

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 08/13/2025
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)
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. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement its policy and procedure to conduct a post-fall evaluation and prevention meeting within 72 hours of two unwitnessed falls for a resident who was rated at moderate risk for falls for one of four sampled residents (Resident 2). This deficient practice placed Resident 2 at risk for future additional falls and injury. Findings: During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included polyneuropathy (multiple peripheral nerves become damaged and include problems with sensation, coordination, or other body functions), paraplegia (loss of movement and/or sensation, to some degree, of the legs), muscle weakness (loss of muscle strength), schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety disorder (excessive, persistent worry or fear), bipolar disorder, (mood swings that range from the lows of depression to elevated periods of emotional highs), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 2's History and Physical (H&P), dated 3/27/25, the H&P indicated, Resident 2 had the capacity to understand and make medical decisions. The H&P also indicated, Based on the clinical picture, diagnoses, and comorbidities Resident 2 is at risk for malnutrition, weight loss, pressure ulcers, dehydration, falls. During a review of Resident 2's Nursing admission Assessment (NAA), dated 3/27/25, the NAA indicated Resident 2's Morse Fall Risk Score was 40 - Moderate Risk (Scoring: High Risk: 45 and higher; Moderate Risk: 25-44; and Low Risk: 0-24). During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 3/31/25, the MDS indicated Resident 2 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 2 required substantial/maximal assistance with toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear. During a review of Resident 2's Care Plan, At Risk for Fall related to Diagnosis and History: Paraplegia and Multiple Medical Comorbidities, the care plan indicated the date initiated was 3/31/25 with a goal target date of 9/29/25. The care plan further indicated it was revised on 7/30/25. Resident 2 was discharged home from the facility on 7/5/25. During a review of Resident 2's Physician Orders (POs) active as of 4/1/25, the POs indicated the following orders: 1. Anti-anxiety: Monitor side effects such as sedation, drowsiness, ataxia (drunk walk), dizziness, nausea, vomiting, confusion, headache, blurred vision, skin rash for the use of Alprazolam. 2. Anti-coagulant: Monitor for signs and symptoms of bleeding such as but not limited to discolored urine, black tarry stool, sudden severe headache, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status, confusion, shortness of breath, nose bleeding, dizziness, ecchymoses, and bleeding gums every shift for use of Eliquis. 3. Anti-depressant: Monitor side effects such as sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photosensitivity, weight gain for use of Escitalopram Oxalate. 4. Anti-psychotic: Monitor side effects such as sedation, drowsiness, dry mouth, constipation, blurred vision, weight gain, edema, sweating, loss of appetite, urinary retention for the use of Haloperidol and Quetiapine Fumarate. During a review of Resident 2's Change of Condition (COC)/Interact Assessment Form (SBAR, a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains), dated 4/19/25, the COC indicated on 4/19/25 Resident 2 suffered an unwitnessed fall, found on the floor inside bedroom. Resident 2 stated he slipped out of the wheelchair while leaning forward. The COC further indicated the recommendation from the primary care physician was to perform neuro checks for 72 hours. During a review of Resident 2's Fall Risk (Morse) Assessment (a nursing tool that uses a scoring system to evaluate resident's risk of fall), dated 4/19/25, the assessment indicated Resident 2 scored a 35 (moderate risk for falling). During a review of Resident 2's Neuro Check List (NCL), the NCL indicated Resident 2 was monitored from 4/19/25 at 00:20 to 4/22/25 at 24:05. During a review of Resident 2's Change of Condition (COC)/Interact Assessment Form, dated 4/22/25, the COC indicated on 4/22/25 Resident 2 had a fall with a pain score of 3 out of 10 pain scale for the left parietal area [where the parietal lobes are located near the back and top of the head. They are important for processing and interpreting somatosensory input]. During a review of Nursing Progress Notes, dated 4/22/25, the notes indicated Resident 2 was found lying on the floor in front of his wheelchair at 22:30. A body check was completed and Resident 2 had a 2.5 x 2.5 cm bump on the left parietal area and complained of pain on a scale of 3 out of 10. Resident 2 stated he was sitting in his wheelchair and wanted to catch the urinal but lost balance and was laying on the floor. Resident</p>		