data Set (MDS - a resident assessment tool), dated 5/13/2026, the MDS indicated the resident was severely impaired with cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 41 required substantial/maximal assistance (helper does more than half the effort. Helper lifts, holds, or supports trunk or limbs and provides more than half the effort) with oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/ taking off footwear and personal hygiene. Resident 41 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with shower/bathe self. The MDS indicated Resident 41 was on a mechanically altered (food that has been changed in texture) and therapeutic diet (specialized diet prescribed for a medical condition). During an observation on 6/29/2026 at 12:49PM, Resident 41 was observed eating three (3) bites of food (Chicken, Vegetables and Bread) with 90% of food still left on the plate. The Speech Therapist (ST, trained professional who helps people improve their speech, language, voice, cognition, and swallowing abilities), who was assisting another resident on the same dining table as Resident 41, stated Resident 41 took a couple bites of food and consumed 10% of her meal. During a review of Resident 41's meal percentage, dated 6/29/2026 at 1:01PM, the meal percentage indicated the resident ate 51 to 75% of her meal. During a concurrent review and interview on 7/1/2026 at 1:10 PM, Resident 41's meal percentage, dated 6/29/2026 at 1:01PM, was reviewed. Certified Nursing Assistant 6 (CNA 6) stated she did not see how much Resident 41 ate for lunch on 6/29/2026. CNA 6 also stated Resident 41 usually eats 50 to 60% of her meals, so CNA 6 documented that Resident 41 ate 51 to 71% of her meal. CNA 6 further stated she did not but should have checked how much Resident 41 ate on 6/29/2026 for lunch prior to documenting the resident's meal intake in the medical records. During an interview on 7/1/2026 at 1:10PM, Registered Nurse 2 (RN 2) stated it is important to document Resident 41's meal percentage correctly because if there are any changes in Resident 41's eating habits, the facility can address it. During an interview on 7/2/2026 at 2:50PM, the Director of Nursing (DON) stated CNA should not have documented 51 to 75% if the CNA did not see how much Resident 41 ate. The DON also stated documentation should be accurate. During a review of the facility's Policy and Procedure (P&P) titled, Documentation in Medical Record, revised 12/19/2022, the P&P indicated false information shall not be documented. The P&P also indicated documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monterey Park Conv Hosp	416 N Garfield Ave Monterey Park, CA 91754

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain essential laundry equipment in safe operating condition by failing to remove the lint as scheduled from the lint trap of one of two (2) dryers in accordance with Policy and Procedure (P&P) This deficient practice resulted in lint buildup within the dryer, creating a fire hazard that placed residents and staff at risk of harm.Findings:During a laundry tour on 7/1/2026 at 2:48 PM, one of the two dryers (Dryer 2) was operating without any items in it. Laundry Aid 1 (LA 1) opened the lint door located underneath the dryer and observed lint build up on the lint trap. During an interview on 7/2/2026 at 9:51 AM, the Maintenance Service Supervisor (MSS) stated the dryer lint trap should be cleaned by every 2 hours as scheduled for fire safety and prevention. During an interview on 7/2/2026 at 12:30PM, LA 2 stated she forgot to clean the lint trap of Dryer 2 on 7/1/2026 at 2 PM. LA 2 also stated the dryer should be regularly cleaned and be free from lint build up to prevent fire. During a review of the facility's P&P titled, Laundry, revised 12/19/2022, the P&P indicated laundry equipment will be used and maintained according to manufacturer's instructions. During a review of the facility's P&P titled, Preventative maintenance program, revised 12/19/2022, the P&P indicated the maintenance director is responsible for developing and maintaining a schedule of maintenance services that the buildings, grounds, and equipment are maintained in a safe and operable manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to maintain safe, clean, comfortable, sanitary and home-like environment for one (1) of two (2) sampled residents (Resident 17) reviewed for environment by failing to ensure Resident 17's gastrostomy tube (G-tube pump, an electronic, battery-powered medical device that delivers liquid nutrition, fluids, or medication at a controlled rate directly into a person's stomach through a surgically placed abdominal tube) was free of dried milk residue and the flooring in Resident 17's room was free of dry milk residue. These deficient practices created an unsafe and unsanitary environment for Resident 17 and had the potential to result in accidents and risk of contamination and infection. Findings: During a review of Resident 17's admission Record, the admission Record indicated the resident was initially admitted), and facility on 8/8/2025 with diagnoses of Parkinson's disease (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), and lack of coordination. During a review of Resident 17's Minimum Data Set (MDS-a resident assessment tool), dated 4/9/2026, the MDS indicated the resident had moderately impaired cognitive (ability to think, remember, and reason) skills for daily decision-making. Resident 17 needed partial to moderate assistance (helper does less than half the effort) with personal hygiene (the ability to maintain personal hygiene) and sit-to-stand (the ability to come to a standing position from sitting in a chair). During an observation in Resident 17's room on 6/29/2026 at 9:27 AM, Resident 17 was sleeping in bed comfortably. The resident was connected to G tube pump which was noted to be turned off. Resident 17's G-tube pump was observed with visible dried milk drippings. Resident 17's room flooring was also observed with visible dried milk drippings. During a concurrent observation and interview on 6/30/2026 at 7:31 AM with Certified Nursing Assistant 1 (CNA1) in Resident 17's room, CNA1 stated that Resident 17's G-tube pump was dirty, with visible dry milk on it. CNA1 also stated there was dried milk on the floor. During an interview on 7/2/2026 at 8:25 AM with the Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated that the G-tube pump and the floor were supposed to always be clean. LVN 1 stated food or milk drippings should be cleaned right away for safety and infection control. During a concurrent interview and record review on 7/2/2026 at 2:58 PM with Registered Nurse 1 (RN 1) of the Resident 17's care plan, dated 5/22/2026, RN 1 stated that the care plan indicated that Resident 17 was at risk for fall related to Parkinson's disease, hypertension (high blood pressure), and depression (severe feelings of sadness and hopelessness). RN 1 stated the care plan interventions indicated to keep the resident's environment safe by having a floor free from spills and clutter. During a concurrent interview and record review on 7/2/2026 at 3:10 PM with RN 1, the facility's Policy and Procedure (P&P) titled, Resident Environmental Quality, revised on 12/19/2022 was reviewed. RN 1 stated that the P&P indicated that it is the policy of this facility to be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. During a concurrent interview and record review on 7/2/2026 at 3:12 PM with RN 1, the facility's P&P titled, Cleaning and Disinfection of Resident Care Equipment, revised on 12/19/2022 was reviewed. RN 1 stated that the P&P indicated that the resident care equipment can be a source of indirect transmission of pathogens. Reusable resident care equipment will be cleaned and disinfected in accordance with the Centers for Disease Control and Prevention (CDC, the primary United States federal public health agency tasked with protecting public health and safety by preventing and controlling disease, injury, and disability) recommendations in order to break the chain of infection. RN 1 also stated that the facility did not follow the P&P.