

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055817	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/17/2026
NAME OF PROVIDER OR SUPPLIER Monte Vista Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation - Reporting and Investigating, dated 4/2021, for one of three sampled residents (Resident 3) on 1/30/2026 by failing to report Resident 3's allegation of abuse within two hours and failing to remove Certified Nursing Assistant (CNA) 1 from resident contact immediately after Resident 3 made an allegation of abuse involving CNA 1. These deficient practices had the potential for Resident 3 to feel unsafe and for Resident 3 to be subjected to abuse. Findings: During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE] with multiple diagnoses including dementia (a progressive state of decline in mental abilities) and urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 3's Minimum Data Set (MDS - resident assessment tool), dated 2/5/2026, the MDS indicated Resident 3 had moderately impaired cognition (ability to understand and process information) and was dependent (helper does all of the effort to complete activity) on staff for toileting hygiene and bathing. During a review of Resident 3's Progress Notes (PN), dated 1/30/2026 and timed at 1:55 PM, the PN indicated two CNAs reported Resident 3 had complained that a CNA (unidentified) grabbed Resident 3's upper arm resulting in a small area of redness. The PN further indicated the two CNAs stated the redness on Resident 3's arm was present before Resident 3 was assisted by the CNAs. During a review of Resident 3's Change in Condition Evaluation (COC), dated 1/30/2026 and timed at 2:30 PM, the COC indicated a CNA grabbed Resident 3's upper arm, resulting in a small area of redness. The COC further indicated Resident 3's mental status was assessed, and Resident 3 did not know the current location, situation and date/time. During a review of Resident 3's Post-Event Review -V2 (PER), dated 1/30/2026 and timed at 6 PM, the PER indicated Resident 3 alleged a Certified Nurse Assistant (CNA) scratched or ripped Resident 3's arm. The PER indicated Resident 3 had a diagnosis of dementia and an active UTI and provided inconsistent statements to staff consistent with dementia and UTI related delirium. During an interview on 2/17/2026 at 2:12 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated LVN 1 worked as a charge nurse during the 7 am to 3 PM shift on 1/30/2026. LVN 1 stated Resident 3 was generally forgetful, anxious and would repeatedly ask for things even after it was already provided to Resident 3. LVN 1 stated CNA 1 reported to LVN 1 that Resident 3 alleged CNA 1 had grabbed Resident 3's arm while changing Resident 3's soiled brief. LVN 1 then went to Resident 3's room to assess Resident 3's skin and found no new marks or discoloration on Resident 3's arms. Afterwards, LVN 1 reported the incident to the Infection Prevention Nurse (IPN) and LVN 1 began documenting the incident. LVN 1 stated Resident 3's PN dated 1/30/2026 at 1:55 PM was correct and the incident happened around that time. During an interview on 2/17/2026 at 2:37 PM with the IPN, the IPN stated on 1/30/2026 CNA 1 had reported the incident with Resident 3 to the IPN. The IPN instructed CNA 1 to report the incident to LVN 1. The IPN went into Resident 3's room to assess Resident 3's skin and the IPN did not</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055817
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>note any scratches, opened skin or redness. The IPN stated the incident occurred around 2 PM on 1/30/2026. The IPN stated it was important to report any allegation of abuse within two hours to ensure an investigation can be done properly and ensure the residents were protected. During a telephone interview on 2/17/2026 at 3:19 PM with CNA 1, CNA 1 recalled the incident with Resident 3 on 1/30/2026. CNA 1 stated on 1/30/2026 after changing Resident 3's soiled brief with CNA 2, Resident 3 accused CNA 1 of ripping off Resident 3's skin while being repositioned. CNA 1 stated CNA 1 did not hurt Resident 3 and tried to show Resident 3 that Resident 3's skin was not torn. CNA 1 stated CNA 1 reported the allegation to LVN 1 and wrote a statement about the incident. CNA 1 stated CNA 1 also reported the incident to the IPN because LVN 1 was a new employee and CNA 1 was unsure how to proceed after the allegation. CNA 1 stated the incident occurred sometime between 2:30 PM and 3 PM on 1/30/2026. CNA 1 stated CNA 1 was not instructed to leave the patient care area and entered Resident 3's room one more time after Resident 3's allegation to answer Resident 3's call light. CNA 1 stated an employee with an allegation of abuse from a resident should not enter the resident's room because it could scare the resident. During an interview on 2/17/2026 at 4:55 PM with the Director of Nursing (DON), the DON stated the DON was in meetings on 1/30/2026 from 2 PM to 3 PM and the facility staff should have reported Resident 3's allegation immediately instead of waiting for the DON to become available. The DON stated, CNA 1 should have been suspended immediately and the incident reported right away to prevent any interference with the facility investigation and to protect the well-being of Resident 3. During a review of the facility's P&P titled, Abuse, Neglect, Exploitation and Misappropriation - Reporting and Investigating, dated 4/2021, the P&P indicated, 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 3. 'Immediately' is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury. 6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete.</p>		