

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Rosemead Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4096 Easy Street El Monte, CA 91731	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>50203</p> <p>Based on observation, interview, and record review, the facility failed to promote the resident's right to choose where to eat during mealtimes for one of three sampled residents (Resident 1).</p> <p>This deficient practice had the potential to violate Resident 1's rights to self-determination and dignified existence.</p> <p>Cross Reference F656</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Records (AR), the AR indicated the facility admitted Resident 1 on 11/14/2021, and readmitted Resident 1 on 2/24/2025, with diagnoses which included bullous pemphigoid (an autoimmune disease that causes large fluid-filled blisters on the resident's skin), dementia (a progressive state of decline in mental abilities), and hemiplegia (total paralysis of the arm, leg, and trunk of the same slight of the body) and hemiparesis (weakness on one side of the body) following cerebrovascular disease (stroke, damage to the brain from interruption of its blood supply) affecting right dominant side.</p> <p>During a review of Resident 1's History and Physical (H&P), dated 2/25/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. The H&P indicated Resident 1 was able to make decisions for Resident 1's activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 3/3/2025, the MDS indicated Resident 1's cognitive (a person's mental process of thinking, learning, remembering, and using judgement) skills were severely impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) with eating (. The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for transferring from bed to chair and rolling from lying on her back to left or right side. The MDS indicated Resident 1 used a wheelchair (a chair fitted with wheels for transportation) for transportation within the facility.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Progress Note (PN) titled, Communication with Family, dated 1/20/2025, timed at 11:32 AM, the PN indicated IDT met with Resident 1's Family Member (FM) 1 and FM 2. The PN indicated FM 1 and FM 2 requested to have Resident 1 eat (Resident 1's) meals in the dining room.</p> <p>During an observation on 4/25/2025 at 12:21 PM, in Resident 1's room, Resident 1 was observed lying in bed with the head of the bed elevated to 90 degrees. Certified Nursing Assistant (CNA) 1 was seated at eye-level next to Resident 1 assisting Resident 1 eat Resident 1's lunch.</p> <p>During an interview on 4/25/2025 at 12:32 PM with CNA 1, CNA 1 stated Resident 1 would have Resident 1's meals in Resident 1's room or in the dining room, depending on Resident 1's mood. CNA 1 stated Resident 1 ate in the dining room on 4/21/2025. CNA stated today (4/25/2025), Resident 1 ate in Resident 1's room. CNA 1 stated Resident 1's assigned CNA for the day decided whether Resident 1 would have Resident 1's meals in the hallway, dining room, or in Resident 1's room. CNA 1 stated Resident 1's assigned CNA would take Resident 1 to the dining room to have Resident 1's meals upon Resident 1's FM's request during visitation.</p> <p>During a concurrent interview and record review on 5/1/2025 at 1:45 PM with the MDS Nurse, Resident 1's care plans were reviewed. The MDS Nurse stated there was no documented evidence a care plan was developed with interventions related to Resident 1's/FM 1 and FM 2's preference to have Resident 1 eat in the dining room or in Resident 1's room.</p> <p>During a concurrent interview and record review on 5/1/2025 at 4 PM with the Director of Nursing (DON), Resident 1's PN titled, Communication with Family, dated 1/20/2025, was reviewed. The DON stated Resident 1's meal location preference was discussed with FM 1 and FM 2. The DON stated there was no care plan developed with interventions to respect Resident 1's right and preference to decide where Resident 1 should eat Resident 1's meals. The DON stated Resident 1's rights and autonomy should be respected to improve Resident 1's quality of life.</p> <p>During a review of the facility's P&P titled, Resident Rights, dated 10/1/2023, the P&P indicated Residents are allowed to choose activities, schedules, and health care that are consistent with their interests, assessments, and plans of care including . sleeping, eating, exercise, and bathing schedules. The P&P indicated, Facility staff will inform and regularly remind the residents of the right to self-determination and participation in preferred activities.</p> <p>During a review of the facility's P&P titled, Resident Rights - Quality of Life, dated 10/1/2023, the P&P indicated, residents are assisted in attending the activities of their choice.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>50203</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement a care plan for one of three sampled residents (Resident 1) as indicated in the facility's policies and procedures titled, Care Planning, and Fall Management Program, by failing to:</p> <ol style="list-style-type: none"> 1. Ensure facility staff implemented Resident 1's care plan for falls dated 10/16/2023 to keep personal items within reach and complete quarterly fall risk assessment per facility's fall protocol. 2. Ensure facility staff developed a comprehensive resident-centered care plan for Resident 1's rights, preferences, and autonomy to be in the dining room during mealtimes. <p>These failures resulted in Resident 1's falls on 3/20/2025 and 4/9/2025. Resident 1 sustained redness to Resident 1's cheek from the fall on 3/20/2025. Resident 1 sustained skin discoloration to Resident 1's right forehead, right eye, and right hand and swelling to Resident 1's right eye and right hand from the fall on 4/9/2025. These failures had the potential to result in a decline in Resident 1's mental, physical, and emotional well-being.</p> <p>Cross Reference F550</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 1's Admission Records (AR), the AR indicated the facility admitted Resident 1 on 11/14/2021, and readmitted Resident 1 on 2/24/2025, with diagnoses which included bullous pemphigoid (an autoimmune disease that causes large fluid-filled blisters on the resident's skin), dementia (a progressive state of decline in mental abilities), and hemiplegia (total paralysis of the arm, leg, and trunk of the same slight of the body) and hemiparesis (weakness on one side of the body) following cerebrovascular disease (stroke, damage to the brain from interruption of its blood supply) affecting right dominant side. <p>During a review of Resident 1's Care Plan (CP) titled, Care Plan Report, revised on 10/16/2023, the CP indicated Resident 1 was at risk for falls related to confusion, gait/balance problems, incontinence (loss of bladder or bowel control), poor communication/comprehension (understanding), and lack of awareness of Resident 1's safety needs. The CP's goal indicated Resident 1 will be free of falls through 5/22/2025. The CP interventions included for the staff to anticipate and meet Resident 1's needs, review information on past falls to determine the cause of Resident 1's falls, follow the facility's fall protocol, and ensure Resident 1's personal items were within reach.</p> <p>During a review of another Resident 1's CP titled, Care Plan Report, revised on 12/18/2023, the CP indicated Resident 1 preferred to sit at the edge of the bed most of the day and have her belongings such as bedside table, shoes, wheelchair next to her always. The CP's goal indicated the staff will accommodate Resident 1's needs and preferences daily through 5/22/2025. The CP interventions included for staff to involve Resident 1's family as needed to determine Resident 1's preferences, help with daily care to meet Resident 1's accommodation requests and needs, and to provide information as to how preferences and accommodation will be incorporated in care.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 1's Fall Risk Assessment (FRA) dated 1/11/2025, the FRA indicated Resident 1 was at high risk for falls due to impaired gait, more than one diagnosis, and overestimating or forgetting limits.</p> <p>During a review of Resident 1's History and Physical (H&P), dated 2/25/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. The H&P indicated Resident 1 was able to make decisions for Resident 1's activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 3/3/2025, the MDS indicated Resident 1's cognitive (a person's mental process of thinking, learning, remembering, and using judgement) skills were severely impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) with eating (. The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for transferring from bed to chair and rolling from lying on her back to left or right side. The MDS indicated Resident 1 used a wheelchair (a chair fitted with wheels for transportation) for transportation within the facility. The MDS indicated Resident 1 did not have a history of falls in the last six months of the assessment.</p> <p>During a review of Resident 1's Change in Condition Evaluation (COC, a document used to record a resident's change of condition), dated 3/20/2025, timed at 2:31 AM, the COC indicated Resident 1 had an unwitnessed fall (on 3/20/2025). The COC indicated Resident 1 was found laying on the floor in horizontal position between Bed A and Bed B. The COC indicated Resident had no change to Resident 1's level of consciousness (LOC, a person's level of consciousness) and did not sustain any skin injuries.</p> <p>During a review of Resident 1's Skin Observation Checks (SOC), dated 3/20/2025, timed at 8:03 AM, the SOC indicated Resident 1 had redness noted on check (specific side not indicated).</p> <p>During a review of Resident 1's COC, dated 4/9/2025, timed at 4:06 PM, the COC indicated Resident 1 had an unwitnessed fall (on 4/9/2025). The COC indicated Resident 1 sustained skin discoloration to Resident 1's right forehead, right eye, and right hand. The COC indicated Resident 1 sustained swelling to Resident 1's right eye and right hand. The COC indicated Resident 1's Primary Care Physician (PCP 1) was notified and recommended an X-ray (diagnostic imaging) of Resident 1's right facial bone and right hand STAT (immediately).</p> <p>During a review of Resident 1's Nursing Progress Notes (NPN), dated 4/9/2025, timed at 4:20 PM, the NPN indicated Resident 1 was found sitting on the floor with Resident 1's right head leaning towards the plastic bedside dresser by Resident 1's head of bed. The COC indicated Resident 1 attempted to stand up from (Resident 1's) bed to reach Resident 1's glasses from the drawer and lost balance.</p> <p>During a review of Resident 1's Radiology Results Report (X-ray Report) of Resident 1's facial bones, dated 4/9/2025, timed at 6:44 PM, the X-ray Report indicated no acute findings.</p> <p>During a review of Resident 1's X-ray Report of Resident 1's right hand, dated 4/9/2025, timed at 6:44 PM, the X-ray Report Resident 1's right hand had mild soft tissue swelling.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 4/25/2025 at 12:46 PM in Resident 1's room, Resident 1 was observed attempting to transfer from lying to sitting position without assistance. Resident 1's plastic three (3) drawer storage container was against the wall, on the right side of Resident 1's bed, by Resident 1's headboard. There was a water pitcher, a cup, a pair of glasses, a tissue box, and personal items on top of Resident 1's storage container. Resident 1's wheelchair was in front of the three-drawer storage container. Resident 1's overbed table (a small, mobile table designed to be placed over a bed) was in front of the wheelchair by Resident 1's padded footboard. Resident 1's overbed table did not have anything on top of it.</p> <p>During a concurrent observation and interview on 4/25/2025 at 12:55 PM with Registered Nurse (RN) 1, in Resident 1's room, Resident 1 was observed with discoloration on the left and right side of Resident 1's face. RN 1 stated Resident 1 had an old bruise (discoloration of the skin caused by small blood vessels breaking and leaking blood beneath the skin's surface) on the left and right side of the face. RN 1 stated RN 1 was unaware if Resident 1 had any falls in 2025. RN 1 stated Resident 1 was at risk for falls.</p> <p>During an interview on 4/25/2025 at 1:30 PM with Certified Nurse Assistant (CNA) 2, CNA 2 stated Resident 1's overbed table did not have any items on top of it because Resident 1 knocks it down. CNA 2 stated when Resident 1 was sitting up in bed, Resident 1 will start knocking things off the table.</p> <p>During an interview on 5/1/2025 at 12:28 PM with the MDS Nurse, the MDS Nurse stated a resident's (in general) fall risk assessment was completed upon admission, quarterly, and post-fall incident.</p> <p>During a concurrent interview and record review on 5/1/2025 at 12:35 PM with the MDS Nurse, Resident 1's fall risk assessments from 1/2025 to 4/2025 were reviewed. The MDS Nurse stated there was no documented evidence Resident 1 had a quarterly fall risk assessment completed in 3/2025. The MDS Nurse stated Resident 1's quarterly fall risk assessment should have been completed on 3/5/2025. The MDS Nurse stated a quarterly fall risk assessment was important to identify if there were any new changes in Resident 1's mobility and to reevaluate Resident 1's specific person-centered interventions.</p> <p>During an interview on 5/1/2025 at 12:38 PM with the MDS Nurse, the MDS Nurse stated the MDS Nurse was unaware of any care plans related to placing Resident's 1 daily items within reach. The MDS Nurse stated Resident 1's daily items should be within reach to prevent any further falls.</p> <p>During a concurrent interview and record review on 5/1/2025 at 4 PM with the Director of Nursing (DON), Resident 1's fall risk assessments from 1/2025 to 4/2025 were reviewed. The DON stated there was no documented evidence Resident 1 had a quarterly fall risk assessment completed in 3/2025. The DON stated a quarterly fall risk assessment was important to assess and identify if Resident 1 was still at high risk for falls and to identify new interventions to implement to ensure Resident 1's safety.</p> <p>During an interview on 5/1/2025 at 4:20 PM with the DON, the DON stated Resident 1 wanted Resident 1's personal items in a particular place and would get agitated if Resident 1's items were not where Resident 1 wanted the items. The DON stated Resident 1's personal items on top of Resident 1's three-drawer plastic storage container were not within Resident 1's reach. The DON stated Resident 1 could continue to fall if Resident 1's daily items were not within reach.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&P titled, Care Planning, dated 10/1/2023, the P&P indicated, Each resident's comprehensive care plan will describe . services that are t furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>During a review of the facility's P&P titled, Fall Management Program, dated 10/1/2023, the P&P indicated, The Licensed Nurse will assess each resident for their risk of falling upon admission, quarterly, and with significant change of condition. The P&P indicated, The Nursing Staff and interdisciplinary team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of their resident) . will identify and implement interventions to reduce the risk of falls. The P&P indicated, The Nursing Staff will develop a plan of care specific to the resident's needs with interventions to reduce the risk of falls . interventions will be implemented .</p> <p>2. During a review of Resident 1's Progress Note (PN) titled, Communication with Family, dated 1/20/2025, timed at 11:32 AM, the PN indicated IDT met with Resident 1's Family Member (FM) 1 and FM 2. The PN indicated FM 1 and FM 2 requested to have Resident 1 eat (Resident 1's) meals in the dining room.</p> <p>During an observation on 4/25/2025 at 12:21 PM, in Resident 1's room, Resident 1 was observed lying in bed with the head of the bed elevated to 90 degrees. CNA 1 was seated at eye-level next to Resident 1 assisting Resident 1 eat Resident 1's lunch.</p> <p>During an interview on 4/25/2025 at 12:32 PM with CNA 1, CNA 1 stated Resident 1 would have Resident 1's meals in Resident 1's room or in the dining room, depending on Resident 1's mood. CNA 1 stated Resident 1 ate in the dining room on 4/21/2025. CNA stated today (4/25/2025), Resident 1 ate in Resident 1's room. CNA 1 stated Resident 1's assigned CNA for the day decided whether Resident 1 would have Resident 1's meals in the hallway, dining room, or in Resident 1's room. CNA 1 stated Resident 1's assigned CNA would take Resident 1 to the dining room to have Resident 1's meals upon Resident 1's FM's request during visitation.</p> <p>During a concurrent interview and record review on 5/1/2025 at 1:45 PM with the MDS Nurse, Resident 1's care plans were reviewed. The MDS Nurse stated there was no documented evidence a care plan was developed with interventions related to Resident 1's/FM 1 and FM 2's preference to have Resident 1 eat in the dining room or in Resident 1's room.</p> <p>During a concurrent interview and record review on 5/1/2025 at 4 PM with the DON, Resident 1's PN titled, Communication with Family, dated 1/20/2025, was reviewed. The DON stated Resident 1's meal location preference was discussed with FM 1 and FM 2. The DON stated there was no care plan developed with interventions to respect Resident 1's right and preference to decide where Resident 1 should eat Resident 1's meals. The DON stated Resident 1's rights and autonomy should be respected to improve Resident 1's quality of life.</p> <p>During a review of the facility's P&P titled, Resident Rights, dated 10/1/2023, the P&P indicated Residents are allowed to choose activities, schedules, and health care that are consistent with their interests, assessments, and plans of care including . sleeping, eating, exercise, and bathing schedules. The P&P indicated, Facility staff will inform and regularly remind the residents of the right to self-determination and participation in preferred activities.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&P titled, Resident Rights - Quality of Life, dated 10/1/2023, the P&P indicated, residents are assisted in attending the activities of their choice.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203</p> <p>Based on interview and record review, the facility failed to revise a care plan (a plan that outlines resident-specific interventions used to guide a resident ' s care for a given area of concern) for one of three sample residents (Resident 1), a known fall risk, who sustained two falls from the bed on 3/20/2025 and 4/9/2025.</p> <p>This failure resulted in Resident 1 not receiving appropriate care treatments and services and sustaining recurrent falls, which caused Resident 1 to sustain bruising (an injury through unbroken skin resulting in discoloration) to Resident 1 ' s face from a recurring fall on 4/9/2025.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Records, the facility admitted Resident 1 on 11/14/2021 and readmitted to the facility on [DATE] with diagnoses which included bullous pemphigoid (an autoimmune disease that causes large fluid-filled blisters on the resident ' s skin), dementia (a progressive state of decline in mental abilities), and hemiplegia (total paralysis of the arm, leg, and trunk of the same slight of the body) and hemiparesis (weakness on one side of the body) following cerebrovascular disease (stroke) affecting Resident 1 ' s right dominant side.</p> <p>During a review of Resident 1 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 2/25/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. The H&P indicated Resident 1 was able to make decisions for her activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily).</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS, a resident assessment tool), dated 3/3/2025, the MDS indicated Resident 1 ' s cognitive (a person ' s mental process of thinking, learning, remembering, and using judgement) skills were severely impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) with eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and to swallow food and/or liquid once the meal is placed before the resident). The MDS indicated Resident 1 was dependent (helper does all the effort) with her functional mobility (a person ' s ability to move safely and independently within their environment) such as transferring from bed to chair and turning from lying on Resident 1 ' s back to the left or right side. The MDS indicated Resident 1 used a manual wheelchair (a chair fitted with wheels for transportation) for transportation within the facility.</p> <p>During a review of Resident 1 ' s Nursing Admission Assessment document, dated 2/24/2025, the document indicated Resident 1 had not fallen before, used a wheelchair, had a weak gait (pattern a resident walks), and overestimated Resident 1 ' s ability to ambulate (walk).</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 1 ' s care plan, revised 10/16/2023, the care plan indicated Resident 1 was at risk for falls related to confusion, gait/balance problems, incontinence (loss of bladder or bowel control), poor communication/comprehension (understanding), and unawareness of safety needs. The care plan ' s goal, target date 5/22/2025, indicated Resident 1 will be free of falls. The care plan interventions included determining the root cause of Resident 1 ' s falls, to ensure a Resident 1 ' s environment was free of clutter, had adequate lighting, bed in low-position, and keep daily personal items within reach, and to anticipate and meet Resident 1 ' s needs.</p> <p>During a review of Resident 1 ' s Change of Condition (COC, a document used to record a resident ' s change of condition) evaluation document, dated 3/20/2025, the document indicated Resident 1 had an unwitnessed fall and was found [lying] on the floor in a horizontal position between A and B bed.</p> <p>During a review of Resident 1 ' s COC evaluation document, dated 4/9/2025, the document indicated Resident 1 had an unwitnessed fall.</p> <p>During a review of Resident 1 ' s Nursing progress note, dated 4/9/2025, the progress notes indicated Resident 1 attempted to stand up from her bed to get Resident 1 ' s glasses and lost Resident 1 ' s balance. The progress note indicated Resident 1 was found sitting on the floor with Resident 1 ' s right side of head leaning against the plastic three (3) drawer- storage container (a storage unit made of plastic with three drawers, designed to hold various items and help organize them).</p> <p>During a review of Resident 1 ' s care plan, initiated 4/9/2025, the care plan indicated Resident 1 had an actual unwitnessed fall with discoloration to Resident 1 ' s right forehead, right eye, and right hand with mild swelling. The care plan ' s goal, target dated 4/30/2025, indicated Resident 1 will be free of falls. The care plan ' s interventions included encouraging Resident 1 to use the call light (a device residents used to request help from staff found within reach) for assistance and to encourage Resident 1 to attend daily activities and to socialize with other residents.</p> <p>During a review of Resident 1 ' s care plan, revised on 4/25/2025, the care plan indicated Resident 1 had fallen on 3/20/2025 and 4/9/2025 due to balance problems and cognitive impairment. The care plan ' s goal, target date 5/9/2025, indicated Resident 1 will have a decrease in falls and injury. The care plans interventions included frequent visual checks and frequent offering of toileting schedule as needed.</p> <p>During a concurrent interview and record review on 5/1/2025 at 12:40PM with the MDS Nurse, Resident 1 ' s care plan related to Resident 1 ' s actual falls on 3/20/2025 and 4/9/2025, revised 4/25/2025, was reviewed. The MDS nurse stated, there was a care plan created for Resident 1 ' s actual falls, but Resident 1 ' s care plan was not revised in a timely manner. The MDS nurse stated, the care plan should have been revised on 3/20/2025 and 4/9/2025, not revised on 4/25/2025. The MDS nurse stated, care plans should be revised at least upon admission, quarterly, and if there are any significant changes.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Rosemead Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4096 Easy Street El Monte, CA 91731	
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)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 5/1/2025 with the Director of Nursing (DON), Resident 1 ' s care plan related to Resident 1 ' s actual falls on 3/20/2025 and 4/9/2025, revised 4/25/2025, was reviewed. The DON stated, Resident 1 ' s care plan should have been revised after each fall, 3/20/2025 and 4/9/2025 respectively. The DON stated, Resident 1 ' s care plan should have been revised after each COC, 3/20/2025 and 4/9/2025 respectively. The DON stated, a care plan should be created or revised the day of the fall incident to 72 hours. The DON stated, care plan revisions were important to indicated the resident ' s goals and intervention as an indicator of the facility ' s care plan for Resident 1 .</p> <p>During a review of the facility ' s policies and procedures (P&P) titled Fall Management Program, dated 10/2023, the P&P indicated the licensed nurse will review the circumstances of the fall, review the plan of are, implement new interventions as appropriate, and revise the plan as indicated.</p> <p>During a review of the facility ' s P&P titled Fall Management Program, dated 10/2023, the P&P indicated the Interdisciplinary Team (IDT, a collaborative approach from multiple medical disciplines who work together towards the goal of the resident) will routinely review the plan of care at a minimum of quarterly, with significant change of condition, and post fall. Interventions will be implemented or changed based on the resident ' s condition and response.</p> <p>During a review of the facility ' s P&P titled Fall Management Program, dated 10/2023, the P&P indicated the committee will meet within 72 hours of the fall incident and review the summary of event following a fall, root cause analysis, referrals, as necessary, and interventions to prevent future falls.</p> <p>During a review of the facility ' s P&P titled Fall Management Program, dated 10/2023, the P&P indicated the nursing staff will develop a plan of care specific to the resident ' s needs with interventions to reduce the risk of falls.</p> <p>During a review of the facility ' s P&P titled Care Planning, dated 10/2023, the P&P indicated each resident ' s care plan will describe services that are to . maintain the resident ' s highest practicable physical, mental, and psychosocial well-being.</p>		