

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  02/21/2025
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>40913</p> <p>Based on observation, interview and record review, the facility failed to promote dignity and privacy during patient care for one of one sampled resident (Resident 22).</p> <p>This deficient practice had the potential to affect Resident 22's psychosocial wellbeing.</p> <p>Findings:</p> <p>During a review of Resident 22's Admission Record (AR), the AR indicated the facility admitted Resident 22 on 7/30/2019, with diagnoses that included malignant neoplasm of the left lung (lung cancer) and retention of urine (is a condition in which your bladder doesn't empty completely even if it's full).</p> <p>During a review of Resident 22's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/31/2024, the MDS indicated Resident 22 had severe cognitive impairment and sometimes understands verbal content and sometimes able to express ideas and wants. The MDS indicated Resident 22 was dependent in toileting hygiene, shower/bathe self and required maximum assistance (helper does more than half the effort) with personal hygiene.</p> <p>During an observation on 2/21/2025 at 9 AM while in Resident 22's room, Certified Nursing Assistant 4 (CNA 4) removed Resident 22's sheet that was covering Resident 22's body. Resident 22 had a diaper on. CNA 4 washed Resident 22's face and neck while the resident's lower body was exposed.</p> <p>During an interview on 2/21/2025 at 9:24 AM with CNA 4, CNA 4 stated when providing care, CNA 4 needed to wash the resident's body by area so the other areas of the body would be covered. CNA 4 stated this would be done to ensure Resident 22 would not be exposed.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Dignity dated February 2021, the P&amp;P indicated staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.</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
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure a proper assessment was conducted for the self-administration (take or do something for yourself that would normally be done by someone else) of Pepto Bismol Ultra (medication used to treat occasional upset stomach, heartburn, and nausea), for one of one sampled resident (Resident 53). On 2/18/2025, there was an almost empty bottle of Pepto Bismol Ultra in Resident 53's room. The facility failed to obtain a consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) from Resident 53 and a physician's order for the self-administration of the medication as indicated in the facility's policy and procedures (P&amp;P), titled, Administering Medications and Self-Administration of Medications.</p> <p>This deficient practice had the potential to harm Resident 53 as a result of overmedicating, improper medication dosage, and a adverse drug event (injuries resulting from medication use including physical and mental harm, or loss of function).</p> <p>Findings:</p> <p>During a review of Resident 53's Admission Record (AR), the AR indicated, Resident 53 was admitted to the facility on [DATE] with multiple diagnoses including end stage renal disease (ESRD - irreversible kidney failure) and type 2 diabetes mellitus (DM2- adult-onset disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic polyneuropathy (a condition that affects multiple peripheral nerves outside of the brain and spinal cord).</p> <p>During a review of Resident 53's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/1/2025, the MDS indicated, Resident 53's cognition (ability to think and make decisions) was moderately impaired.</p> <p>During a review of Resident 53's Order Summary Report (OSR), active orders dated as of 2/21/2025, the OSR did not indicate an order for Pepto Bismol Ultra medication or an order for Resident 53 to self-administer the medication.</p> <p>During an observation on 2/18/2025 at 2:50 PM in Resident 53's room, there was an almost empty 12 fl oz (fluid ounce - a unit of volume, typically used for measuring liquids) bottle of Pepto Bismol Ultra on top of the dresser located by Resident 53's foot of the bed.</p> <p>During an interview on 2/20/2025 at 2:20 PM with Resident 53, Resident 53 stated Resident 53 bought the Pepto Bismol Ultra for Resident 53 because the resident had bad indigestion (pain, general discomfort, or burning feeling in your upper belly). Resident 53 stated Resident 53 had the Pepto Bismol Ultra, for a while. Resident 53 stated, Resident 53 notified staff and staff did not say anything.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 2/20/2025 at 2:56 PM with the Registered Nurse Supervisor (RNS), Resident 53's medical record was reviewed. The RNS stated, there was no order or consent for Resident 53 to self-administer Pepto Bismol Ultra. The RNS stated [facility practice for self-administration of medications included] assessing the resident's [ability] to self-administer the medication [to ensure safe administration]. The RNS stated, if the resident was able to self-administer [safely], the facility proceeded and obtained a physician's order for the self-administration. The RNS stated, residents (in general) were not allowed to keep Pepto Bismol Ultra at the bedside, that's not even our brand. The RNS stated, Resident 53 needed to be watched for self-administration of the medication because Resident 53 was a dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) patient and for contraindication (a condition that serves as a reason not to take a certain medical treatment or medication due to the harm that can be caused), and for the safety of Resident 53.</p> <p>During a review of the facility's P&amp;P, titled, Administering Medications, date revised 4/2019, the P&amp;P indicated, residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team (IDT- a group of health care professionals who work together to coordinate care for a resident), has determined that they have the decision-making capacity to do so safely.</p> <p>During a review of the facility's P&amp;P titled, Self-Administration of Medications, revised 2/2021, the P&amp;P indicated, residents had the right to self-administer medications if IDT assessed each resident's cognitive (relating to thinking, learning, and understanding) and physical abilities to determine whether self-administering medications was safe and clinically appropriate for the resident. The P&amp;P indicated, self-administered medications were stored in a safe and secure place, which was not accessible by other residents. Any medications found at the bedside that were not authorized for self-administration were turned over to the nurse in charge for return to the family or responsible party.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913</b></p> <p>Based on observation, interview, and record review, the facility failed to maintain a clean, safe, sanitary, and homelike environment for the following by failing to:</p> <p>a) One of one sampled resident's bathroom (Resident 29) did not have a clogged toilet.</p> <p>b) Maintain Seven of Seven resident bathrooms (Bathrooms 1, 2, 3, 4, 5, 6, and 7) affecting 18 residents (Resident 3, Resident 4, Resident 5, Resident 7, Resident 8, Resident 11, Resident 15, Resident 20, Resident 24, Resident 27, Resident 30, Resident 31, Resident 32, Resident 33, Resident 36, Resident 39, Resident 49, and Resident 211).</p> <p>c) Maintain Four of Four resident rooms (Rooms A, B, C and D) affecting six residents (Resident 3, Resident 4, Resident 5, Resident 8, Resident 20, and Resident 36).</p> <p>These deficient practices had the potential for Residents 3, 4, 5, 7, 8, 11, 15, 20, 24, 27, 30, 31, 32, 33, 36, 39, 49, and 211 to be exposed to dirt, mold, rust and drywall dust, which can lead to a decline in the residents' health and result in irritation of the eyes, skin, nose, throat, and lungs. Additionally, prolonged exposure can cause serious problems such as acute (sudden) respiratory illness, persistent coughing, and asthma (narrowed airways in the lungs that make it difficult to breath). The clogged toilet led to Resident 29 being unable to use the toilet for toileting hygiene for the past two days.</p> <p>Findings:</p> <p>a. During a review of Resident 29's Admission Record, (AR), the AR indicated the facility admitted Resident 29 on 1/19/2022, with diagnoses that included cerebral infarction (stroke - occurs when blood flow to a part of the brain stops. The brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage), \ hemiplegia and hemiparesis (weakness and paralysis to one side of the body).</p> <p>During a review of Resident 29's MDS, the MDS indicated Resident 29 had intact cognition. The MDS indicated Resident 29 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting hygiene and personal hygiene.</p> <p>During an interview on 2/18/2025 at 11:50 AM, Resident 29 stated Resident 29 would use the toilet if it was not broken. The toilet had been broken for two days. Resident 29 stated the resident had reported the clogged toilet to both the nurses and the certified nursing assistants assigned to Resident 29 the past two days.</p> <p>During an interview on 2/18/2025 at 11:55 AM, Certified Nursing Assistant 5 (CNA 5) stated CNA 5 thought the clogged toilet was already fixed. CNA 5 stated CNA 5 called the MTD when the toilet was clogged over the weekend.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 2/18/2025 at 11:57 AM, Resident 29's toilet had unflushed brown stool inside the toilet.</p> <p>During an interview on 2/18/2025 2:50 PM, Resident 29 stated Resident 29 had two watery bouts of diarrhea in the morning.</p> <p>During an interview on 2/18/2025 at 4:20 PM, the Maintenance Director (MTD) stated the problem was just reported to the MTD that day on 2/18/2025.</p> <p>During an interview on 2/21/2025 at 9:32 AM, the MTD stated the facility's process for any repairs and maintenance issues, is that the staff needed to contact the MTD and write the request on the Maintenance Log because the MTD would check the log multiple times a day. The MTD stated the problem with just a verbal notification of the maintenance issue or problem, would be the likelihood the problem would be missed because the MTD had other work he would be attending to.</p> <p>45553</p> <p>b) During an observation on 2/18/25 at 9:18 a.m. in Bathroom [ROOM NUMBER] (Resident 33's bathroom) the following were observed:</p> <ol style="list-style-type: none"> <li>1) Unpainted plaster above the wall baseboard (covers the lowest part of an interior wall) on the left and right side of the toilet.</li> <li>2) Cracked/missing caulking where floor meets the wall on the left and right side of the toilet.</li> <li>3) Chipped paint, scratches on door (exposing wood) and on right/left door frames.</li> <li>4) Unpainted plaster on the wall to the left of the soap dispenser.</li> <li>5) Unpainted wall area under the paper towel dispenser.</li> <li>6) Cracked/peeling caulking where the countertop meets wall (below paper towel dispenser).</li> <li>7) Cracked/peeling caulking where the countertop meets the door frame.</li> </ol> <p>During an observation on 2/18/25 at 9:33 a.m. in Bathroom [ROOM NUMBER] (Resident 32's bathroom) the following were observed:</p> <ol style="list-style-type: none"> <li>1) Unpainted wall area under bathroom sink.</li> <li>2) Corner of right wall above vinyl baseboard, unpainted, and wall with peeling/bubbling paint, and at bottom of baseboard where it meets the floor, brown stains were present.</li> <li>3) On the left side of the toilet where the shut-off water valve is located, unpainted plaster and brown color substance on wall near pipe with shut-off valve.</li> <li>4) Below paper towel dispenser, cracked caulking, peeling paint where countertop meets right wall.</li> </ol> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5) To the left of the paper towel dispenser, a GFCI outlet (an electrical outlet that shuts off power in the event of a ground fault; designed to protect people from electrical shocks and fires outlet) switch with a Test Button hanging from outlet).</p> <p>During an observation on 2/18/25 at 10:13 a.m. in Bathroom [ROOM NUMBER] (Resident 3's bathroom) the following were observed:</p> <ol style="list-style-type: none"> <li>1) Unpainted plaster on wall to left of soap dispenser.</li> <li>2) Peeling paint exposing wood on the left and right door frames, and door.</li> <li>3) Peeling caulking and black marks on right door frame.</li> <li>4) Peeling paint along wall above vinyl baseboard exposing dark brown color underneath the paint.</li> <li>5) Unpainted plaster underneath the paper towel dispenser.</li> <li>6) Cracked and peeling caulking where the countertop meets the wall in the corner to the right side of the bathroom sink.</li> <li>7) Corner of countertop where the countertop meets the wall and adjacent to the door frame, caulking is peeling and there are reddish/brownish marks present along the corner.</li> </ol> <p>During an observation on 2/18/25 at 10:43 a.m. in Bathroom [ROOM NUMBER], (shared bathroom between Resident 31, Resident 36, Resident 39 and Resident 49) the following were observed:</p> <ol style="list-style-type: none"> <li>1) Unpainted plaster on wall to left side of soap dispenser.</li> <li>2) Above paper towel dispenser located on right side of bathroom sink, unpainted wall (from bottom of paper towel dispenser to 4 from top of paper towel dispenser).</li> <li>3) Below paper towel dispenser, cracked and peeling caulking (20 inches in length) where countertop meets wall.</li> <li>4) Peeling and chipped paint on left and right door frames, and on both doors that lead to shared bathroom.</li> </ol> <p>During an observation on 2/18/25 at 11:27 a.m. in Bathroom [ROOM NUMBER], (shared bathroom between Resident 4, Resident 8, and Resident 11) the following were observed:</p> <ol style="list-style-type: none"> <li>1) [NAME] color on 2 chrome toilet paper dispensers, toilet safety rail (free standing toilet grab bar and rail that assists in the transfer on and off the toilet), right corner where countertop meets wall, and underneath sink on pipes.</li> <li>2) Unpainted plaster on wall to left side of soap dispenser.</li> <li>3) Unpainted plaster above baseboard (3 inches in height) and runs entire length of wall on all sides under sink.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5) Chipped paint on door frames on both doors that lead to shared bathroom.</p> <p>4) Bottom of both doors that lead to shared bathroom with black marks and chipped paint.</p> <p>5) Cracked caulking on right side of sink where countertop meets wall, and underneath sink around pipe that enters wall.</p> <p>6) Pipe under sink that enters wall is missing escutcheon (metal plate that hides hole in wall).</p> <p>During an observation on 2/18/25 at 1:16 p.m. in Bathroom [ROOM NUMBER], (shared bathroom between Resident 5, Resident 20, Resident 24, and Resident 30) the following were observed:</p> <p>1) Unpainted plaster (20 inches in width x 18 inches in height) on back wall next to left and right sides of toilet.</p> <p>2) Unpainted plaster (6 inches in height) along base of wall extending from right wall to back wall to left wall.</p> <p>3) Chipped paint and scratches on door and left and right door frames.</p> <p>4) Peeling paint, cracked caulking along corner where countertop meets wall adjacent to door frame.</p> <p>5) Paper towel dispenser unpainted underneath; now in higher position and exposed plaster patched screw hole and other unpainted screw hole.</p> <p>6) Unpainted plaster on wall left of soap dispenser.</p> <p>7) Unpainted plaster (6 inches in height) underneath sink at base of wall that extends from right wall, back wall and to the left wall.</p> <p>During an observation on 2/18/25 at 3:47 p.m. in Bathroom [ROOM NUMBER], (shared bathroom between Resident 7, Resident 15, Resident 27 and Resident 211) the following were observed:</p> <p>1) Unpainted plaster below light switch.</p> <p>2) Unpainted plaster above paper towel dispenser.</p> <p>3) Unpainted plaster above and to the left of the soap dispenser.</p> <p>4) Chipped paint, black marks, and scratches on both doors and door frames that lead to the shared bathroom.</p> <p>5) Cracked caulking along where countertop meets wall on right side of bathroom sink.</p> <p>c) During an observation on 2/18/25 at 10:15 a.m. in Room A (Resident 3's room) the following were observed:</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1) In between the window and the electrical outlet, unpainted plastered area (15 x 8 wide) above baseboard at bottom of the wall.</p> <p>2) Black mark (one half inch by 4 feet wide) across the bottom of the wall, to the left of the unpainted plastered area.</p> <p>During an observation on 2/18/25 at 10:59 a.m. in Room B (Resident 36's room) the following were observed:</p> <p>1) At the head of the bed on the left side, and adjacent to an electrical plug, there was unpainted plaster.</p> <p>2) On left side of the bed, 2 feet from the edge of the room doorway; cracked, unpainted plaster located 6 inches above the floor.</p> <p>During an observation on 2/18/25 at 11:28 a.m. and 3:11 p.m. in Room C (Resident 4 and Resident 8's room) the following were observed:</p> <p>1) On the left side of the wall near Resident 4's bed along the baseboard, there was unpainted plastered (30 inches in length).</p> <p>2) Across from Resident 4's foot of the bed, and adjacent to the bathroom door (on both sides), there was unpainted plaster at the base of the wall.</p> <p>3) Chipped paint on the edge of the closet wall where it meets the 4-drawer dresser.</p> <p>4) At the entrance of the doorway to the room, chipped paint on the left side of the door.</p> <p>5) Black markings on the lower part of the door.</p> <p>6) The door frame had multiple chipped paint and black markings.</p> <p>7) The door has a brownish colored hinge, scratches, and dents with exposed and unpainted wood.</p> <p>During an observation on 2/18/25 at 1:18 p.m. in Room D (Resident 5 and Resident 20's room) the following were observed.</p> <p>1) At the base of the wall in the corner of the room, adjacent to the left side of the bathroom door, unpainted plaster (4 inches in height by 24 inches in width).</p> <p>2) At the base of the wall, adjacent to the right side of bathroom door, unpainted plaster (4 inches in height by 18 inches in width).</p> <p>During an interview with the Maintenance Director (MTD) on 2/21/25, the MTD stated Bathrooms 1, 2, 3, 4, 5, 6, 7 and Rooms A, B, C, D needed to be repaired. The MTD stated has informed staff to report maintenance issues by using the binder with log, but some staff failed to report the issues to him. The MTD stated these bathrooms and rooms condition could pose a risk to the residents' health.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45553</p> <p>Based on interview and record review, the facility failed to develop a care plan for one of one sampled resident (Resident 32) after receiving positive lab results for clostridium difficile (C. diff- a highly contagious bacteria that causes severe diarrhea).</p> <p>This deficient practice had the potential to negatively affect the provision of care and services for Resident 32.</p> <p>Findings:</p> <p>During a review of Resident 32's Admission Record (AR), the AR indicated, Resident 32 was admitted to the facility on [DATE] with diagnoses that included atherosclerotic heart disease (plaque buildup in artery walls), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), gastro-esophageal reflux disease (stomach acid repeatedly flows back up into the tube connecting the mouth and stomach), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).</p> <p>During a review of Resident 32's Laboratory Results Report with a report date to the facility on [DATE] at 7:42 p.m., the report indicated C.diff antigen (testing evaluates the potential presence of Clostridium difficile bacteria in stool) detected.</p> <p>During a review of Resident 32's Nursing Progress Note, dated 2/2/25 at 8:46 p.m., the note indicated, Resident's stool result came, positive for C-DIFF. Notified Primary Physician (MD 1) regarding positive result.</p> <p>During a review of Resident 32's Nursing Progress Note, dated 2/2/25 at 10:51 p.m., the note indicated, Received call back from MD 1 with orders to start Vancomycin (Vancocine, antibiotic) 250 mg QID x 7 days starting at 9:00 a.m. on 2/3/25. Order faxed to pharmacy.</p> <p>During a review of Resident 32's Nursing Progress Note, dated 2/3/25 at 4:47 a.m., the note indicated, Resident on monitoring status post positive for C-Diff. PM shift charge nurse received ordered from MD 1 to start vancomycin. Resident has not yet started the medication.</p> <p>During a review of Resident 32's Nursing Progress Note, dated 2/3/25 at 10:40 a.m., the note indicated, Vancocin Oral Capsule 250 mg, give 1 capsule by mouth four times a day for C-DIFF for 7 days. 2 capsules from e-kit. Approved by pharmacist.</p> <p>During a review of Resident 32's Advance Practice Registered Nurse 1 (APRN 1) Note, dated 2/3/25 at 12:20 p.m., the note indicated, The patient is on contact isolation [isolation involved stricter isolation measures like a private room and dedicated equipment to prevent transmission of infectious agents spread through direct or indirect contact, often requiring more extensive personal protective equipment (PPE, including gloves, masks, eye protection) use and activity restrictions for the patient.] for testing positive for C-diff and has been put on oral Vancomycin with end date 2/10.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 32's Advance Practice Registered Nurse 2 (APRN 2) Note, dated 2/13/25, the note indicated, Interval History: Today visit, patient is seen at bedside. Alert and oriented x 3-4, completed course of Vaco for C-diff. Diarrhea improved. Assessment/Plan: Enterocolitis [an inflammation that occurs in a person's digestive tract] due to Clostridium difficile, Vancocin 250 mg QID x 7 days until 2/10 completed, Diarrhea improved.</p> <p>During a review of Resident 32's Medication Administration Record (MAR), dated February 2025, the MAR indicated, Resident 32 received Vancocin Oral Capsule 250 mg (Vancomycin HCl) for C-DIFF from 2/3/25 to 2/9/25.</p> <p>During a review of Resident 32's care plans dated 2/2/25 to 2/10/25, there were no care plans indicating Resident 32 has antibiotic therapy related to C. diff or Resident 32 has C.diff with active symptoms.</p> <p>During an observation of Resident 32's room on 2/18/25 at 8:22 a.m., Resident 32's room was observed to have signage outside of the room for Enhanced Barrier Precautions (precautions that focus on using gowns and gloves only during high-contact care activities to reduce the spread of multidrug-resistant organisms). No contact isolation signage was observed.</p> <p>During a concurrent electronic record review and interview on 2/19/25 at 4:13 p.m. with Registered Nurse Supervisor (RNS), RNS confirmed there was no care plan created for Resident 32 from 2/2/25 to 2/10/25 after the facility was notified of the positive C. diff lab result for Resident 32. RNS stated a care plan for active C. diff was initiated on 2/19/25 for Resident 32 after Resident 32 reported having diarrhea on 2/16/25.</p> <p>During an observation of Resident 32's room on 2/19/25 at 4:45 p.m., Resident 32's room was observed to have signage outside of the room for Enhanced Barrier Precautions and contact isolation.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Care Plans, Comprehensive Person-Centered, revised March 2022, the P&amp;P indicated, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&amp;P further indicated, Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</b></p> <p>Based on interview and record review, the facility failed to ensure, one of one sampled resident (Resident 25), received proper care by failing to follow Resident 25's physician's order that included parameters (specific instructions that can be measured) indicating when to hold (not give) the administration of Losartan Potassium (medication used to treat high blood pressure [hypertension]) for as indicated in the facility's policy and procedure (P&amp;P), titled, Administering Medications.</p> <p>This deficient practice could potentially result in Resident 25's blood pressure to drop too low (hypotension) and result in a medical emergency due to not enough oxygen (O<sub>2</sub> - colorless, odorless, tasteless gas essential for life) and nutrients to Resident 25's vital organs.</p> <p>Findings:</p> <p>During a review of Resident 25's Admission Record (AR), the AR indicated, Resident 25 was admitted to the facility on [DATE] with multiple diagnoses including acute respiratory failure (when the lungs can't release enough oxygen into your blood) with hypoxia (low levels of O<sub>2</sub> in your body tissues) and essential (primary) hypertension (high blood pressure).</p> <p>During a review of Resident 25's Minimum Data Set (MDS, a resident assessment tool), dated 3/10/2024, the MDS indicated, Resident 25's cognition (ability to think and make decisions) was intact.</p> <p>During a review of Resident 25's History and Physical (H&amp;P), dated 11/18/2024, the H&amp;P indicated Resident 25 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 25's Physician's Order (PO), dated 11/25/2024, timed at 9:53 AM, the PO indicated Losartan Potassium oral tablet 25 mg (milligrams - metric unit of measurement), give 1 tablet by mouth one time a day for hypertension HOLD [if] SBP (systolic blood pressure - the upper number in a blood pressure reading) &lt; (less than) 140 mmhg (millimeters of mercury, unit of measurement) or HR (heart rate) &lt; 85.</p> <p>During a review of Resident 25's undated Care Plan (CP), titled, The resident has hypertension, the CP's interventions indicated to give antihypertensive medications as ordered.</p> <p>During a review of Resident 25's Medication Administration Record (MAR), dated 1/1/2025 - 1/31/2025, the MAR indicated, Losartan Potassium oral (by mouth) tablet 25 mg, the following dates indicated Resident 25's SBP and HR readings:</p> <ul style="list-style-type: none"> <li>-On 1/5/2025 with SBP=122/82 and HR=68</li> <li>-On 1/6/2025 with SBP=122/75 and HR=69</li> <li>-On 1/7/2025 with SBP=115/61 and HR=71</li> <li>-On 1/8/2025 with SBP=132/70 and HR=66</li> </ul> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 1/25/2025 with SBP=122/78 and HR=72.</p> <p>The MAR indicated Losartan Potassium oral tablet 25 mg was administered on those dates.</p> <p>During a concurrent interview and record review on 2/20/2025 at 12:40 PM with Licensed Vocational Nurse (LVN) 1, Resident 25's MAR dated 2/1/2025 - 2/28/2025, was reviewed. The MAR indicated, Losartan Potassium oral tablet 25 mg, the following dates indicated Resident 25's SBP and HR readings:</p> <p>-On 2/5/2025 with SBP=122/80 and HR=72</p> <p>-On 2/8/2025 with SBP=120/70 and HR=65</p> <p>-On 2/13/2025 with SBP=138/74 and HR=66</p> <p>-On 2/14/2025 with SBP=124/69 and HR=77</p> <p>-On 2/15/2025 with SBP=120/72 and HR=70</p> <p>-On 2/16/2025 with SBP=108/58 and HR=66</p> <p>-On 2/17/2025 with SBP=127/78 and HR=70</p> <p>-On 2/19/2025 with SBP=126/72 and HR=70</p> <p>-On 2/20/2025 with SBP=122/84 and HR=84.</p> <p>LVN 1 stated, on those dates, Losartan Potassium was administered. LVN 1 stated, Losartan Potassium was for hypertension and the physician's parameter in the order indicated to hold the medication if Resident 25's SBP was less than 140 or the HR was less than 85. LVN 1 stated, LVN 1 did not follow the physician's parameter and it was important to follow the parameter for the administration of Losartan to avoid hypotension episodes. LVN 1 stated, LVN 1 was not paying attention to the parameters, I guess.</p> <p>During a concurrent interview and record review on 2/20/2025 at 2:56 PM with the Registered Nurse Supervisor (RNS), Resident 25's MAR dated 2/1/2025 - 2/28/2025, was reviewed. The RNS stated, staff needed to check doctor's orders including medication parameters. The RNS stated Resident 25's Losartan should have been held on those dates. The RNS stated, Resident 25's Losartan Potassium parameters were not followed, and they were important to follow because if they were not followed, can cause side effects, hypotension.</p> <p>During a review of the facility's P&amp;P titled, Administering Medications, date revised 4/2019, the P&amp;P indicated, medications were administered in a safe and timely manner, and as prescribed.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42307</p> <p>Based on observation, interview, and record review, the facility failed to ensure two of four sampled residents (Resident 41 and Resident 22), were provided treatment consistent with professional standards of practice to promote the healing of Resident 41's existing pressure ulcer/injury (PI - localized, pressure related damage to the skin and/or underlying tissue usually over a bony prominence) and to prevent the development of PI to Resident 22 by failing to ensure:</p> <p>a. Resident 41's low air loss mattress (LAL - a mattress attached to a blower pump designed to circulate a constant flow of air to remove excess moisture and regulate the pressure levels, thereby improving blood flow to the wound site) was set correctly on 2/19/2025.</p> <p>b. Resident 22 was turned and repositioned in accordance with Resident 22's care plan (CP).</p> <p>These deficient practices could potentially result in delayed healing of Resident 41's existing PI and the potential for development of a new PI to Resident 22.</p> <p>Findings:</p> <p>a. During a review of Resident 41's Admission Record (AR), the AR indicated, Resident 41 was admitted to the facility on [DATE] with multiple diagnoses including pressure ulcer on the right buttock, stage 4 (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), and paraplegia (loss of movement and/or sensation, to some degree, of the legs).</p> <p>During a review of Resident 41's History and Physical Examination (H&amp;P), dated 2/14/2024, the H&amp;P indicated, Resident 41 had the capacity to understand and make decisions.</p> <p>During a review of Resident 41's CP, titled, The resident is at risk for unavoidable PI or the potential for PI development r/t (related to) dehydration, date initiated 3/7/2024, the CP's interventions included to administer treatments as ordered .and follow facility policies/protocols for the prevention/treatment of skin breakdown.</p> <p>During a review of Resident 41's CP, titled, pressure injury stage 4 right ischium (the large bone in the lower part of the hip), date initiated 1/7/2025, the CP's interventions indicated, an LAL mattress related to multiple PI.</p> <p>During a review of Resident 41's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 2/4/2025, the MDS indicated, Resident 41's cognition (ability to understand and process information) was intact. The MDS indicated, Resident 41 had a PI and Resident 41 was at risk of developing PIs. The MDS indicated, Resident 41 had one stage 4 PI that was present upon admission. The MDS indicated, Resident 41 had a pressure reducing device for bed.</p> <p>During a review of Resident 41's Order Summary Report (OSR), active orders dated as of 2/21/2025, the OSR indicated, a physician's order, dated 2/16/2024, for LAL mattress for wound care, monitor placement and range (light#3) every shift.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/19/2025 at 8 AM with Resident 41, Resident 41 was lying in bed on a LAL mattress. The LAL mattress pump had a Patient Weight Settings (PWS) sticker. The PWS indicated, the weight range with the corresponding setting by number of light bars. Resident 41's LAL mattress pump had 2 lights on. Resident 41 stated, Resident 41 had a small PI and still have a problem with it. Resident 41 stated, the LAL mattress was supposed to be by weight and Resident 41 weighed about 167 pounds. The PWS indicated, for weight ranging from 145 - 175 (pounds), the setting was 3 light bars.</p> <p>During a concurrent observation and interview on 2/19/2025 at 8:16 AM with Treatment Nurse (TN) 1 and Resident 41, Resident 41 was lying in bed on a LAL mattress. The LAL mattress pump had 2 lights on. TN 1 stated, the mattress setting should indicate 3 lights, based on the weight indicated on the sticker. TN 1 stated, it was important for the LAL mattress to be set correctly for Resident 41's comfort and for Resident 41's treatment to not be delayed. Resident 41 stated, Resident 41 felt better after TN 1 corrected the LAL to the right setting.</p> <p>During an interview on 2/19/2025 at 8:52 AM with the Registered Nurse Supervisor (RNS), the RNS stated, the LAL mattress was for pressure sore wound management and set according to resident's (in general) weight. The RNS stated, TN 1 put a sticker on the LAL pump to indicate number of lights on based on resident's weight. The RNS stated, it was important to have the correct LAL mattress setting to provide the correct pressure and benefits of the LAL mattress.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Support Surface Guidelines revised date 2/7/2024, the P&amp;P indicated, to follow any air support surface mattress (i.e. LAL) manufacturer guidelines in conducting safety operations and use during care and or transfers.</p> <p>During a review of the facility's P&amp;P titled, Prevention of Pressure Injuries revised date 2/2024, the P&amp;P indicated, select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice.</p> <p>During a review of the undated facility's LAL mattress User Manual (UM), titled, Power Pro Elite Mattress System, the UM indicated, the intended use of the LAL system was to help and reduce the incidence of PI while optimizing patient's comfort. The UM indicated, the weight and comfort level reference for weight 120-175 was 3 lights on a 36 (inches, unit of length) mattress.</p> <p>40913</p> <p>b. During a review of Resident 22's AR, the AR indicated the facility admitted Resident 22 on 7/30/2019, with diagnoses that included malignant neoplasm of the left lung (lung cancer) and retention of urine (is a condition in which your bladder doesn't empty completely even if it's full).</p> <p>During a review of Resident 22's MDS, dated [DATE], the MDS indicated Resident 22 had severe cognitive impairment and sometimes understands verbal content and sometimes able to express ideas and wants. The MDS indicated Resident 22 was dependent with toileting hygiene, shower/bathe self and required maximum assistance (helper does more than half the effort) with personal hygiene and bed mobility such as rolling left and right, sit to lying, lying to sitting and sit to stand.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 22's CP titled At risk for impaired skin integrity as evidence by easy skin bruising/skin discoloration, skin tears/abrasions including pressure skin injury, initiated on 11/9/2023, the care plan indicated to assist Resident 22 in turning and repositioning at least every 2 hours.</p> <p>During a review of Resident 22's CP titled non-compliance with care manifested by refusing repositioning while in bed, removing positioning pillows, adjusts himself back to prior position, initiated on 2/4/2025, the care plan indicated to provide education on the importance of repositioning to prevent skin breakdown and to provide frequent encouragement and education with risks and benefits and to include family education to assist with compliance.</p> <p>During an observation on 2/21/2025 at 9 AM, Certified Nursing Assistant 4 (CNA 4) was providing morning care to Resident 22 by washing his face and neck and changing the incontinent pad. During this observation, there were two open areas on the right buttocks. CNA 4 stated CNA 4 would notify the Treatment Nurse. CNA 4 positioned Resident 22 on the resident's back after the morning care was provided.</p> <p>During an observation on 2/21/2025 at 11:08 AM, Resident 22 was lying on his back.</p> <p>During a concurrent observation and interview on 2/21/2025 at 1:55 PM, Resident 22 was lying on his back. CNA 4 stated CNA 4 had not attempted to reposition Resident 22 on to his side because CNA 4 knew from history Resident 22 will just move back. CNA 4 stated Resident 22 would just tell me to remove the pillow.</p> <p>During a wound observation with 2/21/25 2 PM with TN 1, Resident 22 was lying on his back, there were no extra pillows except for the pillow under Resident 22's head. Resident 22 had open scratch marks on the right and left buttocks and small scabs from the midback to the upper back. TN 1 stated the open areas looked like scratch marks. TN 1 stated when Resident 22 would refuse, the CNA's (in general) would still need to offer and assist Resident 22 to reposition.</p> <p>During a review of Resident 22's CP titled non-compliance with care manifested by refusing repositioning while in bed, removing positioning pillows, adjusts himself back to prior position, initiated on 2/4/2025, the care plan indicated to provide education on the importance of repositioning to prevent skin breakdown and to provide frequent encouragement and education with risks and benefits and to include family education to assist with compliance.</p> <p>During a review of the facility's P&amp;P titled Prevention of Pressure Injuries dated February 2024, the P&amp;P indicated to reposition all residents with or at risk of pressure injuries.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40913</p> <p>Based on observation, interview, and record review, the facility failed to ensure toileting was offered to one of one sampled resident (Resident 14) every two hours as indicated in Resident 14's care plan (CP), titled, At Risk for Falls.</p> <p>This deficient practice had the potential to result in falls and injury to Resident 14.</p> <p>Findings:</p> <p>During a review of Resident 14's Admission Record (AR), the AR indicated the facility admitted Resident 14 on 9/15/2023, with diagnoses that included dementia (a progressive state of decline in mental abilities), repeated falls.</p> <p>During a review of Resident 14's CP, titled At Risk for Falls, initiated on 7/14/2024, the CP included an intervention to meet Resident 14's toileting needs every two hours.</p> <p>During a review of Resident 14's Minimum Data Set (MDS - a resident assessment tool) dated 12/2/2024, the MDS indicated Resident 14 had a memory problem and had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 14 required moderate assistance (helper does less than half the effort) with toileting hygiene, toilet transfers, walking 10 feet, walking 50 feet and make two turns. The MDS dated [DATE] indicated Resident 14 had falls since admission or prior assessment.</p> <p>During an observation on 2/18/2025 at 4:40 PM, Resident 14 got up from Resident 14's bed by himself, walked slowly toward the foot of Resident 14's bed and held on to the top of the bed. Resident 14 stated Resident 14 felt dizzy.</p> <p>During a review of a change of condition (COC) dated 2/15/2025, the COC indicated Charge nurse was in front of Station 1 nurse's station during medication pass, resident noted to enter wrong room, ambulating via wheelchair. Charge nurse approached room and witnessed resident in middle of the room standing in front of wheelchair attempting to pick up pants then lost his balance and fell back. Patient fell on to wheelchair in sitting position then the ground, remaining in the sitting position.</p> <p>During a concurrent interview and observation on 2/21/2025 at 1:30 PM, Certified Nursing Assistant 4 (CNA 4) stated Resident 14 had a bedside commode at the bedside the resident can use. CNA 4 stated Resident 14 was at times both continent (ability to control urination) and incontinent (loss of bladder control, varying from a slight loss of urine after sneezing, coughing, or laughing to complete inability to control urination). CNA 4 stated Resident 14 did not have a toileting schedule [to assist Resident 14 every two hours]. There were items stored on top of the bedside commode and the rolling bedside table was in front of the bedside commode.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent record review of Resident 14's CP and interview, the Director of Nursing (DON) stated one of the interventions was to meet Resident 14's toileting needs every two hours. The DON stated a toileting schedule could help prevent falls because Resident 14 did not have to get up to the toilet by himself when his needs were met.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Falls - Clinical Protocol dated March 2018, the P&amp;P indicated staff will try various relevant interventions based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance).</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>40913</p> <p>Based on observation, interview and record review, the facility failed to ensure the licensed nurse followed the physician's order for indwelling catheter care for one of one resident (Resident 22).</p> <p>This deficient practice had the potential to result in Resident 22 experiencing complications with the use of an indwelling catheter and to affect Resident 22's physical wellbeing.</p> <p>Findings:</p> <p>During a review of Resident 22's Admission Record (AR), the AR indicated the facility admitted Resident 22 on 7/30/2019, with diagnoses that included malignant neoplasm of the left lung (lung cancer) and retention of urine (is a condition in which your bladder doesn't empty completely even if it's full).</p> <p>During a review of Resident 22's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/31/2024, the MDS indicated Resident 22 had severe cognitive impairment and sometimes understands verbal content and sometimes able to express ideas and wants. The MDS indicated Resident 22 was depended in toileting hygiene, shower/bathe self and required maximum assistance (helper does more than half the effort) with personal hygiene.</p> <p>During an observation on 2/18/2025 at 11:30 AM, there were brown sediments on the foley catheter tubing.</p> <p>During an interview on 2/20/2025 at 2:37 PM, the RN Supervisor stated when a resident (in general) had a foley catheter, the licensed nurses needed to monitor for placement and monitor for cloudiness of the urine.</p> <p>During an observation on 2/20/2025 at 2:43 PM with the Registered Nurse Supervisor (RN Supervisor), the RN Supervisor stated there were light colored sediments on the foley catheter tubing.</p> <p>During a concurrent observation and interview on 2/20/2025 at 2:53 PM, Treatment Nurse 1(TN 1) stated the sediments inside the foley catheter tubing were light yellow in color. TN 1 stated there was an order to flush the foley catheter with acetic acid one time a day for foley catheter maintenance.</p> <p>During a concurrent interview and record review on 2/20/2025 at 3:31 PM, TN 1 stated the foley catheter needed to be checked daily and according to the physician's order to irrigate the foley catheter as needed to prevent obstruction of the foley catheter. TN 1 reviewed the Treatment Administration Record and stated the last time the foley catheter was irrigated was on 2/16/2025. TN 1 stated Resident 22 had chronic sediments on the foley catheter tubing and had recurrent urinary tract infections. TN 1 stated he would notify the physician Resident 22 continued to have sediments on his foley catheter.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 22's care plan The resident has bladder incontinence r/t Active infections with symptoms of UTI, Disease Process, Impaired Mobility admitted with ESBL urine At risk for recurrent UTI indicated to monitor signs and symptoms of UTI including cloudiness of the urine.</p> <p>During a review of Resident 22's Medication Administration Record (MAR) dated February 2025, the MAR indicated Resident 22 was on Ciprofloxacin 250 milligrams two times a day for UTI for 7 days from 2/4/2025 to 2/10/2024.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Catheter Care, Urinary dated August 2022, the P&amp;P indicated observe the resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P), titled, urinary Tract Infection/Bacteriuria - Clinical Protocol dated April 2018, the P&amp;P indicated when a resident has persistent or recurrent urinary tract infection after treatment with antibiotics, the physician will review the situation carefully with the nursing staff and consider other or additional issues (such as urinary obstruction or indwelling catheter change or removal) before prescribing additional course of antibiotics).</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42307</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 28), received appropriate care and services during gastrostomy tube (G-Tube - tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) medication administration. On 2/20/2025, Licensed Vocational Nurse (LVN) 1 used apple sauce to mix Resident 28's medications during administration via Resident 28's G-Tube.</p> <p>This deficient practice had the potential to cause tube-associated complications such as feeding tube occlusions (risk of clogging) to Resident 28's G-Tube.</p> <p>Findings:</p> <p>During a review of Resident 28's Admission Record (AR), the AR indicated, Resident 28 was admitted to the facility on [DATE] with multiple diagnoses including encounter for attention to gastrostomy and type 2 diabetes mellitus (DM2- adult-onset disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic polyneuropathy (a condition that affects multiple peripheral nerves outside your brain and spinal cord).</p> <p>During a review of Resident 28's Care Plan (CP), titled The resident requires tube feeding r/t [related to] dysphagia [difficulty swallowing], date initiated 2/12/2021, the CP indicated, one of the goals was for Resident 28 to remain free of side effects [adverse effects (unwanted, uncomfortable, or dangerous effects that a resident may have due to a medication)]or complications to tube feeding.</p> <p>During a review of Resident 28's History and Physical Examination (H&amp;P), dated 10/21/2024, the H&amp;P indicated, Resident 28 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 28's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/31/2025, the MDS indicated, Resident 28's cognition (ability to understand and process information) was severely impaired. The MDS indicated, Resident 28 had a feeding tube (e.g., nasogastric or abdominal [PEG]) while a resident.</p> <p>During a review of Resident 28's Order Summary Report (OSR), active orders dated as of 2/21/2025, the OSR indicated, multiple medications to be given via G-Tube included:</p> <ol style="list-style-type: none"> <li>1. Bactrim DS (a combination of two antibiotics used to treat a wide variety of infections [the invasion and growth of germs in the body]) tablet 800-160 mg, give 1 tablet, via G-Tube, one time a day for UTI (urinary track infection - an infection in the bladder/urinary tract) PPX (prophylactically, to prevent), order start date: 2/12/2024.</li> <li>2. Bupropion (medication used to treat depression) HCL (hydrochloride, unit of measurement) tablet 100 mg, give 300 mg one time a day for major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), order start date: 12/31/2021.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Docusate Sodium (medication used to prevent and treat occasional constipation) tablet, give 100 mg via G-Tube two times a day for bowel management, order start date: 3/19/2021. The order did not indicate to use apple sauce to mix the medications when administering medications via G-Tube.</p> <p>During a review of Resident 28's Medication Administration Record (MAR), dated 2/1/2025 - 2/28/2025, the MAR indicated, the medications Bactrim DS, Bupropion HCL and Docusate Sodium were administered via G-Tube on 2/21/2025.</p> <p>During a concurrent medication administration observation and interview on 2/20/2025 at 9:26 AM, with LVN 1. LVN 1 prepared Resident 28's medications by crushing the tablets separately and putting the tablets separately into a 30 ml medicine cup and mixed the crushed medication with water to dissolve the medication. LVN 1 did not crush the Bactrim DS, Bupropion HCL, or the Docusate Sodium tablets and put the tablets separately into a 30 ml medicine cup and added apple sauce. LVN 1 stated, LVN 1 did not crush the tablets because they were coated. LVN 1 stated, that is how LVN 1 was taught and LVN 1 had been a nurse for [AGE] years. LVN 1 encountered some slight resistance when checking Resident 28's G-Tube patency (the condition of not being blocked or obstructed), used a 60 ml piston syringe (a medical device) and slowly pushed some air into the GT to check for tube for patency. LVN 1 administered the crushed medications first via Resident 28's G-Tube. LVN 1 added water to the medications and dissolved in apple sauce prior to administering the medications.</p> <p>During an interview on 2/20/2025 at 2:56 PM with the Registered Nurse Supervisor (RNS), the RNS stated a physician's order was required to mix medications in apple sauce for G-Tube administration.</p> <p>During an interview on 2/21/25 at 3:18 p.m. with the Director of Staff Development (DSD), the DSD stated, staff was not supposed to use apple sauce to mix medications for G-Tube administration to prevent clogging the G-Tube and could decrease the potency (strength and effectiveness) of the medication.</p> <p>During a review of the facility's policy and procedure P&amp;P titled, Administering Medications, revised date 4/2019, the P&amp;P indicated, medications were administered in a safe and timely manner, and as prescribed.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Administering Medications through an Enteral Tube, date revised 11/2018, the P&amp;P indicated, the procedure to provide guidelines for the safe administration of medications through an enteral tube. The P&amp;P indicated, to use warm, purified water for diluting medications and for flushing. The P&amp;P did not indicate to use apple sauce to dilute medications.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure, three of three sampled residents (Resident 21, 52, and 111), were provided appropriate respiratory care and services in accordance with the facility's policy and procedures (P&amp;P) by failing to ensure:</p> <p>a. One of three sampled resident's (Resident 21) nebulizer (a medical device that turns liquid medications into a mist, which is then inhaled through a mouthpiece or a mask) was changed timely.</p> <p>b. Two of three sampled resident's (Resident 52 and 111) oxygen (O<sub>2</sub> - colorless, odorless, tasteless gas essential for life) tubing and breathing treatment's humidifier (a device that adds moisture to the air to prevent dryness) were labeled with a date to ensure the equipment was changed timely. Additionally, the facility failed to ensure there was a physician's order for the administration of oxygen for one of two sampled residents (Resident 52).</p> <p>These deficient practices could potentially result in the growth of harmful bacteria (living organism that can cause an infection) or fungus prone to grow in a constantly moist environment and the potential for physical declines to Resident 21, 52, and 111.</p> <p>Findings:</p> <p>a. During a review of Resident 21's Admission Record (AR), the AR indicated, Resident 21 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus (DM2- adult onset disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (nerve damage that is caused by diabetes), and chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 21's History and Physical Examination (H&amp;P), dated 8/31/2024, the H&amp;P indicated, Resident 21 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 21's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/6/2025, the MDS indicated, Resident 21's cognition (ability to think and make decisions) was severely impaired.</p> <p>During a review of Resident 21's Order Summary Report (OSR), active orders dated as of 2/21/2025, the OSR indicated, an order dated 2/13/2025 for Ipratropium Albuterol (a combination medication used to treat COPD) inhalation solution 0.5-2.5 (3) mg/3ml (milligrams per milliliters - metric unit of measurement used for medication dosage and/or amount) (Ipratropium Albuterol) 1 vial inhale orally every 6 hours for wheezing (a high-pitched sound made when breathing is restricted/obstructed in the lungs/SOB [short of breath]).</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a current observation and interview on 2/18/2025 at 11:41 AM with the Director of Staff Development (DSD), in Resident 21's room. There was an unlabeled and unwrapped handheld nebulizer dated 2/6/2025 hooked up to a [NAME] AIRE Elite compressor (pressurized gas source). The unwrapped handheld nebulizer was inside a plastic wrapped wash basin on top of Resident 21's bedside table. The DSD stated, nebulizers (in general) were changed every week and Resident 21's nebulizer should have been changed, last Sunday, labeled, and stored inside a bag, that's the protocol, especially because Resident 21 was in contact isolation (measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment) and for infection control [purposes].</p> <p>During a review of the facility's P&amp;P titled, Administering Medications through a Small Volume (Handheld) Nebulizer, revised date 10/2010, the P&amp;P indicated, equipment was to be stored in a plastic bag with the resident's name and the date on it. The P&amp;P indicated, to change the equipment and tubing every seven days, or according to facility protocol.</p> <p>40913</p> <p>b). During a review of Resident 52's AR, the AR indicated the facility admitted Resident 52 on 6/22/2024, with diagnoses that included malignant neoplasm of the bone (bone cancer) and a history of antineoplastic chemotherapy (drugs used to treat cancer).</p> <p>During a review of Resident 52's MDS, dated [DATE], the MDS indicated Resident 52 had intact cognition. The MDS indicated Resident 52 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene and setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. The MDS indicated respiratory treatments included oxygen therapy.</p> <p>During a review of Resident 52's Order Recap Report (ORR), dated 2/21/2025, the ORR did not have an order indicating to infuse oxygen.</p> <p>During an observation on 2/18/2025 at 11:02 AM with the Registered Nurse Supervisor (RNS), Resident 52 had oxygen infusing via nasal cannula ([INC] a device-lightweight flexible plastic tubing used to deliver supplemental oxygen, tubing ending is placed in the nostrils and is fitted over the patient's ears). Additionally, the oxygen tubing did not have a label to indicate a date and when the tubing was last changed.</p> <p>During a review of Resident 111's AR, the AR indicated the facility admitted Resident 111 on 2/1/2025, with diagnoses that included pneumonia (lung infection), and acute respiratory failure with hypoxia (when your lungs cannot release enough oxygen into your blood, which prevents your organs from properly functioning).</p> <p>During a review of Resident 111's ORR, dated 2/21/2025, the ORR indicated the following physician orders,</p> <ul style="list-style-type: none"> <li>- dated 2/12/2025, to infuse oxygen at 4-5 liter per minute via nasal canula continuously.</li> <li>- dated 2/14/2025, to change the nasal cannula every week on Monday and prn along with the label date.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/18/2025 at 10:40 AM, with the RNS, the RNS stated the nasal cannula tubing, humidifier and breathing treatment tubing and mask needed to be labeled with the date because that would be the process for staff to know when the oxygen tubing, breathing treatment tubing and humidier was changed.</p> <p>During an observation on 2/18/2025 at 11:01 AM with the RNS, Resident 111 had oxygen infusing via a nasal cannula that was attached to the humidifier and the humidifier was attached to the oxygen concentrator (take air from your surroundings, extract oxygen and filter it into purified oxygen for you to breathe). The nasal cannula tubing was not labeled with a date.</p> <p>During a review of the facility's P&amp;P titled Oxygen Administration dated October 2010, the P&amp;P indicated to verify that there is a physician's order for oxygen administration. The P&amp;P did not indicate infection control measures during use, cleaning, storage including infection control measure during the use of humidifiers.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure the facility medication error rate was not 5 percent or greater for one of three sampled residents (Resident 28). There were 3 errors observed during medication administration with 31 opportunities for errors which yielded a 9.68 % error rate.</p> <p>On 2/20/2025, the facility failed to administer the full dose of 3 out of 13 medications for Resident 28 via Resident 28's gastrostomy tube (G-Tube - tube that is placed directly into the stomach through an abdominal wall incision for the administration of food, fluids, and medications).</p> <p>This deficient practice could potentially result in Resident 28 not getting the full efficacy (the ability to produce a desired or intended result) and benefits of the medications.</p> <p>Findings:</p> <p>During a review of Resident 28's Admission Record (AR), the AR indicated, Resident 28 was admitted to the facility on [DATE] with multiple diagnoses including encounter for attention to gastrostomy and type 2 diabetes mellitus (DM2- adult-onset disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic polyneuropathy (a condition that affects multiple peripheral nerves outside your brain and spinal cord).</p> <p>During a review of Resident 28's History and Physical Examination (H&amp;P), dated 10/21/2024, the H&amp;P indicated, Resident 28 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 28's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/31/2025, the MDS indicated, Resident 28's cognition (ability to understand and process information) was severely impaired. The MDS indicated, Resident 28 had a feeding tube (e.g., nasogastric or abdominal [PEG]).</p> <p>During a review of Resident 28's Order Summary Report (OSR), active orders dated as of 2/21/2025, the OSR indicated, multiple medications to be given via G-Tube included:</p> <ol style="list-style-type: none"> <li>1. Pro-Stat Sugar Free one time a day for increase protein/albumin (most abundant circulating protein) level administer 30 cc (cubic centimeter, [mL]) - a measurement of volume, most often for the dosing of medications), order date: 8/31/2023.</li> <li>2. Ascorbic Acid tablet give 500 mg (milligrams - metric unit of measurement, used for medication dosage and/or amount) one time a day for supplement, order date: 2/12/2021.</li> <li>3. Bupropion HCL (hydrochloride, unit of measurement) tablet 100 mg, give 300 mg one time a day for major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), order date: 12/30/2021.</li> <li>4. Glipizide tablet give 2.5 mg two times a day for DM, order date: 3/1/2021.</li> </ol> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. Metformin HCL 500 mg, give 500 mg one time a day for DM, order date: 3/1/2021.</p> <p>6. Bactrim DS (a combination of two antibiotics used to treat a wide variety of infections [the invasion and growth of germs in the body]) tablet 800-160 mg, give 1 tablet one time a day for UTI (urinary track infection - an infection in the bladder/urinary tract) PPX (prophylactically, to prevent), order date: 2/11/2024.</p> <p>7. Multivitamin-Minerals oral tablet give 1 tab one time a day for supplement, order date: 11/18/2023.</p> <p>8. Carbidopa-Levodopa oral tablet 25-100 mg, give 2.5 tablet four times a day for idiopathic Parkinson's (a progressive disease of the nervous system where the underlying cause is unknown marked by tremor, muscular rigidity, and slow, imprecise movements) every four hours during waking hours, order date: 10/10/2023.</p> <p>9. Miralax oral powder 17 gm/scoop give 1 scoop one time a day every other day for constipation, order date: 2/13/2023.</p> <p>10. Entacapone oral tablet 200 mg give 200 mg four times a day for Parkinson's [Disease], order date: 10/10/2023.</p> <p>11. Senna Tablet 8.6 mg give 1 tab two times a day for bowel management, order date: 3/18/2021.</p> <p>12. Docusate Sodium tablet, give 100 mg two times a day for bowel management, order date: 3/18/2021.</p> <p>13. Cholecalciferol Tablet give 4000 unit[s] one time a day for supplement, order date: 5/5/2021.</p> <p>During a review of Resident 28's Medication Administration Record (MAR), dated 2/1/2025 - 2/28/2025, the MAR indicated, the 12 medications (except Docusate Sodium) administration time was scheduled at 9 AM, the administration scheduled time for Docusate Sodium was 10 AM.</p> <p>During a concurrent medication administration observation and interview on 2/20/2025 at 9:26 AM, with LVN 1. LVN 1 prepared Resident 28's medications by crushing the tablets separately and putting the tablets separately into a 30 ml medicine cup and mixed the crushed medication with water to dissolve the medication. LVN 1 threw away the medicine cups each time into the trash can after administering the medications. There were 3 medicine cups thrown away with leftover medication residue in the medicine cups. LVN 1 stated, LVN 1 was not able to identify which medications were in the medicine cups and LVN 1 could probably tell by the color of the medication. LVN 1 stated, the medicine cup with a golden yellow colored liquid was the Pro-Stat and the medicine cup with a dark brown liquid w/ grainy, crusty looking material residue was the Senna. LVN 1 could not identify the medicine cup that had a white, thick, grainy, pasty consistency and small pill fragments, I wouldn't know cuz she [Resident 28] has a few white ones. LVN 1 stated, LVN 1 should have added more water to mix the medication (for administration) so Resident 28 would get the full dose. LVN 1 stated, it was important for Resident 28 to get the full dose of the medication as ordered [by the physician] for therapeutic (having a healing effect) level.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/20/2025 at 2:56 PM with the Registered Nurse Supervisor (RNS), the RNS was shown a photo of the 3 medicine cups discarded. The RNS stated, the leftover medication residue left in the medicine cups was a significant amount. The RNS stated, Resident 28 did not get the full dose and LVN 1 could have added more water to mix the medications [to prevent from settling at the bottom]. The RNS stated, Resident 28 did not get the full effectiveness and benefits of the medications.</p> <p>During a review of the facility's policy and procedure P&amp;P titled, Administering Medications, revised date 4/2019, the P&amp;P indicated, medications were administered in a safe and timely manner, and as prescribed.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42307</p> <p>Based on observation, interview, and record review, the facility failed to ensure two of two medications (Senna and Docusate Sodium [medications used to treat constipation and were labeled properly in one of two sampled medication carts (Med Cart 2) in accordance with the facility's policy and procedure (P&amp;P), titled, Administering Medications.</p> <p>This deficient practice had the potential for residents to be administered ineffective and contaminated medications and the potential to compromise the health, safety, and well-being of the residents.</p> <p>Findings:</p> <p>During an observation and interview on [DATE] at 9:26 AM with Licensed Vocational Nurse (LVN) 1, during the medication administration, an opened bottle of Senna and an opened bottle of Docusate Sodium did not have an opened date label and were stored inside Med Cart 2. LVN 1 stated, the bottles of Senna and Docusate Sodium were the facility's house supply (medications stocked at the facility). LVN 1 stated, the house supply medications should be dated once opened because, they expire after 28 days after opening. LVN 1 stated, once expired, the medication would not have a strong effect as before. LVN 1 stated, LVN 1 would discard the unlabeled Senna and Docusate Sodium.</p> <p>During an interview on [DATE] at 2:56 PM with the Registered Nurse Supervisor (RNS), the RNS stated, once opened, staff needed to label house supply medications with opened dates to maintain the potency (strength and effectiveness) of the medication.</p> <p>During a review of the facility's P&amp;P, titled, Administering Medications, revised date ,d+[DATE], the P&amp;P indicated, the expiration/beyond date use date on the medication label is checked prior to administering. The P&amp;P indicated, when opening a multi-dose container, the date opened is recorded on the container.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40913</p> <p>Based on observation, interview, and record review, the facility failed to ensure fortified diets were provided for two of two sampled residents (Resident 29 and Resident 112).</p> <p>This deficient practice had the potential for Residents 29 and 112 not to get the caloric intake ordered by the physician.</p> <p>Findings:</p> <p>During a review of Resident 29's Admission Record, (AR), the AR indicated the facility admitted Resident 29 on 1/19/2022 with diagnoses that included cerebral infarction (stroke - occurs when blood flow to a part of the brain stops, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage), hemiplegia and hemiparesis (weakness and paralysis to one side of the body).</p> <p>During a review of Resident 29's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/9/2024, the MDS indicated Resident 29 had intact cognition. The MDS indicated Resident 29 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting hygiene, and personal hygiene.</p> <p>During a review of Resident 112's AR, the AR indicated the facility admitted Resident 112 on 2/3/2025, with diagnoses that included metabolic encephalopathy (occurs when problems with your metabolism cause brain dysfunction) and type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine).</p> <p>During a review of Resident 112's MDS dated [DATE], the MDS indicated Resident 112 sometimes understood others and sometimes was able to express ideas and wants. The MDS indicated Resident 112 required supervision or touching assistance with eating. The MDS indicated Resident 112's cognition (ability to understand and process information) was severely impaired.</p> <p>During a review of the facility's Diet Roster dated 2/19/2025, the diet roster indicated Resident 29 required a fortified/high protein diet with aspiration (condition in which food, liquids, saliva, or vomit is breathed into the airways) precautions and Resident 112 required fortified/high protein diet.</p> <p>During a review of the facility's Cycle 1 2025 Winter Menu, last approved 5/11/2025, the menu for Thursday, 2/20/2025, indicated residents with physician orders for fortified diets/high protein diets included 6 ounces (oz.) of super soup.</p> <p>During an observation on 2/20/2025 at 1:15 PM, the licensed nurses and the certified nursing assistants (CNA's) were distributing meal trays, there were no super soups on Resident 29's or Resident 112's lunch trays.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/20/2025 at 1:26 PM, with the Dietary Supervisor (DS), the DS stated fortified diet provided extra calories, the DS stated Resident 29 and 112's diet orders needed to be followed.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Therapeutic Diets dated 10/2017, the P&amp;P indicated a therapeutic a diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify nutrients in the diet or alter the texture of a diet.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>40913</p> <p>Based on observation, interview, and record review the facility failed to ensure food served to the residents was served at a temperature that was safe and appetizing.</p> <p>This deficient practice had the potential to result in food that was not appetizing or palatable to the residents consuming the food and result in resident caloric goals not met.</p> <p>Findings:</p> <p>During an observation on 2/20/2025 at 1:15 PM, the licensed nurses and the certified nursing assistants (CNA's) were distributing food trays to the residents, the last cart sent out from the kitchen was sampled.</p> <p>During a review of the facility's Cycle 1 2025 Winter Menu, last approved 5/11/2025, the menu indicated on Thursday, 2/20/2025, the following food items would be served for lunch: baked chicken, mashed potatoes/gravy, green beans, bread/margarine, snickerdoodle, cake/icing, and water.</p> <p>During a review of the facility's Resident Council Minutes, dated 12/2024 and 1/2025, the Resident Council Minutes indicated in December 2024, a resident complained food was always cold by the time food was received. The January 2025, minutes indicated residents mentioned residents received cold food at times.</p> <p>During a concurrent observation and interview on 2/20/2025 at 1:23 PM, the Dietary Supervisor (DS) checked the temperature of the following food items on the test tray of the last sampled kitchen cart.</p> <p>Chicken was, 103 degrees Fahrenheit F.</p> <p>Green Beans, 104 F</p> <p>Mashed Potato, 134 F</p> <p>The DS stated the chicken was not cold but not warm either. The DS stated If the food was cold, it would not be appetizing [to the residents], the residents might not eat the food and not eating the food served could lead to weight loss.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Food Preparation and Service dated 10/2017. The P&amp;P indicated the danger zone for food temperatures was between 41 F (Fahrenheit, unit of measurement) and 135 F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40913</p> <p>Based on observation, interview, and record review, the facility failed to ensure there were no expired items, in one of one kitchen's (Kitchen 1) storage.</p> <p>This deficient practice had the potential to cause food-borne illnesses (illness caused by food contaminated with infectious organisms) among the residents consuming food at the facility.</p> <p>Findings:</p> <p>During a concurrent observation and interview on [DATE] at 8:22 AM, with the Dietary Aide (DA), the following items were expired and still kept in Kitchen 1's dry storage.</p> <ol style="list-style-type: none"> <li>1 open package of corn meal, a quarter full had an expiration date of ,d+[DATE].</li> <li>1 open package of baking powder, half full had an expiration date of ,d+[DATE].</li> </ol> <p>The DA stated the expired items needed to be discarded right away.</p> <p>During an interview on [DATE] at 2:30 PM, with the Dietary Supervisor (DS), the DS stated expired food items needed to be discarded right away so kitchen staff did not use it. The DS stated every kitchen staff member was responsible for checking if any food items were expired. The DS did not answer when asked for the reason why there were expired items if everyone in the kitchen were responsible for checking for expired items. The DS stated there was no specific Policy and Procedure regarding expired food items, the DS stated staff just needed to discard the expired food items due to the risk for foodborne illness if the expired items were used. The DS stated kitchen staff followed the Produce Storage Guidelines, Refrigerated Storage Guidelines, Freezer Storage Guidelines, and Dry Storage Guidelines.</p> <p>During a review of the facility's undated Dry Goods Storage Guidelines, the guidelines indicated corn meal could be stored for 1 year once opened on the shelf and baking powder can be stored 3 months once opened on the shelf. The guidelines indicated to check expiration dates on boxes of foods to be sure the length of time is correct.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40913</p> <p>Based on observation, interview and record review, the facility failed to follow infection control practices for 20 of 20 sampled residents (Residents 112, 13, 17, 42, 25, 9, 10, 21, 40, 162, 6, 35, 161, 50, 56, 53, 111, 29, 30, and 114) by failing to ensure,</p> <p>a.&amp;b. two of eight sampled residents (Residents 29 and 30) who exhibited signs and symptoms of norovirus (a highly contagious virus that can cause vomiting, diarrhea and dehydration) were asymptomatic (did not have signs and symptoms [S/S]) prior to discontinuing contact (microorganisms spread through the direct and indirect contact) isolation (staying away/kept away from others) precautions.</p> <p>c. Ensure staff were wearing appropriate personal protective equipment (PPE - protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission) during contact with residents and/or the resident's environment who were on transmission-based precautions (infection control precautions in health care, used in addition to standard precautions-isolation precautions).</p> <p>d.Ensure personal toiletries and resident care items were labeled and not stored inside the [NAME] n' [NAME] restroom (a restroom that has two doors and is sandwiched between two bedrooms and is accessible by both bedrooms) of the residents.</p> <p>These deficient practices had the potential to result in cross contamination (process by which bacteria can be transferred from one area to another) and/or the development and transmission of communicable diseases (an illness or sickness) for Residents 112, 13, 17, 42, 25, 9, 10, 21, 40, 162, 6, 35, 161, 50, 56, 53, 111, 29, 30, and 114 and facility staff and could increase the incidence of the facility's Norovirus (stomach flu) outbreak (a sudden increase in occurrences of a disease).</p> <p>Findings:</p> <p>a. During a review of Resident 29's Admission Record, (AR), the AR indicated the facility admitted Resident 29 on 1/19/2022, with diagnoses that included cerebral infarction (stroke - occurs when blood flow to a part of the brain stops. the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage), and hemiplegia and hemiparesis (weakness and paralysis to one side of the body).</p> <p>During a review of Resident 29's Minimum Data Set (MDS - a resident assessment tool), dated 1/6/2025, the MDS indicated Resident 29 had intact cognition. The MDS indicated Resident 29 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting hygiene and personal hygiene.</p> <p>b. During a review of Resident 30's AR, the AR indicated the facility admitted Resident 30 on 9/13/2021, with diagnoses that included type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine), and chronic kidney disease (a long-term condition where the kidneys do not work as well as they should).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 2/18/2025 from 9:26 AM to 10:30 AM, multiple rooms had contact isolation precaution signage posted.</p> <p>During a concurrent observation and interview on 2/18/2025 at 10:30 AM, Infection Prevention Nurse (IPN) removed contact precaution signs from multiple rooms. The IPN stated the IPN was discontinuing the contact isolation precaution signs because the IPN received a recommendation from the Public Health Nurse (PHN) to discontinue isolation precautions if affected residents did not exhibit any signs and symptoms of norovirus.</p> <p>During a review of the document titled Gastrointestinal Illness/Norovirus Outbreak Line List indicated 13 residents were listed as exhibiting signs and symptoms of norovirus.</p> <p>During a review of an e-mail communication from the PHN to the facility dated 2/14/25, the e-mail communication indicated a recommendation that symptomatic residents should remain in contact isolation until 48 hours free of symptoms.</p> <p>During an interview on 2/18/2025 at 4:34 PM, the IPN stated prior to discontinuing contact isolation precautions in the morning, the IPN reviewed the progress notes and other documentation if the residents involved continued to have signs and symptoms of norovirus. The IPN stated if there were no S/S, the IPN then removed the contact isolation precaution signs.</p> <p>During an interview 2/18/2025 at 4:50 PM with the Director of Nursing (DON), Resident 29 stated the resident had two watery diarrheas that morning.</p> <p>During an interview on 2/18/2025 at 4:55 PM, Resident 30 stated the resident had been feeling nauseous all day.</p> <p>During an interview on 2/18/2025 at 5 PM, the DON stated since Resident 29 and Resident 30 continued to exhibit S/S of norovirus, the contact isolation needed to be continued to prevent further spread of the norovirus.</p> <p>During a review of the document titled Gastrointestinal Illness/Norovirus Outbreak Line List the line list indicated Resident 29 was exhibiting watery diarrhea since 2/10/2025. The line list indicated Resident 30 exhibited nausea and vomiting since 2/14/2025.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Surveillance for Infections dated 09/2017, the P&amp;P indicated the infection preventionist will conduct ongoing surveillance for healthcare-associated infections and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventive interventions. The P&amp;P indicated the surveillance should include review of any or all of the following information to help identify possible indicators of infections including infection documentation records, infection control rounds or interviews.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Center for Disease Control (CDC, national public health agency of the United States), facts and stats regarding Norovirus dated 4/24/2024, the CDC indicated most people with norovirus illness get better within 1 to 3 days; but they can still spread the virus for a few days after. The CDC fact sheet indicated the most common symptoms of norovirus are diarrhea, vomiting, nausea and stomach pain. These symptoms could lead to dehydration (loss of body fluids) especially in young children, older adults and people with other illnesses.</p> <p>42307</p> <p>c. During a review of Resident 112's Admission Record (AR), the AR indicated, Resident 112 was admitted to the facility on [DATE] with multiple diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain tissue to die) affecting right dominant side and personal history of COVID-19 (coronavirus - a mild to severe respiratory illness that spread from person to person).</p> <p>During a review of Resident 112's History and Physical Examination (H&amp;P), dated 2/5/2025, the H&amp;P indicated, Resident 112 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 112's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 2/8/2025, the MDS indicated, Resident 112's cognitive skills (ability to think and process information) for daily decision making was severely impaired (never/rarely made decisions).</p> <p>During a review of Resident 13's AR, the AR indicated, Resident 13 was admitted to the facility on [DATE] with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and type 2 diabetes mellitus (DM2- adult-onset disorder characterized by difficulty in blood sugar control and poor wound healing) with other specified complication.</p> <p>During a review of Resident 13's H&amp;P, dated 10/10/2024, the H&amp;P indicated, Resident 13 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 13's MDS, dated [DATE], the MDS indicated, Resident 13's cognition (ability to understand and process information) was moderately impaired.</p> <p>During a review of Resident 17's AR, the AR indicated, Resident 17 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus without complications and personal history of COVID-19.</p> <p>During a review of Resident 17's H&amp;P, dated 2/3/2024, the H&amp;P indicated, Resident 17 was only able to make decisions for basic needs.</p> <p>During a review of Resident 17's MDS, dated [DATE], the MDS indicated, Resident 17's cognitive skills for daily decision making was severely impaired.</p> <p>During a review of Resident 25's AR, the AR indicated, Resident 25 was admitted to the facility on [DATE] with multiple diagnoses including acute respiratory failure (when the lungs can't release enough oxygen into your blood) with hypoxia (low levels of O2 in your body tissues) and essential (primary) hypertension.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 25's MDS, dated [DATE], the MDS indicated, Resident 25's cognition was intact.</p> <p>During a review of Resident 25's H&amp;P, dated 11/18/2024, the H&amp;P indicated, Resident 25 did not have the capacity to understand and make decisions.</p> <p>During an observation on 2/18/2025 at 9:10 AM in the shared room of Resident 112 and Resident 13, there were Contact Precaution (a precaution with measures that are intended to help prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment), Droplet Precaution (a precaution with measures used to prevent the spread of germs that are spread through the air when someone with a respiratory infection coughs, sneezes, or talks), and a sequence for donning (putting on) PPE signages posted on the room's door. Additionally, there was a PPE cart was outside the room. Certified Nursing Assistant (CNA) 1 was inside the room transporting Resident 112 and assisting Resident 112 from the wheelchair back to bed, CNA 1 was only wearing a surgical mask.</p> <p>During an interview on 2/18/2025 at 9:16 AM with the Director of Nursing (DON), the DON stated, to wear gloves, gown, and a mask for contact precautions because potentially get it (infection) through contact to prevent spread of infection and for infection control [purposes].</p> <p>During an interview on 2/18/2025 at 9:28 AM with the Infection Preventionist (IP - a healthcare professional who specializes in preventing the spread of infections in healthcare settings), the IP stated, there were contact precaution signages posted because the facility currently had a norovirus outbreak. The IP stated, it was important to wear the proper PPE for contact precautions, because in general, it's easily transmissible through contact and for the prevention of spread of infection.</p> <p>During an observation on 2/18/2025 at 9:47 AM in the shared room of Resident 17 and Resident 25, a Contact Precautions, and a sequence for donning PPE signages were posted on the room's door and a PPE cart was outside of the room.</p> <p>During a concurrent observation and interview on 2/18/2025 at 10:05 AM inside Resident 17 and Resident 25's room, CNA 2 was inside the room, only wearing a surgical mask, and picked up Resident 25's breakfast tray and carried the breakfast tray up against CNA 2's abdomen (belly) touching CNA 2's uniform. CNA 2 stated, CNA 2 was aware Resident 17 was in contact precautions and CNA 2 should have worn [the appropriate] PPE.</p> <p>During a concurrent observation and interview on 2/18/2025 at 10:10 AM with the Director of Staff Development (DSD), the Central Supply (CS) was wearing a surgical mask only, was carrying a package of clean diapers, and entered Resident 17 and 25's room. The CS placed the package of clean diapers on top of the counter below the tv located across from Residents 17 and 25's beds. The CS was observed touching doors of Resident 17 and 25's shared closet that had a partition in the middle inside and the CS stocked the closet with diapers. The DSD stated, the DSD notified the CS to put on PPE.</p> <p>d. During a review of Resident 9's AR, the AR indicated, Resident 9 was originally admitted to the facility on [DATE] and readmitted the resident on 11/20/2024 with multiple diagnoses including other specified sepsis (a life-threatening blood infection) and other pneumonia (an infection/inflammation in the lungs).</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 9's H&amp;P, dated 11/20/2024, the H&amp;P indicated, Resident 9 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 9's MDS, dated [DATE], the MDS indicated, Resident 9's cognition was moderately impaired.</p> <p>During a review of Resident 42's AR, the AR indicated, Resident 42 was originally admitted to the facility on [DATE] and readmitted the resident on 2/3/2025 with multiple diagnoses including other specified sepsis and other infectious disease.</p> <p>During a review of Resident 42's H&amp;P, dated 1/29/2025, the H&amp;P indicated, Resident 42 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 42's MDS, dated [DATE], the MDS indicated, Resident 42's cognition was severely impaired.</p> <p>During a review of Resident 10's AR, the AR indicated, Resident 10 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with multiple diagnoses including essential (primary) hypertension (high blood pressure) and unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow).</p> <p>During a review of Resident 10's H&amp;P, dated 4/18/2024, the H&amp;P indicated, Resident 10 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 10's MDS, dated [DATE], the MDS indicated, Resident 10's cognition was severely impaired.</p> <p>During a review of Resident 21's AR, the AR indicated, Resident 21 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus (DM2- adult onset disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (nerve damage that is caused by diabetes), and chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 21's History and Physical Examination (H&amp;P), dated 8/31/2024, the H&amp;P indicated, Resident 21 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 21's MDS, dated [DATE], the MDS indicated, Resident 21's cognition was severely impaired.</p> <p>During a review of Resident 161's AR, the AR indicated, Resident 161 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus with other specified complication and chronic systolic (congestive) heart failure.</p> <p>During a review of Resident 161's H&amp;P, dated 2/10/2025, the H&amp;P indicated, Resident 161 had the capacity to understand and make decisions.</p> <p>During a review of Resident 161's MDS, dated [DATE], the MDS indicated, Resident 161's cognition was intact.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 50's AR, the AR indicated, Resident 50 was admitted to the facility on [DATE] with multiple diagnoses including other bacterial infections of unspecified site and COVID-19.</p> <p>During a review of Resident 50's H&amp;P, dated 1/1/2025, the H&amp;P indicated, Resident 50 had the capacity to understand and make decisions.</p> <p>During a review of Resident 50's MDS, dated [DATE], the MDS indicated, Resident 50's BIMS Summary Score was intact.</p> <p>During a review of Resident 56's AR, the AR indicated, Resident 56 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus with other specified complication and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.</p> <p>During a review of Resident 56's H&amp;P, dated 1/25/2025, the H&amp;P indicated, Resident 56 could make needs known but could not make medical decisions.</p> <p>During a review of Resident 56's MDS, dated [DATE], the MDS indicated, Resident 56's cognitive skills for daily decision making were severely impaired.</p> <p>During a review of Resident 53's AR, the AR indicated, Resident 53 was admitted to the facility on [DATE] with multiple diagnoses including end stage renal disease (ESRD - irreversible kidney failure) and type 2 diabetes mellitus with diabetic polyneuropathy (a condition that affects multiple peripheral nerves outside your brain and spinal cord).</p> <p>During a review of Resident 53's MDS, dated [DATE], the MDS indicated, Resident 53's cognition was moderately impaired.</p> <p>During a review of Resident 6's AR, the AR indicated, Resident 6 was originally admitted to the facility on [DATE] and last readmitted on [DATE] with multiple diagnoses including personal history of COVID-19 and essential (primary) hypertension.</p> <p>During a review of Resident 6's H&amp;P, dated 1/7/2024, the H&amp;P indicated, Resident 6 had the capacity to understand and make decisions.</p> <p>During a review of Resident 6's MDS, dated [DATE], the MDS indicated, Resident 6's cognition was intact.</p> <p>During a review of Resident 35's AR, the AR indicated, Resident 35 was admitted to the facility on [DATE] with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and personal history of COVID-19.</p> <p>During a review of Resident 35's H&amp;P, dated 1/16/2024, the H&amp;P indicated, Resident 35 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 35's MDS, dated [DATE], the MDS indicated, Resident 35's cognitive skills for daily decision making were severely impaired.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 40's AR, the AR indicated, Resident 40 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus with diabetic chronic kidney disease and heart failure, unspecified.</p> <p>During a review of Resident 40's H&amp;P, dated 9/11/2023, the H&amp;P indicated, Resident 40 had the capacity to understand and make decisions.</p> <p>During a review of Resident 40's MDS, dated [DATE], the MDS indicated, Resident 40's cognition was severely impaired.</p> <p>During a review of Resident 162's AR, the AR indicated, Resident 162 was admitted to the facility on [DATE] with multiple diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and syphilis (a bacterial infection that's usually spread through sexual contact), unspecified.</p> <p>During a review of Resident 162's H&amp;P, dated 11/20/2024, the H&amp;P indicated, Resident 162 was not having memory loss.</p> <p>During a review of Resident 162's MDS, dated [DATE], the MDS indicated, Resident 162's cognition was intact.</p> <p>During a concurrent observation and interview on 2/18/2025 at 10:37 AM with CNA 3, inside the shared restroom of Residents 17, 25 and 9, there were an unlabeled gray colored wash basin, and an opened unlabeled bottle of peri cleanser stored on top of the sink. CNA 3 stated, the wash basin and peri cleanser should have been labeled with the resident's names and room number so staff knew who the wash basin and peri cleanser belonged to, and the items should be kept in the resident's bedside drawer for infection control [purposes].</p> <p>During a concurrent observation and interview on 2/18/2025 at 11:03 AM with the DSD, inside the shared restroom of Resident 42, 10 and 21, there were an unlabeled emesis (vomiting) basin, and a drinking cup stored on top of the sink. The DSD stated, the emesis basin and drinking cup should be labeled [with the resident's name] and kept at the bedside for infection control, especially that (room of Resident 10 and Resident 21) is in contact isolation.</p> <p>During an observation on 2/18/2025 at 11:27 AM, in the shared room of Resident 10 and Resident 21, a Contact Precautions, and a sequence for donning PPE signages were posted and a PPE cart was outside the room.</p> <p>During an observation on 2/18/2025 at 11:50 AM, in the shared room of Residents 161 and Resident 50, an Enhanced Barrier Precaution (a set of infection control practices that use gowns and gloves to reduce the spread of multidrug-resistant organisms [MDROs]) and sequence for donning PPE signages were posted on the door and a PPE cart was outside of the room. Inside the shared restroom of Residents 161, 50, 56 and 53, there were three opened unlabeled tubes of toothpaste and 3 unlabeled used toothbrushes inside an unlabeled emesis basin, two unlabeled opened shaving creams and one unlabeled used roll-on anti-perspirant stored on top of the sink and an unlabeled cannister stored on top of the toilet tank.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 2/18/2025 at 12:14 PM, in the shared room of Resident 6 and Resident 35, an Enhanced Barrier Precautions, and a sequence for donning PPE signages were posted on the room's door and a PPE cart was located outside the room. Inside the shared restroom of Residents 6, 35, 40 and 162, there was a wash basin labeled with Resident 35's name that was stored on top of the toilet tank and an unlabeled emesis basin with a used unlabeled toothbrush inside, stored on top of the wall mounted soap dispenser of the sink.</p> <p>During a review of the facility's undated Line List (LL - a table that organizes information about each case of a disease or outbreak), titled, Gastrointestinal Illness/Norovirus Outbreak Line List, the LL indicated, thirteen residents on the list included Resident 17 and Resident 40 as having signs and symptoms of the norovirus.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Norovirus Prevention and Control, revised 10/2011, the P&amp;P indicated, the facility would implement strict infection control measures to prevent the transmission of norovirus infection.</p> <p>During a review of the facility's P&amp;P titled, Infection Control Guidelines for All Nursing Procedures, revised 8/2012, the P&amp;P indicated, guidelines for general infection control while caring for residents included to wear PPE as necessary to prevent exposure to spills or splashes of blood or body fluids or other potentially infectious materials and in addition to the general guidelines, to refer to procedures for any specific infection control precautions that may be warranted.</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45553</p> <p>Based on observation, interview, and record review, the facility failed to provide a functioning call light for one of one sampled resident (Resident 7).</p> <p>This deficient practice had the potential for delay in care and services to meet Resident 7's needs for hydration, toileting, and activities of daily living.</p> <p>Findings:</p> <p>During a review of Resident 7's Admission Record (AR), the AR indicated, Resident 7 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side) following cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), epilepsy (a chronic brain disorder in which groups of nerve cells, or neurons, in the brain sometimes send the wrong signals and cause seizures), and muscle weakness (lack of muscle strength).</p> <p>During an interview on 2/18/25 at 12:50 p.m. with Resident 7, Resident 7 stated his call light was not working since last night (2/17/25). Resident 7 stated he was told by the night shift Certified Nursing Assistant (no name given) to Yell for me. Resident 7 stated he was upset that he would have to yell for help, and Resident 7 stated he wanted his call light fixed on 2/18/25.</p> <p>During a concurrent observation and interview on 2/18/25 at 12:55 p.m. with Certified Nursing Assistant 6 (CNA 6), CNA 6 was observed pushing the button on the call light, and the light inside Resident 7's room and above the door did not turn on. CNA 6 stated, The call light does not work now, the light does not turn on. CNA 6 stated, It is important for the call light to work. CNA 6 stated Resident 7 could not call for help with his needs, especially in an emergency when the call light did not work. CNA 6 stated she would inform the maintenance director about the call light not working.</p> <p>During an observation on 2/18/25 at 1:00 p.m. in front of Resident 7's room, CNA 6 was seen entering the room with a bell to give to Resident 7 to use to call for help.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Answering the Call Light, revised September 2022, the P&amp;P indicated, The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines: Be sure that the call light is plugged in and functioning at all times. Report all defective call lights to the nurse supervisor promptly.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45553</p> <p>Based on observation, interview, and record review, the facility failed to ensure:</p> <ol style="list-style-type: none"> <li>1) A call light was functional for 1 of 1 sampled resident (Resident 7).</li> <li>2) 7 out of 7 bathrooms were in good repair.</li> <li>3) 1 of 1 sampled resident's (Resident 13) bed control was functional.</li> </ol> <p>These deficient practices had the potential for Residents 7, 13, and residents in Rooms A-D to be placed at risk for injury, a decline in the resident's health, and a delay in meeting the resident's needs for toileting and assistance.</p> <p>Cross Reference F584 and F919.</p> <p>Findings:</p> <p>1) During an interview on 2/18/25 at 12:50 p.m. with Resident 7, Resident 7 stated Resident 7's call light was not working since last night (2/17/25). Resident 7 stated he was told by the night shift Certified Nursing Assistant (no name given) to Yell for me. Resident 7 stated he was upset that he would have to yell for help. Resident 7 stated he requested staff to fix his call light on 2/18/25.</p> <p>During a concurrent observation and interview on 2/18/25 at 12:55 p.m. with Certified Nursing Assistant 6 (CNA 6), CNA 6 was observed pushing the button on the call light, and the light inside Resident 7's room and above the door did not turn on. CNA 6 stated, The call light does not work now, the light does not turn on.</p> <p>2) During a concurrent observation and interview on 2/21/25 at 10:40 a.m. in Bathrooms 1-7 and Rooms A-D with the Maintenance Director (MTD), MTD acknowledged all bathrooms and rooms reviewed need repairs, and the bathroom conditions and room conditions can pose a risk to the resident's health. Bathroom [ROOM NUMBER]-7 and Rooms A-D had multiples issues such as chipped paint, scratches on the doors, unpainted [NAME], unpainted walls, cracked/peeling caulking on the floors. The MTD stated he would immediately fix all areas reviewed.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Answering the Call Light, revised September 2022, the P&amp;P indicated, The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines: Be sure that the call light is plugged in and functioning at all times. Report all defective call lights to the nurse supervisor promptly.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&amp;P) titled, Homelike Environment, revised February 2021, the P&amp;P indicated, Policy Statement: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation: The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean, sanitary and orderly environment.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Maintenance Service, revised December 2009, the P&amp;P indicated, Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation: The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personal include but are not limited to: Maintaining the building in good repair and free from hazards. Providing routinely scheduled maintenance service to all areas.</p> <p>40913</p> <p>3) During a review of Resident 13's Admission Record (AR), the AR indicated the facility admitted Resident 13 on 10/8/2024, with diagnoses that included cerebral infarction (stroke - sudden death of brain cells in a localized area due to inadequate blood flow), type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine).</p> <p>During a review of Resident 13's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/9/2025, the MDS indicated Resident 13 understood verbal content and was able to express ideas and wants. The MDS indicated Resident 13 had moderate cognitive impairment. The MDS indicated Resident 13 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating and oral hygiene.</p> <p>During a concurrent observation and interview on 2/19/2025 at 9:37 AM, in Resident 13's room, with Resident 13. Resident 13 stated the resident's bed control was not working. Resident 13 stated the resident ended up in a certain position for an extended period of time and ended up having pain in the legs. Resident 13 stated Resident 13 had informed almost all the certified nursing assistants (CNA's) assigned to Resident 13 and the CNA's informed Resident 13 they would notify the maintenance staff but maintenance staff never came to fix the bed control. Resident 13 pressed the bed control and the head of the bed (HOB) moved up then Resident 13 pressed the bed control to move the head of the bed down and the HOB stayed in the up position. Resident 13 was stuck sitting up, approximately close to a 90 degree angle.</p> <p>During a concurrent observation and interview on 2/19/2025 at 9:42 AM, Resident 13 pressed the bed control for the HOB to go down and the HOB went down. Resident 13 stated that's the problem with the bed control, sometimes it works and sometimes it does not work.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/19/2025 at 3:50 PM, Licensed Vocational Nurse 2 (LVN 2) stated Resident 13's bed control issue was not reported because Resident 13's bed control eventually worked. LVN 2 stated when equipment or a device was not working, staff needed to report the issue to maintenance and write the request on the Maintenance log so the request for repair could be tracked. LVN 2 stated Resident 13 could get stuck in one position if the bed control did not work and Resident 13 could get stuck in one position could cause Resident 13 to experience discomfort.</p> <p>During an interview on 2/21/2025 at 9:32 AM, with the Maintenance Director (MTD), the MTD stated the MTD fixed Resident 13's bed control two days ago on 2/19/2025 when it was reported to the MTD, the MTD stated the MTD replaced the bed control and the bed control was working. The MTD stated Resident 13 reported to the MTD on 2/19/2025 that Resident 13 had reported the issue to the CNA's. The MTD stated the staff needed to write request for repairs in the Maintenance Log because the MTD checked the Maintenance Log multiple times a day. The MTD stated if the request for repair was verbally reported to the MTD, the repair could get missed because the MTD had a lot of other things to do.</p> <p>During a review of the facility's undated, Maintenance Log, the log indicated there was no request for Resident 13's bed control repair.</p> <p>During a review of the facility's P&amp;P titled Maintenance Service dated 12/2009, the P&amp;P indicated Maintenance service shall be provided to all areas of the building, grounds, and equipment. The P&amp;P indicated the functions of maintenance personnel include other maintenance that may become necessary or appropriate.</p> <p>During a review of the facility's P&amp;P, titled, Work Orders, Maintenance dated 4/2010, the P&amp;P indicated in order to establish a priority of maintenance service, work orders must be filled out and forwarded to the maintenance director.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>40913</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of one kitchen (Kitchen 1) area was kept free of pest. On 2/18/2025, two dead cockroaches were found in Kitchen 1.</p> <p>This deficient practice had the potential to result in food-borne illnesses (illness caused by food contaminated with infectious organisms) due to harboring of pest.</p> <p>Findings:</p> <p>During a tour of the Kitchen 1 on 2/18/2025 at 8:45 AM, there were two dead cockroaches at the back of the walk-in freezer, the roaches were visible when checking the 3- inch gap located between the walk-in freezer and the wall. The Dietary Aide (DA) used a broom to sweep the cockroaches from the back wall. The broom used had dust and green beans that were swept together with the dead roaches.</p> <p>During an interview on 2/18/2025 at 8:47 AM, with the DA, the DA stated it was dead cockroaches.</p> <p>During an interview on 2/18/2025 at 2:40 PM, with the Dietary Supervisor (DS), the DS stated the cockroaches could have come out of hiding after the monthly pest control visit more than a week ago. The DS stated kitchen staff needed to clean all areas of Kitchen 1.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Sanitization dated 10/2008, the P&amp;P indicated all kitchen, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies, and other insects.</p>