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	06/03/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure complete and accurate medical records for one of three sampled residents (Resident 1) when Resident 1's Documentation Survey Report (DSR - certified nursing assistant's [CNA's] documentation of care provided to the resident) regarding turning and repositioning Resident 1 every two hours was not completed on 4/12/2026, 4/13/2026, 4/15/2026, 4/17/2026, 4/18/2026, and on 4/20/2026 to 4/25/2026.This failure resulted in Resident 1's medical record containing incomplete information and had the potential for Resident 1 to receive inappropriate care and treatment resulting in delayed wound healing or worsening of Resident 1's pressure ulcers (localized damage to the skin and/or underlying tissue usually over a bony prominence).Findings:During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was initially admitted to the facility on [DATE] with diagnoses including malignant neoplasm of prostate (prostate cancer), malignant neoplasm of bone and articular cartilage (primary bone cancer), pressure ulcer sacral (localized damage to the skin and/or underlying tissue of the tailbone), and paraplegia (partial or complete paralysis of the lower half of the body).During a review of Resident 1's History & Physical Examination (H&P), dated 4/10/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 4/19/2026, the MDS indicated Resident 1's cognitive (the ability to think and process information) skills for daily decision making were independent (decisions consistent/reasonable). The MDS indicated Resident 1 required extensive assistance of staff to move around in bed, to move to or from bed, chair, and wheelchair, and with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 1's CPs, titled Sacrum Unstageable Pressure Injury and Right Gluteus (buttocks) Pressure Injury Stage 3 (Full-thickness loss of skin. Dead and black tissue may be visible), dated 4/9/2026, the CPs indicated a goal of, Will heal without further complication until next review date and an intervention of, Turn and reposition every 2 hours and prn (done as needed or requested). During a review of Resident 1's DSR, dated April 2026, the DSR indicated there was no documentation that Resident 1 was turned and repositioned regarding turning and repositioning Resident 1 every two hours on:a. 4/12/2026 at 7 AM, 9 AM, 11 AM, and 1 PM.b. 4/13/2026 at 5 AM, 7 AM, 9 AM, 11 AM, and 1 PM.c. 4/15/2026 at 11 PM.d. 4/17/2026 and 4/22/2026 at 3 PM, 5 PM, 7 PM, and 9 PM.e. 4/18/2026 at 7 AM, 9 AM, 11 AM,1 PM, and 11 PM.f. 4/20/2026 to 4/25/2025 at 7 AM, 9 AM, 11 AM,1 PM.During a concurrent interview and record review on 6/3/2026 at 3:30 p.m. with the Director of Nursing (DON), Resident 1's DSR, dated April 2026, and the facility's policy and procedure (P&P) titled, Charting and Documentation, revised July 2017, were reviewed. The P&P's policy statement 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. The P&P's policy interpretation and implementation indicated, The following information is to be documented in the resident medical record: Treatments (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or services performed. The DON stated the facility's P&P was not followed when Resident 1's DSR had missing documentation on some dates. Additionally, the DON stated there should be documentation indicating Resident 1 was turned every two hours.