STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055202	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosemead Healthcare Center	4096 Easy Street El Monte, CA 91731

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the call light (an alerting to assist a resident when needed) was within reach and appropriate to the patient's physical ability for three of three sampled residents (Residents 10, 14, and 26). These failures had the potential to result in a delay in meeting Residents 10, 14, and 26's needs for assistance and placed the residents at risk for a fall, injury or accident.Findings: a. During a review of Resident 10's admission Record (AR), the AR indicated the facility admitted Resident 10 on 2/8/2024 and re admitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (one-sided muscle weakness) and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 10's Care Plan (CP), the CP indicated Resident 10 had: 1. An actual fall without injury related to functional problems, poor balance, unsteady gait, with an intervention to keep the call light within reach. The CP was dated 2/14/2024. 2. Alteration in musculoskeletal status related to contracture of the right elbow, with an intervention to ensure the call light was within reach and all assistance requests were promptly responded to. The CP was dated 2/12/2026. During a review of Resident 10's History & Physical (H&P) dated 2/22/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool) dated 2/24/2026, the MDS indicated Resident 10 had moderately impaired cognition (ability to understand) and was dependent on upper and lower body dressing (helper does all of the effort). During a concurrent observation and interview on 3/24/2026 at 9:56 am with Licensed Vocational Nurse 1 (LVN 1) in Resident 10's room, Resident 10 was lying in bed with a pad sensor call light above Resident 10's head on the right side of the pillow. LVN 1 stated Resident 10 could not reach the call light, and it needed to be within reach to allow Resident 10 to notify staff if Resident 10 was unwell or to call for help/assistance. During an interview on 3/26/2026 at 12:35 pm with the Director of Nursing (DON), the DON stated the call light should always be within reach for the resident. The DON stated the purpose of having the call light within reach was to prevent any falls and alert the staff if a resident needed help. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Communication-Call System, dated 2/20/2026, the P&P indicated the purpose of the call system was providing a mechanism for residents to promptly communicate with nursing staff. The P&P indicated, call cords would be placed within the resident's reach in the resident's room. b. During a review of Resident 14's AR, the AR indicated Resident 14 was admitted to the facility on [DATE] with diagnosis including metabolic encephalopathy (a brain dysfunction caused by chemical imbalances), muscle weakness and abnormalities of gait (a person's manner in walking) and mobility. During a review of Resident 14's H&P dated 2/10/2026, the H&P indicated Resident 14 had the capacity to understand and make decisions. During a review of Resident 14's MDS dated [DATE], the MDS indicated Resident 14 required partial/moderate assistance (helper does less than half the effort) for shower or bathing self, upper and lower body dressing and putting on or taking off footwear. The MDS indicated Resident 14 required supervision (helper provides verbal cues) for eating, oral and toileting hygiene. During a review of Resident 14's CP initiated on 1/22/2026, the CP indicated Resident 14 was at risk for falls. The CP intervention indicated Resident 14 would have available resources including use of the call light. During an observation inside Resident 14's room on 3/24/26 at 10:03 am, Resident 14 was sitting at the side of the bed. Resident 14 stated, I used to have a call light on top of the mattress, but today they left it all the way on the other side of the bed. If I have an emergency, I won't be able to reach it. Resident 14 stated that when the staff changed the bed linen, the staff left the call light hanging on the other side of the bed. During an interview with Certified Nursing Assistant 1 (CNA1) on 3/24/2026 at 10:20 am, CNA1 stated it was important for the residents to have the call light within reach. CNA1 stated if the resident had an emergency or needed assistance, the resident should be able to use the call light to call the staff. CNA1 stated if the resident's call light was not within reach, the resident could suffer a fall trying to use/reach out the call light. During an interview with the DON on 3/26/2026 at 12:35 pm, the DON stated the call light should be within every resident's reach. The DON stated the purpose of having the call light within reach was to prevent any falls and to alert staff if the residents needed help. During a review of the facility's policy and procedure (P&P) titled, Communication-Call System, dated 2/20/2026, the P&P indicated the purpose of the call system was providing a mechanism for residents to promptly communicate with nursing staff. The P&P indicated, call cords would be placed within the resident's reach in the resident's room. c. During a review of Resident 26's AR, the AR indicated Resident 26 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (type of ischemic [deficient supply of blood] stroke [sudden death of brain cells in a localized area due to inadequate blood flow] resulting from a blockage in the blood vessels supplying blood to the brain) affecting right dominant side, and unspecified dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily (continued on next page)

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	055202	A. Building B. Wing	03/27/2026

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	functioning). During a review of Resident 26's CP dated 9/8/2023, the CP indicated Resident 26 was at risk for fall related to Cerebrovascular Accident (CVA -blood flow to a part of the brain was stopped), dementia and history of falls. The CP intervention indicated for nursing staff to orient Resident 26 to Resident 26's room and ensure resources were available including use of the call light. During a review of Resident 26's Fall Risk Assessment (FRA- method of assessing a patient's likelihood of falling) dated 2/23/2026, the FRA indicated Resident 26 was assessed as higher moderately at risk for falls due to weak gait (a person's manner of walking) and use of the wheelchair for mobility assistive device. During a review of Resident 26's MDS dated [DATE], the MDS indicated Resident 26 had moderately impaired cognition. The MDS indicated Resident 26 needed moderate assistance (helper does less than half the effort) from staff for shower. The MDS indicated Resident 26 needed supervision (helper provides verbal cues) from staff for toileting, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. During a concurrent observation and interview on 3/24/2026 at 9:40 am with Registered Nurse 1 (RN 1) in Resident 26's room, Resident 26 was awake, sitting in a wheelchair at the bottom right side of the bed with the call light on the left upper side of the bed. RN 1 stated, Resident 26 was unable to reach the call light because it was placed on the upper left side of the bed and was hanging on the left side rails. RN 1 stated, the call light needed to be within resident's reach at all times for safety. RN 1 stated, residents could be in danger if help was not provided. During an interview on 3/26/2026 at 12:35 pm with the DON, the DON stated Resident 26's call light should always be within reach to prevent any falls and if Resident 26 needed help or assistance. During a review of the facility's policy and procedure (P&P) titled, Communication-Call System, dated 2/20/2026, the P&P indicated the purpose of the call system was providing a mechanism for residents to promptly communicate with nursing staff. The P&P indicated, call cords would be placed within the resident's reach in the resident's room.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure one of one sampled resident (Resident 1) was provided with care and services to maintain personal hygiene and nail care, by failing to:1, Ensure Resident 1 was seen by a Podiatrist (a medical doctor who specializes in caring for feet and ankles) as indicated in the resident's care plan.2. Ensure Resident 1's feet were not dry and toenails were trimmed. These deficient practices had the potential to result in a negative impact on Resident 1's health, quality of life and self-esteem. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was originally admitted to the facility on [DATE] and re admitted on [DATE] with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar) and heart failure (the heart muscle cannot pump blood efficiently enough to meet the body's needs for oxygen). During a review of Resident 1's Care Plan (CP) initiated on10/16/23, the CP indicated Resident 1 had diabetes. The CP interventions indicated for nursing staff to inspect the resident's feet daily, to refer Resident 1 to a Podiatrist, provide foot care, cut long nails and to monitor and document foot care needs. During a review of Resident 1's CP initiated on 6/2/24, the CP indicated Resident 1 had impaired nail integrity related to fungal infection as evidence by thickening, brittleness, and deformity of the toenails. The CP intervention indicated to schedule regular follow-up with a Podiatrist. During a review of Resident 1's History and Physical (H&P) dated 3/4/26, the H&P indicated Resident 1 could make needs known but could not make medical decisions. During a review of Resident 1's Minimum Data Set (MDS - a comprehensive standardized assessment and screening tool), dated 3/9/26, the MDS indicated Resident 1 required substantial/maximal assistance (helped does more than half the effort) for showers, upper and lower body dressing and putting or taking off footwear. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for oral and toileting hygiene. During an observation inside Resident 1's room on 3/26/26 at 8:10 AM, Resident 1 was resting in bed. Resident 1's feet were dry and the toenails were long, brown, and untrimmed. During an interview and record review with License Vocational Nurse 4 (LVN 4) on 3/26/26 at 11:28 AM, LVN 4 stated the Certified Nursing Assistants (CNAs) should provide/assist Resident 1 with Activities of Daily Living (ADL) including foot care so that Resident 1's feet would not be dry. LVN 4 stated there was no Podiatrist appointment documented in the Electronic Health Record (EHR) for Resident 1. LVN 4 stated the Social Service Director (SSD) was responsible for arranging a Podiatrist appointment for Resident 1. During a concurrent observation and interview with LVN 4 inside Resident 1's room on 3/26/26 at 11:35 AM, Resident 1 was resting in bed. LVN 4 stated Resident 1's feet were very dry and the toenails were brown and long. LVN 4 stated Resident 1's feet were very dry and that Resident 1 had cracked skin on the feet. LVN 4 stated the CNAs should have applied lotion on Resident 1's feet. LVN 4 stated the CNAs needed to trim Resident 1's toenails. LVN 4 stated Resident 1 was diabetic and needed to see a Podiatrist. During an interview with the SSD on 3/26/26 at 11:38 AM, the SSD stated staff had not documented Resident 1 needed a Podiatrist appointment due to dry feet and long toenails. The SSD stated the Podiatrist would visit the facility on as needed basis. During an interview with the Director of Nursing (DON) on 3/26/2026 at 12:46 PM, the DON stated every resident should have their ADLs attended, including application of lotion to the feet. The DON stated if a resident's toenails were long and dry, the resident should be seen by a Podiatrist. The DON stated any staff member who saw that the resident's feet were dry and toenails were brown and long should have reported the incident right away. The DON stated Resident 1's toenails should only be trimmed by a Podiatrist and not by a CNA. The DON stated CNAs could trim or clip fingernails but not toenails. During a review of the facility`s policy and procedure (P&P) titled, Nail Care, revised 2/24/26, the P&P indicated, Toenails are trimmed by Certified Nursing Assistants except for residents with the following conditions: diabetes or circulatory impairments, ingrown, infected or painful nails, (continued on next page)

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	055202	A. Building B. Wing	03/27/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nails that are too hard and thick or difficult to cut easily. The P&P indicated that high risk residents and resident with hypertrophic (abnormal enlargement or thickening), mycotic (having fungus or fungal infection) and keratotic (thick or rough) toenails will be referred to podiatrist as ordered by the attending physician.

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	055202	A. Building B. Wing	03/27/2026

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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:a. Provide necessary care and services for gastrostomy tube (GT, a tube inserted through the abdomen that delivers nutrition/medication directly to the stomach) site as ordered by the physician and as indicated in the plan of care for one of two sampled residents (Resident 53).b. Elevate the resident's head of the bed (HOB) while receiving feeding formula through the GT in accordance with the resident's plan of care and physician's order for one of two sampled residents (Resident 66). These failures had the potential to result in complications related to tube feedings for Residents 53 and 66.Findings: a. During a review of Resident 53's admission Record (AR), the AR indicated the facility initially admitted Resident 53 on 5/19/2015 and readmitted on [DATE] with diagnoses including gastrostomy (a surgical opening fitted with a device to allow feedings/medication to be administered directly to the stomach), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control), and diverticulosis (small bulging pouches that form in the lining of the large intestine due to pressure on weak spots.) During a review of Resident 53's Care Plan (CP) dated 3/25/2024, the CP indicated Resident 53 required tube feeding related to dysphagia (difficulty swallowing). The CP interventions included providing care to the GT site as ordered. During a review of Resident 53's Order Summary Report (OSR), dated 10/14/2025, the OSR indicated Resident 53 had an order for licensed staff to cleanse the GT stoma (a surgically created opening on the abdomen that connects an internal organ to the outside of the body) with normal saline (NS), pat dry, cover with T-drain sponge (or split sponge designed to fit securely around external medical tubing), then secure with a tape every day and as needed for GT care if soiled or dislodged. During a review of Resident 53's Minimum Data Set (MDS, a resident assessment tool) dated 2/13/2026, the MDS indicated Resident 53 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 53 was dependent (helper did all the effort, resident did none) with oral hygiene, toileting, shower, upper/lower body dressing and personal hygiene. The MDS indicated Resident 53 had a feeding tube for nutrition. During a concurrent observation inside Resident 53's room and interview on 3/24/2026 at 10:17 am with the Infection Prevention Nurse (IPN), Resident 53 was lying in bed, on Resident 53's back with gastrostomy tube. The IPN stated Resident 53's GT site dressing was loose and not secured with a tape on the abdomen. The IPN stated the GT dressing should be changed every day and as necessary to prevent skin irritation around the site and to tape the dressing to secure and prevent accidental pulling during bed mobility. During an interview on 3/26/2026 at 1:10 pm with the Director of Nursing (DON), the DON stated the GT site dressing should be changed as needed to keep the GT site clean and dry to prevent infection. During a review of facility's Policy and Procedure (P&P) titled, Feeding Tube-Site Care, revised February 24, 2026, the P&P indicated The site of a well-established enteral feeding tube would be inspected daily for signs and symptoms of irritation, gastric leakage or infection. Place a gauze drainage sponge around the site for irritation, drainage, or leakage. (continued on next page)

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	055202	A. Building B. Wing	03/27/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 66's AR, the AR indicated the facility admitted Resident 66 on 7/17/2025 with diagnoses including encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support) and chronic obstructive pulmonary disease (COPD- type of obstructive lung disease characterized by long-term poor airflow) During a review of Resident 66's OSR dated 7/17/2025, the OSR indicated for staff to elevate Resident 66's HOB at 30 to 45 degrees at all times during feeding delivery and one hour after feeding has stopped every shift. During a review of Resident 66's MDS dated [DATE], the MDS indicated Resident 66 had severely impaired cognition. The MDS indicated Resident 66 was dependent on staff for oral hygiene, toileting, lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 66's untitled CP dated 2/17/2026, the CP indicated Resident 66 required tube feeding related to dysphagia. The CP interventions indicated for licensed nursing staff to administer enteral feeding as prescribed and to keep Resident 66's HOB elevated at 30 to 45 degrees at all times during feeding and at least one hour after feeding. During a review of Resident 66's OSR dated 3/21/2026, the OSR indicated Resident 66 was on continuous GT feeding of Glucerna 1.2 (formula) via enteral feeding pump to run at 50 milliliters (ml, unit of measurement) per hour (hr.) for 20 hours to provide 1,000 m/1,200 kilocalories (kcal, unit of measurement) of formula in 24 hours; start the infusion at 6 pm and stop the infusion at 2 pm. During a concurrent observation and interview on 3/24/2026 at 2:08 pm, together with Licensed Vocational Nurse 1 (LVN 1), Resident 66 was awake, lying in bed, in supine position with the HOB not elevated to 30 to 45 degrees and was connected to an ongoing GT feeding. LVN 1 stated Resident 66 was lying flat in bed and the HOB was not elevated to 30 to 45. LVN 1 stated Resident 66's HOB should have been elevated to 30 to 45 degrees while the feeding is ongoing to prevent aspiration pneumonia (a lung infection that occurs when food, liquid, saliva, or vomit was breathed into the airways instead of being swallowed into the stomach). During an interview on 3/26/2026, at 12:36 pm, with the Director of Nursing (DON), the DON stated Resident 66's HOB needed to be elevated from 30 to 45 degrees while receiving GT feeding to prevent aspiration.

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	055202	A. Building B. Wing	03/27/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services for residents receiving respiratory therapy (a specialized healthcare field focused on assessing, treating, and managing patients with breathing or cardiopulmonary disorders) in accordance with professional standards of practice for two of two sampled residents (Residents 41 and 67) by failing to: a. Ensure Resident 67's bilevel positive airway pressure (BIPAP, a non-invasive ventilator used to assist breathing) mask and nebulizer (a medical device accessory that fits over the nose and mouth to deliver liquid medication directly into the lungs) mask were stored appropriately when not in use. b. Ensure Resident 41's oxygen was set as ordered and nasal cannula tubing was not touching the floor while oxygen was in use. These failures placed Residents 41 and 67 at risk for complications related to the use of oxygen, shortness of breath and/or hypoxia (low levels of oxygen in the body tissues) and the risk of infection which could lead to respiratory complications. Findings: a. During a review of Resident 67's admission Record (AR), the AR indicated the facility initially admitted Resident 67 on 2/17/2026 and readmitted on [DATE] with diagnoses including acute respiratory failure (the lungs could not adequately supply oxygen to the blood or remove carbon dioxide), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty breathing), and bronchitis (inflammation if the bronchial tubes/airways in the lungs). During a review of Resident 67's Care Plan (CP) dated 2/18/2026, the CP indicated Resident 67 had COPD exacerbation (sudden worsening or increase in the severity of the disease). The CP interventions included the use of inhalation medication delivered via nebulizer. During a review of Resident 67's Minimum Data Set (MDS, a resident assessment tool) dated 2/23/2026, the MDS indicated Resident 67 had intact cognition (ability to understand and process information). The MDS indicated Resident 67 required setup or clean-up assistance (helper sets up or cleans up; resident completes the activity) with eating. The MDS indicated Resident 67 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene, toileting, upper/lower body dressing and personal hygiene. During a review of Resident 67's Order Summary Report (OSR) dated 3/13/2026, the OSR indicated Resident 67 had an order for licensed staff to administer BIPAP at bedtime and as needed for shortness of breath and an order for breathing treatment of Ipratropium-Albuterol solution to administer via nebulizer every six (6) hours for COPD exacerbation. During a review of Resident 67's CP dated 3/13/2026, the CP indicated Resident 67 required the use of BIPAP to assist with breathing and to maintain adequate oxygenation. During a concurrent observation inside Resident 67's room and interview on 3/26/2026 at 9:36 am with Registered Nurse Supervisor (RNS), Resident 67 was lying in bed with BIPAP and nebulizer mask left on top of Resident 67's bedside table. The RNS stated the BIPAP and nebulizer masks should be stored inside a clear, transparent bag intended for respiratory supplies when not in use to prevent contamination and spread of infection. During an interview on 3/26/2026 at 1:09 pm with the Director of Nursing (DON), the DON stated all respiratory supplies should be stored inside the transparent bag when not in use for infection control. (continued on next page)

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	055202	A. Building B. Wing	03/27/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedures (P&P) titled, Oxygen Administration, implemented on October 1, 2023, the P&P indicated, All oxygen tubing, humidifiers, masks, and cannulas used to deliver oxygen are for single use only and would be changed weekly and when visibly soiled. Oxygen items would be stored in a plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use. b. During a review of Resident 41's AR, the AR indicated the facility admitted Resident 41 on 8/23/2002 and re admitted on [DATE] with diagnoses including COPD and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 41's OSR dated 12/7/2025, the OSR indicated Resident 41 had an active order for oxygen at two liters per min (L/min) via nasal cannula (NC, a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) continuously for chronic hypoxic respiratory failure (the lungs cannot effectively exchange oxygen and carbon dioxide, leading to chronically low oxygen levels or high carbon dioxide levels in the blood). During a review of Resident 41's History & Physical (H&P) dated 12/8/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 41's CP revised 12/9/2025, the CP indicated Resident 41 was at risk for respiratory distress related to diagnoses of chronic heart failure (heart does not pump blood effectively causing fluid buildup in the lungs or body), COPD, pneumonia (an infection/inflammation in the lungs), acute respiratory failure (a condition caused by inadequate supply of oxygen and/or the inability to remove carbon dioxide from the lungs), interstitial pulmonary disease (progressive lung disease that occurs when lung tissue is damaged and scarred), and pleural effusion (a collection of fluid around the lungs). The CP interventions included for licensed staff to administer medication as ordered and oxygen at 2L/min via NC continuously. During a concurrent observation and interview on 3/24/2026 at 9:45 am with Licensed Vocational Nurse 1 (LVN 1) in Resident 41's room, Resident 41 was lying in bed with ongoing oxygen via NC. The NC tubing touched the bedroom floor. LVN 1 stated Resident 41 had COPD and used oxygen. LVN 1 stated Resident 41's ongoing oxygen level was set at 3.5 L/min and the tubing should not be touching the floor to prevent the resident from developing an infection. During an interview on 3/26/2026 at 1:00 pm with the DON, the DON stated the NC tubing on a resident receiving oxygen should not touch the floor and should be replaced for infection control. The DON stated registered nurses titrate oxygen levels and for a resident with an order of 2L of oxygen via NC and COPD diagnosis, the physician's order should be followed to prevent the resident from receiving excessive oxygen. The DON stated, the incorrect oxygen administration could lead to complications, putting the resident at risk for respiratory acidosis (body builds up carbon dioxide and becomes too acidic causing fatigue and other symptoms). During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, dated 10/1/2023, the P&P indicated, the P&P purpose was to prevent or reverse hypoxemia (low level of oxygen in the blood) and provide oxygen to the tissues. The P&P indicated, a physician's order was required to initiate oxygen therapy, except in an emergency situation and the order would include the oxygen flow rate. The P&P indicated, oxygen is stored in a clean, dry location for safe handling of oxygen/equipment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055202	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosemead Healthcare Center	4096 Easy Street El Monte, CA 91731

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to: a. Ensure three Bisacodyl suppositories (a fast-acting, rectal stimulant laxative used to treat constipation) were labeled with the resident's name and expiration date inside one of one medication storage room refrigerator. This deficient practice had the potential to result in adverse consequences for the residents. b. Ensure one of one E-Kit (Emergency Kit) IV (intravenous) did not have expired Levaquin (antibiotic to treat severe bacterial infections) medication. This deficient practice had the potential to result in harm from administration of expired medication. c. Ensure one of one resident (Resident 15) did not have a bottle of glucose tablets and one tube of diclofenac sodium topical gel (a medication used to relieve joint pain) in the resident's nightstand. This deficient practice had the potential to harm Resident 15 due to risk of error in dispensing and administration.Findings: a. During an observation and interview inside the medication storage room's refrigerator located in Nursing Station 1 with Registered Nurse 1 (RN1) on 3/27/26 at 7:23 AM, three Bisacodyl suppositories did not have a box. The suppositories did not have the resident's name or date indicating when the box was opened or when the suppositories will expire. RN1 stated the Bisacodyl suppositories should be inside a box indicating the expiration date. RN1 stated the Bisacodyl suppositories would not contain a specific resident's name because they were used on as needed basis for any resident who needed the medication. RN1 stated if the suppositories were kept in the refrigerator, they should have a date of when the box was opened and include an expiration date. b. During a concurrent observation and interview with RN1 on 3/27/26 at 7:41 AM, an E-kit containing IV medications was inspected. On the back of the E-Kit was a sticker indicating Levaquin 500mg with an expiration date of 4/30/24. RN1 stated RN1 was not sure if the Levaquin inside the E-kit was expired. RN1 stated that E-kits needed to be checked every shift by the Nursing Supervisor. RN1 stated licensed staff was supposed to document if any E-Kit had been opened. RN1 stated if a staff opened an E-Kit, the staff needed to call the pharmacy for a replacement and document who the staff spoke to at the pharmacy, documenting the date and time. RN1 stated an emergency kit needed to be available for the next resident who will need the medication and if it is not available or if the medication was expired, it would cause a delay for the resident to get the medication. During an interview with the Director of Nursing (DON) on 3/27/2026 at 8:52 AM, the DON stated nursing staff were responsible for checking the E-kits for expiration dates. The DON stated as soon as staff opened an E-kit, the staff needed to call the pharmacy for a replacement. The DON stated if staff sees an expired medication in the E-kit, the process was for the staff to call the pharmacy and report it so the pharmacy could exchange the E-kit, and the facility would get a new E-kit. The DON stated the suppositories that were found inside the refrigerator in the medication room of Nursing Station 1 should have been inside a box with either a resident's name or an expiration date. The DON stated the suppositories should not have been stored individually without proper identification. The DON stated it was not safe to administer expired medications to the residents. The DON state expired medication could be less effective over time, potentially losing the strength of the drug causing the residents not to receive the full effect of the medication. During a review of the facility's Policy and Procedure (P&P) titled, Storage of Medications, revised 12/2023, the P&P indicated, To ensure that medications are stored in an environment that guarantees (continued on next page)

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	055202	A. Building B. Wing	03/27/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	integrity and security in the facility. All expired medications should be removed from storage and destroyed per policy. During a review of the facility's P&P titled, Medication Labeling, revised 12/2023, the P&P indicated, To set forth a guideline for the labeling of medications from the pharmacy and in the facility. PRN (as needed) medications must have indication for use and frequency printed on the label. Non-legend (nonprescription) drugs may be packaged and labeled as above or may be used as ward stock or House Supply and remain in the original manufacturer's labeled container with the expiration date clearly readable. During a review of the facility's P&P titled, Availability and Use of Emergency Medications Kits, revised 12/2023, the P&P indicated, To provide the facility with medications for use in emergency situations, and to set guidelines for proper usage, documentation, and replacement by the pharmacy. The contents of all emergency kits are reviewed for usage, necessity, and prescribing patterns. During a review of the facility's P&P titled, Availability and Use of Intravenous Emergency Medications Kits, revised 12/2023, the P&P indicated, All E-kit contents are reviewed for upcoming outdates and recalls by the pharmacist.'' c. During a review of Resident 15's admission Record (AR), the AR indicated the facility admitted Resident 15 on 10/18/2025 and readmitted on [DATE] with diagnoses including osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of both knees and Type II Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 15's History & Physical (H&P) dated 10/19/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 15's Minimum Data Set (MDS, a resident assessment tool) dated 3/6/2026, the MDS indicated Resident 15 was cognitively intact (ability to think). During a review of Resident 15's Order Summary Report (OSR) dated 2/28/2026, the OSR indicated Resident 15 had an active order for Diclofenac Sodium External Gel 1% (Topical) to be applied to both ankles every six hours as needed for mild to moderate to severe joint pain. During a medication pass observation on 3/26/2026 at 8:35 am in Resident 15's room, Resident 15 was informed by Licensed Vocational Nurse 3 (LVN 3) that the Diclofenac Sodium External Gel 1% needed to be re-ordered and could not be administered at that time. Resident 15 stated, Resident 15 had Resident 15's own medication for Resident 15's legs and told LVN 3 to retrieve it from the nightstand for application. Inside Resident 15's bedside nightstand, LVN 3 found one store brand bottle of glucose tablets (15 grams of fast-acting carbohydrates per serving, with 38 tablets remaining in the bottle) and one used prescription tube of Diclofenac Sodium Topical Gel 1% (net weight 3.53 ounces [100 grams]) with a minimally intact prescription sticker that did not have information who the medication was prescribed for. During an interview on 3/26/2026 at 8:45 am with LVN 3, LVN 3 stated Resident 15 was not allowed to keep any medications at the bedside. LVN 3 stated the possession of glucose tablets and Diclofenac Sodium topical gel was dangerous for Resident 15 because the licensed nurses would not know when Resident 15 was taking the medications, allowing for re-administration after the (continued on next page)

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	055202	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosemead Healthcare Center	4096 Easy Street El Monte, CA 91731

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication had already been taken. LVN 3 stated, the Diclofenac topical gel was an NSAID (nonsteroidal anti-inflammatory drug-medication that treats pain, fever, and inflammation) and should come from the facility's pharmacy. LVN 3 stated licensed nurses kept the residents' medications in the medication cart, so they could monitor what medications the residents were receiving for their safety. During an interview on 3/26/2026 at 9:00 am with Registered Nurse Supervisor 1 (RN 1), RN 1 stated Resident 15 did not have a physician's order for glucose tablets nor to keep medications at the bedside and or to self-administer medications. RN 1 stated, it was dangerous for Resident 15 to have the glucose tablets because Resident 15 was diabetic and received insulin. RN 1 stated Resident 15 could have been double-dosing and there could have been contraindications between the medications (drugs that should not be used together due to the risk of adverse reactions). During an interview on 3/26/2026 at 9:07 am with the Director of Nursing (DON), DON stated there were no residents within the facility permitted to have medications at their bedside or self-administer medications. The DON stated all medications must be verified by the pharmacy or the physician to ensure it was appropriate for the resident. The DON stated medications kept by Resident 15 were a hazard because Resident 15 could have overdosed or had an adverse reaction. The DON further stated the resident may not know what they're taking, other residents could obtain and use the medications, and the licensed nurses would not know what medications the residents were taking. During a review of the facility's Policy and Procedure (P&P) titled, Storage of Medications, revised December 2023, the P&P indicated, its purpose was to ensure that medications were stored in an environment that guaranteed integrity and security in the facility. The P&P indicated, medications were stored in locked medication carts and/or locked medication rooms.

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	055202	A. Building B. Wing	03/27/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow proper food storage handling practices in accordance with its policy and procedure (P&P) for one of one facility kitchen. The test strips to measure the concentration of the sanitizing solution inside the red bucket did not have an expiration date. This deficient practice had the potential to result in foodborne illnesses. Findings: During the initial kitchen observation and interview with the Dietary Supervisor (DS) on 3/24/2026 at 8:30 AM, the DS used the test strips for the red bucket solution to measure the concentration of the sanitizing solution. The DS stated the kitchen staff use the solution in the red bucket to sanitize the food preparation areas in the kitchen. Upon closer inspection of the test strips, the test strip container did not have an expiration date. The DS stated the DS was not sure if the test strips were expired since there was no expiration date on the test strip container. During an interview with the kitchen staff dishwasher (DW) on 3/24/26 at 9:24 AM, the DW stated it was the responsibility of the DW to test the red bucket solution to ensure it had the required concentration of chemicals to kill bacteria. The DW stated this was important to prevent cross-contamination when the kitchen staff prepared food that would be served to the residents. The DW stated the test strips that were being used for the red bucket did not have an expiration date. The DW stated, I don't know if the testing results were correct if the strips were without an expiration date. The DW stated the kitchen staff use the red bucket solution to sanitize the surfaces where staff prepare food for the residents. The DW stated bacteria could be spread if the red bucket solution does not have the proper concentration to sanitize the areas. The DW stated if the residents ate contaminated food, it would make them sick. During a concurrent interview with the DS on 3/24/2026 at 9:38 AM, the DS stated if the facility was using the solution in the red bucket to clean and did not know if the test strips have expired, it would not give accurate reading, and the solution would not effectively sanitize. The DS stated this would cause cross contamination of the food and would make the residents sick. During an interview with the facility's Infection Control Nurse (IPN1) on 3/25/2026 at 11:40 AM, the IPN1 stated there could be cross contamination if the kitchen staff were testing the red bucket solution with strips that did not have an expiration date. The IPN1 stated, without an expiration date, staff would not know if the solution had the proper concentration to disinfect the food preparation areas. During a review of the facility's P&Ps titled, Infection Prevention and Control Program, reviewed 10/1/23, the P&P indicated, The ensure the Facility establishes and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with Federal and State requirements.

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	055202	A. Building B. Wing	03/27/2026

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to properly cover one of three large trash bins as indicated in the facility's Policy and Procedure (P&P) on garbage disposal. This deficient practice had the potential to attract vermin (animals that are harmful and carry diseases) and pests (any living thing that has a negative effect on humans) that could potentially enter the facility, affect the resident care areas, and expose the residents and staff to diseases. Findings: During a facility tour on 3/25/2026 at 7:39 AM, one large recycling trash bin had open lid and there was trash on the floor surrounding the trash bin area. During an observation and interview with Central Supply Staff (CS) on 3/25/2026 at 8:00 AM, CS was outside the facility in the parking lot with over twenty boxes of supplies that were delivered earlier in the morning. CS stated there was no more room for additional cardboard boxes in the recycling bin. CS stated CS would remove the new supplies from the cardboard boxes. CS stated CS would break down the empty boxes and leave them on the side of the trash bins or throw them inside the regular trash bins. CS stated the trash would be picked up the next day (3/26/26). During an interview with the Infection Prevention Nurse (IPN1) on 3/25/2026 at 11:39 AM, IPN1 stated the trash bin lids should be closed even if it was the recycling bin. The IPN1 stated the floor surrounding the trash bin area should be cleaned by housekeeping staff (HKP) because it was not sanitary and even if it was outside the facility, it could attract vermin or cockroaches. During an interview with the Dietary Supervisor (DS) on 3/25/2026 at 12:11 PM, the DS stated it was not acceptable to have trash on the floor surrounding the trash bin area and the trash bin lid left open. The DS stated the trash bin lid should be kept closed at all times because it was unsanitary and to prevent cross contamination (transfer from one substance or object to another, with harmful effect) and rodent infestation. During an interview with the Maintenance Supervisor (MS) on 3/26/2026 at 12:22 PM, MS stated the area where the big trash bins were located should be kept clean. The MS stated one of the kitchen staff went to throw out the trash and left the bag on the floor next to the trash bin overnight. The MS stated it was not acceptable for staff to leave trash bags or any type of trash outside the trash bins because it would attract rodents. The MS stated the trash bin lids should be closed to prevent any type of rodent activity and infestations causing harm to the residents. During an interview with the Director of Nursing (DON) on 3/26/2026 at 12:41 PM, the DON stated the trash bins should be always covered with lids for infection control. During a review of the facility's P&P titled, Garbage and Trash Can Use and Cleaning, revised 10/1/2023, the P&P indicated, Food waste will be placed in covered garbage and trash cans. During a review of the facility's P&P titled, Pest Control, revised 10/1/2023, the P&P indicated, To ensure the facility is free of insects, rodents, and other pests that could compromise the health, safety, and comfort of residents, facility staff, and visitors. Garbage and trash are not permitted to accumulate in any part of the facility.

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	055202	A. Building B. Wing	03/27/2026

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: a. Keep two of two laundry dryers in a safe and sanitary condition for residents. This deficient practice posed as potential fire hazard.b. Keep electric fans (a powered machine used to create a flow of air to cool and ventilate rooms and control humidity) provided to the residents were in a safe, operating, and sanitary condition for two of two sampled residents (Residents 30 and 90). This deficient practice had the potential to affect Resident 30 and Resident 90's health and quality of life. Findings: a. During a concurrent observation and interview on 3/26/2026 at 10: 36 am with Housekeeping 2 (HKP 2) in the facility's laundry room, there were two dryers in the laundry room. Both dryers had multiple random thick patches of brown material in the dryer lint trap. HKP 2 stated the dryer lint trap accumulated thick lint. HKP 2 stated the dryer lint trap needed to be cleaned every 2 hours to avoid potential fire. During an interview on 3/26/2026 at 12:20 pm with the Maintenance Supervisor (MS), the MS stated the dryer lint trap was thick and lint had accumulated since the morning of 3/26/2026. The MS stated the dryer lint trap should have been cleaned every 2 hours to avoid fire. During a review of the undated facility's Policy and Procedure (P&P) titled, Policy on Dryer Lint Traps Cleaning and Reporting of Faulty Equipment, the P&P indicated a clean dryer vent lint trap is important not only does it lead to greater efficiency in the dryer but will also prevent any kind of fire hazard. Lint traps MUST be cleaned every 2 hours by designated laundry staff personnel. b. During a review of Resident 30's admission Record (AR), the AR indicated the facility initially admitted Resident 30 on 9/26/2025 and readmitted on [DATE] with diagnoses including malignant neoplasm (a cancerous, abnormal growth of cells) of the cervix, immunodeficiency (compromised immune system), and diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 30's Minimum Data Set (MDS, a resident assessment tool) dated 1/9/2026, the MDS indicated Resident 30 had intact cognition (ability to understand and process information). The MDS indicated Resident 30 was independent (resident completes the activity by self) with eating and oral hygiene. The MDS indicated Resident 30 required partial/moderate assistance (helper did less than half the effort) with toileting, shower, upper/lower body dressing and personal hygiene. During a concurrent observation inside Resident 30's room and interview on 3/24/2026 at 10:56 am with Licensed Vocational Nurse 2 (LVN 2), Resident 30 was lying in bed with a standing black electric fan spinning next to Resident 30's bed. LVN 2 stated the black fan's cover and blades were dusty. During a review of Resident 90's AR, the AR indicated the facility initially admitted Resident 90 on 10/3/2025 and readmitted on [DATE] with diagnoses including heart failure (the heart muscle could not pump enough blood to meet the body's needs for oxygen), chronic kidney disease (CKD, long-term, progressive loss of kidney function), and anemia (a condition where the body does not have enough healthy red blood cells). (continued on next page)

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	055202	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosemead Healthcare Center	4096 Easy Street El Monte, CA 91731

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 90's MDS dated [DATE], the MDS indicated Resident 90 had moderately impaired cognition. The MDS indicated Resident 90 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity) with eating, partial/moderate assistance with oral hygiene and upper body dressing and substantial/maximal assistance (helper did more than half the effort) with toileting, shower, and lower body dressing. During a concurrent observation inside Resident 90's room and interview on 3/24/2026 at 10:41 am with LVN 2, Resident 90 was sitting in a wheelchair with a standing black electric fan in front of Resident 90. LVN 2 stated the electric fan's cover and blades were dusty. LVN 2 stated the facility provided electric fans inside the residents' room. LVN 2 stated the electric fans should be maintained clean to prevent the residents from inhaling the dust and causing respiratory complications. During an interview on 3/25/2026 at 11:22 am with the Infection Prevention Nurse (IPN), the IPN stated housekeeping staff should clean the electric fan inside the resident's room to prevent the resident from breathing in dust leading to exacerbation of respiratory infections. During an interview on 3/26/2026 at 1:44 pm with the Director of Nursing (DON), the DON stated all equipment inside the resident's room should be maintained clean, free from dust and in good working condition for the safety of the resident. During a review of the facility's P&P titled, Maintenance Services, implemented on October 1, 2023, the P&P indicated the facility will protect the health and safety of residents, visitors, and facility staff. The P&P indicated the facility will maintain all mechanical, electrical, and patient care equipment in safe operating condition.

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	055202	A. Building B. Wing	03/27/2026

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote and treat one of one sampled resident (Resident 66) with respect, privacy and dignity in accordance with facility's policy titled Resident Rights - Quality of Life. This deficient practice had the potential to cause psychosocial (mental and emotional well-being) decline and low self-esteem.Findings: During a review of Resident 66's admission Record (AR), the AR indicated Resident 66 was admitted to the facility on [DATE] with diagnoses including encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support), and chronic obstructive pulmonary disease (COPD-type of obstructive lung disease characterized by long-term poor airflow) During a review of Resident 66's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/21/2026, the MDS indicated Resident 66 had severely impaired cognition for daily decision making. The MDS indicated Resident 66 was dependent (helper did all the effort and lifted or held trunk or limbs) on staff for oral hygiene, toileting, lower body dressing, putting on/taking off footwear, and personal hygiene. During a concurrent observation and interview on 3/24/2026 at 10:12 am with Registered Nurse 1 (RN 1), Resident 66's room. Resident 66 was awake, lying in bed. RN 1 pulled up Resident 66's gown and assessed Resident 66's GT site. RN 1 did not pull and close the privacy curtain to provide Resident 66's privacy exposing Resident 66's abdominal area to roommate and the hallway. RN 1 stated the privacy curtain and Resident 1's door needed to be closed prior to providing care and treatment to the resident to provide privacy, comfort and prevent embarrassment from the roommate and passerby. During a concurrent interview on 3/26/2026 at 12:37 pm with the facility's Director of Nursing (DON), the DON stated the resident's privacy curtain needed to be closed prior to providing care and treatment to residents to provide privacy and dignity to the residents. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights - Quality of Life, dated 10/1/2023, the P&P indicated Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect and individuality. Facility staff promotes, maintains, and protects resident privacy, including bodily privacy, when assisting with personal care and during treatment procedures.

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	055202	A. Building B. Wing	03/27/2026

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure policies and procedures (P&P) on Advance Directive (AD, a legal document indicating resident preferences on end-of-life treatment decisions) were implemented for one of one sampled resident (Resident 93) by failing to ensure Resident 93's AD information was available in the medical record.This failure had the potential for the facility staff to provide medical treatment and services against the will of Resident 93.Findings:During a review of Resident 93's admission Record (AR), the AR indicated the facility admitted Resident 93 on 8/14/2025 with diagnoses including acute osteomyelitis (an inflammation of bone or bone marrow, usually due to infection) of the right femur (thigh bone) and Type II Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet). During a review of Resident 93's History & Physical Note (H&P), dated 8/15/2025, the H&P indicated the resident had the capacity to understand and make decisions and no Physician Orders for Life-Sustaining Treatment (POLST, a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) or AD record was in the medical record. During a review of Resident 93's Minimum Data Set (MDS, a resident assessment tool), dated 2/18/2026, the MDS indicated Resident 93 had moderately impaired cognition (ability to think). During a concurrent interview and record review on 3/25/2026 at 10:13 am with Licensed Vocational Nurse 1 (LVN 1), Resident 93's medical record (paper chart and electronic medical record) was reviewed. Resident 93's medical record indicated no AD or POLST documentation was present. LVN 1 stated that the AD and POLST should be in Resident 93's medical record. LVN 1 further stated that the information should be available to nurses for emergency situations to allow acknowledgment and respect of the resident's code status (refers to a patient's documented wishes about what medical actions should be taken if their heart or breathing stops [a life-threatening emergency]) choices and decisions. During an interview on 3/25/2026 at 10:20 am with Social Services Director (SSD), SSD stated that SSD kept a folder with copies of residents' POLST and Advance Directives in the SSD office. SSD stated that the original copies should be kept in the resident's paper chart or in the electronic medical record. SSD stated she did not know why Resident 93's chart lacked copies of the POLST or AD, but stated SSD would make copies and add them in the medical records. During an interview on 3/26/2026 at 12:58 pm with the Director of Nursing (DON), DON stated that the AD and POLST should be kept in the resident's chart and the Medical Records Director should maintain a copy. DON stated, during an emergency, nursing staff needed access to the resident's AD information quickly and the DON preferred a hard copy present in the physical chart for convenience. DON stated that it was important to have this information to allow the licensed nurses to respect the resident's wishes and decide what was the resident's next step of care based on their condition. During a review of the facility's policy and procedure (P&P) titled, Advance Directives, dated 10/1/2023, the P&P indicated during emergency situations the Charge Nurse would be required to inform emergency medical personnel of the resident's AD regarding treatment options. The P&P indicated, nursing staff would provide emergency staff with a copy of the directive if the resident was transferred to the hospital in an ambulance. The P&P indicated, copies of a resident's AD will be included in the resident's medical record.

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	055202	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosemead Healthcare Center	4096 Easy Street El Monte, CA 91731

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident's (Resident 41) Minimum Data Set (MDS, a federally mandated resident assessment tool) assessment was accurately coded regarding supplemental oxygen (is extra oxygen [a gas essential for life] given to a person to help them breathe when their body is not getting enough oxygen on its own) use. This failure had the potential to result in a delay of necessary care and treatments, incorrect plan of care, and interventions for Resident 41.Findings:During a review of Resident 41's admission Record (AR), the AR indicated the facility admitted Resident 41 on 12/7/2025 with diagnoses including chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 41's History & Physical (H&P), dated 12/8/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 41's Order Summary Report (OSR) for the active orders as of 3/26/2026, the OSR indicated Resident 41 had an active order for oxygen at two liters per minute (L/min) via nasal cannula (NC, a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) continuously for a diagnosis of chronic hypoxic respiratory failure (a long-term chronic condition where the lungs cannot supply enough oxygen to the blood), ordered on 12/7/2025. During a review of Resident 41's Minimum Data Set (MDS, a resident assessment tool), dated 12/31/2025, the MDS indicated Resident 41 had intact cognition (ability to think) and did not indicate oxygen therapy use while a resident. During a review of Resident 41's Care Plan Report (CP), dated 12/9/2025, the CP indicated, Resident 41 was at risk for respiratory distress related to diagnoses of chronic heart failure (heart does not pump blood effectively causing fluid buildup in the lungs or body), COPD, pneumonia (an infection/inflammation in the lungs), acute respiratory failure (a condition caused by inadequate supply of oxygen and/or the inability to remove carbon dioxide from the lungs), interstitial pulmonary disease (progressive lung disease that occurs when lung tissue is damaged and scarred), and pleural effusion (a collection of fluid around the lungs). The CP had an intervention to administer medication as ordered: oxygen at 2L/min via NC continuously, initiated on 2/17/2026. During a concurrent observation and interview on 3/24/2026 at 9:45 am with Licensed Vocational Nurse 1 (LVN 1) in Resident 41's room, Resident 41 was lying in bed receiving oxygen via NC on, and the NC tubing was touching the bedroom floor. LVN 1 stated that Resident 41 had COPD and used oxygen. During an interview on 3/26/2026 at 1:00 pm with the Director of Nursing (DON), DON stated Resident 41 used oxygen due to respiratory issues. DON stated, Resident 41's oxygen usage should be indicated on the MDS and MDS submissions needed to be accurate as they reflected a resident's current status. During a concurrent interview and record review on 3/26/2026 at 1:51 pm with Minimum Data Set Coordinator (MDSC), Resident 41's Order Summary Report and MDS were reviewed. Resident 41's MDS indicated no use of oxygen while a resident and OSR indicated oxygen at two liters per min (L/min) via nasal cannula continuously for a diagnosis of chronic hypoxic respiratory failure, ordered on 12/7/2025. MDSC stated that it was coded incorrectly on the MDS and should have been coded for continuous oxygen use while a resident. MDSC stated that it was important to code accurately for reimbursement purposes, to allow The Centers for Medicare and Medicaid Services (CMS) to see the resident's condition, and because it was the basis of the residents' care plans. During a review of the facility's policy and procedure (P&P) titled, RAI Process, last revised on 5/19/2025, the P&P indicated the facility will utilize the Resident Assessment Instrument (RAI, a standardized system used to assess, plan, and evaluate a resident's care needs) process as the basis for the accurate assessment of each resident's functional capacity and health status, as outlined in the CMS RAI Manual. The P&P indicated each resident's assessment will be coordinated by and certified as complete by a registered nurse, and all individuals who complete a portion of the assessment will sign and certify to the accuracy of the portion of the assessment he or she completed. The P&P indicated, all information (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recorded within the MDS Assessment must reflect the resident's status at the time of the Assessment Reference Date (ARD). During a review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1, dated October 2025, the manual indicated the RAI process had multiple regulatory requirements. The manual indicated, federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) required that the assessment accurately reflect the resident's status.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review, the facility failed to maintain the integrity and proper labeling of a peripheral intravenous (IV, within a vein, a small, flexible tube [catheter] inserted into a vein to deliver fluids, medications, or nutrients directly into the bloodstream) site in accordance with professional standards of practice for one of one sampled resident (Resident 99). This failure had the potential to result in infection and accidental IV dislodgement for Resident 99. Findings: During a review of Resident 99's admission Record (AR), the AR indicated the facility admitted Resident 99 on 3/23/2026 with diagnoses including urinary tract infection (UTI, an infection in the bladder/urinary tract), dementia (characterized by progressive decline in cognitive function), and muscle weakness (loss of muscle strength). During a review of Resident 99's Minimum Data Set (MDS, a resident assessment tool), dated 3/29/2026, the MDS indicated Resident 99 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 99 required partial/moderate assistance (helper did less than half of the effort) with eating and oral hygiene. The MDS indicated Resident 99 required substantial/maximal assistance (helper did more than half the effort) with toileting, shower, upper/lower body dressing, and personal hygiene. The MDS indicated Resident 99 had an IV peripheral line. During a review of Resident 99's Order Summary Report (OSR) for the active orders as of 3/26/2026, the OSR indicated Resident 99 had an order to monitor IV site for signs of inflammation (the vein becomes irritated and inflamed)/infiltration (IV fluid leaks out of the vein into the surrounding tissue) every shift with an order date of 3/23/2026. During a review of Resident 99's Care Plan Report (CP), initiated on 3/24/2026, the CP indicated Resident 99 had IV peripheral line for antibiotic (a type of medication used to treat bacterial infection) medication administration. The CP's Interventions section included an intervention to change and label IV dressing and to monitor IV site for signs of inflammation and infiltration. During a concurrent observation inside Resident 99's room and interview on 3/24/2026 at 9:59 am with the Director of Nursing (DON), Resident 99 was lying in bed with peripheral IV line on Resident 99's right hand. The DON stated the IV site dressing was loose and tapes were coming out. Observed the IV site dressing was not labeled with the insertion date. The DON stated peripheral IV line should be labeled with date the IV line was inserted to keep track of when to change or rotate the IV site. The DON stated IV site should be changed or rotated every seventy-two (72) hours to prevent infection and skin irritation. During a review of the facility's policy and procedure (P&P) titled, Intravenous Site Care, implemented on October 1, 2023, the Purpose section of the P&P indicated, Reduce the risk of local and bloodstream infections (such as phlebitis or catheter-related bloodstream infections) through proper routine site maintenance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its infection control policy for one of five sampled residents (Resident 91) by failing to ensure Resident 91's urinal filled with urine was not placed on top of Resident 91's side table. This deficient practice had the potential to result in Resident 91 developing an infection.Findings: During a review of Resident 91's admission Record (AR), the AR indicated Resident 91 was admitted to the facility on [DATE] with diagnosis including encephalopathy (a brain dysfunction caused by infection and brain injury), respiratory failure (lungs can't supply oxygen to the blood) and other immunodeficiencies (immune system in the body is weak or absent reducing the body's ability to fight infectious diseases). During a review of Resident 91's History and Physical (H&P) dated 3/4/26, the H&P indicated Resident 91 had the capacity to understand and make decisions. During a review of Resident 91's Minimum Data Set (MDS, a resident assessment and care screening tool), dated 3/10/26, the MDS indicated Resident 91 was dependent (helper does all of the effort) for eating, oral and toileting hygiene, shower, upper and lower body dressing, putting on and taking off footwear and personal hygiene. During a review of Resident 91's CP initiated on 3/16/26, the CP indicated the resident had impaired immunity related to immunodeficiencies. The CP interventions indicated Resident 91 was at risk for contracting infections due to impaired immune status and to keep the environment clean and people with infection away. During an observation and interview inside Resident 91's room on 3/24/26 at 9:56 AM, Resident 91 was resting in bed holding a urinal with yellow liquid inside. Resident 91 placed the urinal on top of Resident 91's side table next to a water pitcher and a cup of water. During a concurrent observation and interview inside Resident 91's room on 3/26/26 at 7:48 AM, Resident 91's side table had a urinal containing yellow liquid inside. Some of the yellow liquid was dripping on the outside of the urinal landing on Resident 91's side table. A urinal holder was attached to the bottom of Resident 91's bed. Resident 91 stated Resident 91 could not reach the urinal holder so Resident 91 placed the urinal on top of the side table. During an observation and interview with the Treatment Nurse (TN) on 3/26/26 at 7:58 AM, the TN stated Resident 91's urinal had urine inside and should not be placed on top of Resident 91's side table. The TN stated Resident 91 would put Resident 91's food and drink on the side table. The TN stated having a urinal filled with urine on top of the side table was an infection control issue. The TN stated having a urinal filled with urine on top of the resident's side table could cause bacteria to spread to Resident 91's foods or drink. During an interview with the Infection Prevention Nurse (IPN) on 3/26/26 at 9:27 AM, the IPN stated a urinal placed on top of a resident's side table was an infection control issue because it was not sanitary and could potentially contaminate the resident's food. The IPN stated the resident's side table should be a clean surface used for meals and personal care. The IPN stated when a urinal filled with urine was kept on the side table, it created a risk for contamination of other items. The IPN stated having a urinal with urine on Resident 91's side table posed a risk of spillage and contaminating areas on Resident 91's table. During a review of the facility's Policy and Procedure titled, Infection Prevention and Control Program, revised 10/1/23, the P&P indicated, The facility establishes and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with Federal and State requirements. During a review of the facility's P&P titled, Urinal and Bedpan-Offering and Removing, revised 10/1/23, the P&P indicated, to remove urinal or bedpan from the resident's bedside stand.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a Surveillance Data Collection Form (SDCF) dated 3/24/2026 for one of five sampled residents (Resident 96) receiving antibiotics. This deficient practice had the potential to result in increased antibiotic resistance and providing antibiotics without justification for Resident 96. Findings: During a review of Resident 96's admission Record (AR), the AR indicated Resident 96 was admitted to the facility on [DATE] with diagnoses including Extended Spectrum Beta-Lactamase (ESBL - bacteria that is not easily killed by antibiotics) resistance and urinary tract infection (UTI- infection that affects part of the urinary tract). During a review of Resident 96's Order Summary Report (OSR) dated 3/23/2026, the OSR indicated a physician's order for licensed staff to administer Meropenem (antibiotics, a substance used to kill bacteria and to treat infections) Intravenous (IV) Solution Reconstituted, one (1) gram (gr.- unit of measurement) IV two times a day for UTI/ESBL urine until 3/30/2026; administer at 6 am and 6 pm. During an interview on 3/26/2026 at 9:56 am with the facility's Infection Preventionist Nurse (IPN- a healthcare professional who specializes in preventing the spread of infections in healthcare settings), the IPN stated when Resident 96 was admitted to the facility from the hospital, Resident 96 continued the antibiotics and the facility did not confirm with Resident 96's physician. The IPN stated the IPN did not fill out the SDCF dated 3/24/2026 completely. The IPN stated the SDCF needed to be filled out to ensure Resident 96 was screened before initiating antibiotic therapy to ensure antibiotic use was appropriate, met the criteria for the provision of antibiotics and prevented antibiotic resistance on Resident 96. During an interview on 3/26/2026 at 12:26 am with the facility's Director of Nursing (DON), the DON stated the SDCF needed to be completely filled out to determine if the resident met the criteria before receiving antibiotic therapy. During a review of the facility's Policy and Procedure (P&P) titled, Antibiotic Stewardship Program, dated 7/31/2025, the P&P indicated the antibiotic stewardship Program (ASP) was designed to promote the appropriate use of antibiotics while optimizing the treatment of infections, and simultaneously reducing the possible adverse events associated with antibiotic use. The P&P indicated, the IP will collect and analyze infection surveillance data and monitor the adherence to the ASP.