STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monte Vista Healthcare Center	802 Buena Vista Street Duarte, CA 91010

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an injury of unknown origin for one of ten sampled residents (Resident 2) to the local Ombudsman (an official appointed to investigate individuals' complaints against facility administration), to the Police, and to the State Survey Agency within two (2) hours of obtaining Resident 2's right hip X-ray results, in accordance with facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating. This failure had the potential to place Resident 2 at risk for further injury and/or harm from abuse and/or other sources.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 which included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness in the arm, leg, and face on one side of the body) following cerebral infarction (stroke, damage to brain tissue caused by loss of blood flow to a part of the brain). During a review of Resident 2's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 4/19/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 10/9/2025, the MDS indicated Resident 2 was dependent (helper does all the effort to complete the activity) on others for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and chair/bed-to-chair transfers. During a review of Resident 2's bilateral hip X-ray results, dated 12/21/2025 and timed at 9:14 am, the X-ray results indicated Resident 2 had a suspected acute right femur fracture. During a review of Resident 2's Change In Condition Evaluation (CIC), dated 12/21/2025 and timed at 1:56 pm, the CIC indicated Resident 2's bilateral hip X-ray results indicated Resident 2 had a suspected right femur fracture and Resident 2's primary physician recommended Resident 2 to be transferred to GACH 1 for further evaluation. During a review of Resident 2's Nurses Note (NN), dated 12/21/2025 and timed at 4:30 pm, the NN indicated Resident 2 was picked up by an ambulance and transferred out to GACH 1 at 4:20 pm. During a review of Resident 2's GACH 1 right hip X-ray, dated 12/22/2025 and timed at 9:11 am, indicated Resident 2 had an acute right femur fracture. During an interview on 1/9/2026 at 3:30 pm with the Director of Nursing (DON), the DON stated the facility did not do an investigation to determine how Resident 2 sustained the right femur fracture and did not report Resident 2's injury of unknown origin (right femur fracture) to the local Ombudsman (an official appointed to investigate individuals' complaints against facility administration), to the Police, and to the State Survey Agency within two (2) hours of obtaining Resident 2's right hip X-ray results. The DON stated the facility did not follow their policy on investigating injuries of unknown origin. During a review of the facility's policy and procedure (P&P) tiled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, (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
	055817	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monte Vista Healthcare Center	802 Buena Vista Street Duarte, CA 91010

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 9/2022, the P&P indicated, All reports of resident abuse (including injuries of unknown origin) .are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monte Vista Healthcare Center	802 Buena Vista Street Duarte, CA 91010

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to investigate an injury of unknown origin for one of ten sampled residents (Resident 2) after Resident 2's bilateral hip (involving both hips) X-ray (picture or digital image of the inside of the body) results, dated 12/21/2025 and timed at 9:14 am, indicated Resident 2 had a suspected acute right femur (thigh bone) fracture (a partial or complete break in the bone). Resident 2 was transferred and admitted to General Acute Care Hospital (GACH) 1 on 12/21/2025 at 4:44 pm. Resident 2's GACH 1 right hip X-ray results, dated 12/22/2025 and timed at 9:11 am, indicated Resident 2 had an acute right femur fracture. This failure had the potential to place Resident 2 at risk for further injury and/or harm from abuse and/or other sources. 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 which included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness in the arm, leg, and face on one side of the body) following cerebral infarction (stroke, damage to brain tissue caused by loss of blood flow to a part of the brain). During a review of Resident 2's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 4/19/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 10/9/2025, the MDS indicated Resident 2 was dependent (helper does all the effort to complete the activity) on others for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and chair/bed-to-chair transfers. During a review of Resident 2's bilateral hip X-ray results, dated 12/21/2025 and timed at 9:14 am, the X-ray results indicated Resident 2 had a suspected acute right femur fracture. During a review of Resident 2's Change In Condition Evaluation (CIC), dated 12/21/2025 and timed at 1:56 pm, the CIC indicated Resident 2's bilateral hip X-ray results indicated Resident 2 had a suspected right femur fracture and Resident 2's primary physician recommended Resident 2 to be transferred to GACH 1 for further evaluation. During a review of Resident 2's Nurses Note (NN), dated 12/21/2025 and timed at 4:30 pm, the NN indicated Resident 2 was picked up by an ambulance and transferred out to GACH 1 at 4:20 pm. During a review of Resident 2's GACH 1 right hip X-ray, dated 12/22/2025 and timed at 9:11 am, indicated Resident 2 had an acute right femur fracture. During an interview on 1/9/2026 at 3:30 pm with the Director of Nursing (DON), the DON stated the facility did not do an investigation to determine how Resident 2 sustained the right femur fracture and did not report Resident 2's injury of unknown origin (right femur fracture) to the local Ombudsman (an official appointed to investigate individuals' complaints against facility administration), to the Police, and to the State Survey Agency within two (2) hours of obtaining Resident 2's right hip X-ray results. The DON stated the facility did not follow their policy on investigating injuries of unknown origin. During a review of the facility's policy and procedure (P&P), dated 9/2022, the P&P indicated, All reports of resident abuse (including injuries of unknown origin) .are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monte Vista Healthcare Center	802 Buena Vista Street Duarte, CA 91010

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 4 did an assessment including vital signs (VS - measurements of the body's basic functions, such as heart rate, breathing rate, blood pressure, and temperature) and documented the assessment and VS on the medical record for one of 10 sampled residents (Resident 2) before and after Resident 2 went to an outside doctor's appointment. This failure had the potential for Resident 2's change in condition to be unmonitored which could result in delayed care and services.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 which included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness in the arm, leg, and face on one side of the body) following cerebral infarction (stroke, damage to brain tissue caused by loss of blood flow to a part of the brain). During a review of Resident 2's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 4/19/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 10/9/2025, the MDS indicated Resident 2 was dependent (helper does all the effort to complete the activity) on others for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and chair/bed-to-chair transfers. During a concurrent interview and record review on 1/8/2026 at 1:30 pm with the Director of Nursing (DON), the DON stated Resident 2 went out to an appointment with a pain doctor (a physician who specializes in treating chronic pain) on 12/19/2025. The DON was unable to find a Nurses Note (NN) and an assessment with VS in Resident 2's medical record regarding Resident 2's appointment with the pain doctor on 12/19/2025. During an interview on 1/9/2026 at 3 pm with Licensed Vocational Nurse (LVN) 4, LVN 4 stated LVN 4 was assigned to take care of Resident 2 on the day shift (7 am - 3:30 pm) of 12/19/2025. LVN 4 stated on 12/19/2025, Resident 2 had an appointment with the pain doctor and went to the appointment with Resident 2's spouse. LVN 4 stated when Resident 2 left for and returned from the pain doctor's appointment on 12/19/2025, LVN 4 did not do an assessment or check Resident 2's vital signs. LVN 4 stated it is facility policy to complete and do assessments including VS when residents leave for and return from outside appointments. During an interview on 1/9/2026 at 3:30 pm with the DON, the DON stated the licensed nurse assigned to the resident should document VS and an assessment when a resident leaves and returns to the facility for doctor's appointment. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 7/2017, the P&P indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.