STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure comprehensive person-centered care plans (CP) were developed for two of two sampled residents (Resident 36 and Resident 14) in accordance with the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered and Fall Risk Assessment. This failure had the potential to result in unmet individualized needs for Residents 36 and 14 and the potential to affect the resident's physical and psychosocial well-being.Cross Reference F689Findings: a. During a review of Resident 36's admission Record (AR), the AR indicated Resident 36 was admitted to the facility on [DATE] with diagnoses that included intervertebral disc displacement (a spinal condition where the soft, gel-like center of a spinal disc pushes through its tough outer ring into the spinal canal) - lumbar region (lower part of the back), cerebellar ataxia (involuntary muscle coordination causing unsteady movements), repeated falls, and lack of coordination, abnormalities in gait and mobility (abnormal walking, characterized by unsteadiness, shuffling, limping, or stiffness). During a review of Resident 36's History and Physical (H&P), dated 10/26/2025, the H&P indicated Resident 36 did not have the capacity to understand and make decisions. During a review of Resident 36's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 1/22/2026, the MDS indicated Resident 36's cognition (the ability to think and process information) was moderately impaired (moderate problems with thinking and memory). The MDS indicated Resident 36 was dependent (helper does all of the effort) with toilet hygiene, lower body dressing and needed maximal assistance (helper does more than half the effort) with upper body dressing. During a review of Resident 36's Fall Risk Assessments (FRA), dated 1/13/2026, 2/3/2026, and 2/9/2026, the FRAs indicated Resident 36 was at risk for falls. During a review of Resident 36's Change in Condition Evaluation (COC), the COC indicated Resident 36 sustained falls on 1/30/2026, 2/9/2026, 2/15/2026, 3/1/2026, and 3/23/2026. During an interview and concurrent record review on 4/24/2026 at 2:28 PM with the Director of Nursing (DON), Resident 36's paper and electronic medical record (chart) was reviewed, the DON stated Resident 36 did not have CPs addressing Resident 36's falls that occurred on 1/30/2026, 2/9/2026, 2/15/2026, 3/1/2026 and 3/23/2026. The DON stated fall CPs were important to [help prevent] re-occurrence of falls and for injuries to be prevented. During a review of the facility's undated P&P titled Fall Risk Assessment, the P&P indicated the (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. b. During a review of Resident 14's AR, the AR indicated Resident 14 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including acute respiratory failure with hypoxia (a medical emergency where the lungs suddenly fail to get enough oxygen [O2, a colorless gas essential to living organisms] into the blood causing severe shortness of breath), and heart failure, unspecified. During a review of Resident 14's undated H&P, the H&P indicated, Resident 14 did not have the capacity to understand or make medical decisions. During a review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 14's cognitive skills (ability to think and process information) for daily decision making were moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 14 was dependent (helper does all of the effort) to requiring partial/moderate assistance (helper does less than half the effort) with activities of daily living (ADL – routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 14 received continuous 02 therapy on admission and while a resident (at the facility). During a review of Resident 14's Order Summary Report (OSR), dated active as of 4/24/2026, the OSR indicated a physician's order, dated 2/26/2026, for 02 at three (3) liters per minute (LPM - the speed or volume of 02 a device delivers in one minute) via nasal cannula continuously. During a concurrent interview and record review on 4/23/2026 at 1:44 PM with the Registered Nurse Supervisor (RNS), Resident 14's medical records were reviewed. The RNS stated Resident 14 had a physician's order for 02 at 3 LPM ordered on 2/26/2026 for respiratory failure. The RNS stated Resident 14 did not have a CP that addressed Resident 14's supplemental 02 therapy. The RNS stated creating a CP was important for the staff (in general) to have a plan for a specific problem including interventions for the residents (in general). During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, date revised March 2022, the P&P indicated 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&P indicated the comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. The P&P indicated assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure three of three sampled residents (Resident 20, 24, 36) received medication or treatment in accordance with the physician's orders and the facility's policy and procedures (P&P) by: A. Failing to administer two grams of lidocaine (medication used to numb tissues for procedures or pain relief) external ointment 5% as indicated on the medication physician order for Resident 20. B. Failing to provide Restorative Nurse Assistant (RNA, specialized rehabilitative care provided by nurse assistants with extra training to help residents regain or maintain mobility, strength, and independence in activities of daily living) services as indicated in Resident 24's physician order.C. Failing to initiate Fall Risk Assessments after Resident 36 sustained falls on 1/30/2026, 2/19/2026, 3/1/2026, 3/23/2026, and on 4/15/2026.This deficient practice had the potential to result in harm and a physical decline to Resident 20, Resident 24, and Resident 36. Additionally, there was a potential for recurrent falls to Resident 36. Cross Reference F689Findings: A. During a review of Resident 20's admission Record (AR), the AR indicated Resident 20 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including spondylosis (degeneration of the bones and disks in the neck) and type 2 diabetes mellitus (condition in which the body cannot properly store or use glucose, the body's main source of energy) with diabetic chronic (long standing) kidney disease (common complication of diabetes that reduces how well kidneys filter waste). During a review of Resident 20's Care Plan (CP), initiated 11/4/2024, the CP's focus indicated acute (sudden)/chronic pain related to multiple medical conditions. The CP's interventions indicated to administer pain medication as ordered. During a review of Resident 20's physician order dated 3/11/2026, the physician order indicated Lidocaine external ointment 5%. The physician order indicated to apply 2 grams (gm-unit of weight) to the right upper arm topically (the application of a substance directly onto a specific surface area of the body, usually the skin) two times a day for right arm pain. During a review of Resident 20's Minimum Data Set (MDS- a resident assessment tool), dated 3/25/2026, the MDS indicated Resident 20 had intact cognition (ability to understand and process information) and was dependent on staff for bathing and toileting. During a concurrent observation and interview on 4/23/2026 at 9:02 AM with Licensed Vocational Nurse (LVN) 2, medication administration for Resident 20's Lidocaine ointment was observed. LVN 2 administered an unmeasured amount of ointment to Resident 20. LVN 2 stated LVN 2 was not sure how much lidocaine was applied (administered) to Resident 20 because the medication label did not indicate how much ointment was 2 gm. LVN 2 stated it was important to give an accurate dose [of Lidocaine] to ensure Resident 20 did not get too much or too little medication. During an interview on 4/23/2026 at 10:29 AM with the Director of Nursing (DON), the DON stated correct dosages of medications should be given to ensure residents are not over dosed or under dosed and [an incorrect dose] could cause harm. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated medications are administered in accordance with prescriber orders, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	including any required time frame. B. During a review Resident 24's AR, the AR indicated Resident 24 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (form of paralysis causing muscle weakness or total loss of motor function on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (type of stroke caused by a blockage in blood vessels supplying the brain resulting in tissue death [NAME] to lack of oxygen) affecting the left non-dominant side, contracture (permanent, shortening of muscles, causing rigid, stiff joints and reduced movement) of the left knee, contracture of the left elbow, contracture of the left hip, lack of coordination, and generalized muscle weakness. During a review of Resident 24's H&P, dated 1/23/2026, the H&P indicated Resident 24 had the capacity to understand and make decisions. During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24 was cognitively intact, had impairment (weakened, or damaged,) on one side of Resident 24's upper and lower extremities (arm and leg), and Resident 24 used a walker and a manual wheelchair for mobility. The MDS indicated Resident 24 required maximal assistance (helper does more than half the effort) with activities of daily living such as upper body dressing and bathing. During a review of Resident 24's CP, dated 4/23/2026, the CP's focus indicated Resident 24 was at risk for decline in range of motion (ROM, how far a person can move a joint or muscle in various directions) and risk for decreased muscle strength . The CP's interventions indicated RNA program to assist Resident 24 with ambulation using a HW support and L HKAFO application, to maintain current level of function. During a review of Resident 24's Order Summary Report (OSR), dated active as of 4/24/2026, the OSR included a physician's order (PO), dated 12/9/2025, the PO indicated RNA program to assist patient with ambulation using a hemi walker (HW, mobility aid designed for individuals who can only use one hand or arm, often due to one sided weakness) support and L [left] Hip-Knee-Angle-Foot Orthosis (HKAFO, custom molded full-leg bracing system that extends from the pelvis [large basin-shaped bone at the base of the spine] down to the foot) application, in order to maintain current level of function 4X/WK [four times a week] every Tuesday, Friday, Saturday, and Sunday. During a review of Resident 24's RNA program medical record, dated April 2026, the record indicated Resident 24 did not receive RNA services on Sunday 4/5/2026, Tuesday 4/7/2026, and on Sunday 4/19/2026. During an observation and concurrent interview on 4/21/2026 at 11:33 AM with Resident 24, at Resident 24's bedside, Resident 24 was sitting on a wheelchair and stated, I don't always get my RNA therapy four times a week, sometimes I only get it three times. The resident stated, I don't like to miss sessions, I can still walk, a little. During a concurrent record review and interview on 4/23/2026 at 2:55 PM, with Restorative Nursing Assistant 1 (RNA 1), Resident 24's RNA program medical record was reviewed. RNA 1 stated Resident 24's RNA treatment was missed on 4/5/2026, 4/7/2026 and 4/19/2024. RNA 1 stated RNA 1 did not recall why Resident 24 did not receive RNA treatments on those dates. RNA 1 stated it was important for Resident 24 to receive RNA treatments for Resident 24 to keep using Resident 24's good leg. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/2026 at 3:24 PM with the Registered Nurse Supervisor (RNS), the RNS stated it was important for RNA services to be done to maintain the function of Resident 24's extremities. During an interview on 4/24/2026 at 9:46 AM with the Director of Staff Development (DSD), the DSD stated RNA treatments should not be missed to maintain, stabilized, and hopefully improve Resident 24's mobility function. During an interview on 4/24/2026, at 2:33 PM with the DON, the DON stated RNA orders should be followed to prevent decline and to maintain what the resident's mobility. During a review of the facility's P&P titled Restorative Nursing Services, dated 7/2017, the P&P indicated residents will receive RNA care as needed to help promote optimal safety and independence. The P&P indicated restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care. The P&P indicated restorative goals may include but not limited to supporting and assisting the resident in developing, maintaining or strengthening their physiological and psychological resources, maintaining their dignity, independence and self-esteem. During a review of the facility's P&P titled Activities of Daily Living (ADL's), Supporting, dated 3/2018, the P&P indicated residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADL's. The P&P indicated residents will be provided with care, treatment, and services to ensure that their ADLs do not diminish. C. During a review of Resident 36's AR, the AR indicated Resident 36 was admitted to the facility on [DATE] with diagnoses that included intervertebral disc displacement (a spinal condition where the soft, gel-like center of a spinal disc pushes through its tough outer ring into the spinal canal) - lumbar region (lower part of the back), cerebellar ataxia (involuntary muscle coordination causing unsteady movements), repeated falls, and lack of coordination, abnormalities in gait and mobility (abnormal walking, characterized by unsteadiness, shuffling, limping, or stiffness). During a review of Resident 36's H&P, dated 10/26/2025, the H&P indicated Resident 36 did not have the capacity to understand and make decisions. During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36's cognition (the ability to think and process information) was moderately impaired (moderate problems with thinking and memory). The MDS indicated Resident 36 was dependent (helper does all of the effort) with toilet hygiene, lower body dressing and needed maximal assistance (helper does more than half the effort) with upper body dressing. During a review of Resident 36's Change in Condition Evaluation (COC), the COC indicated Resident 36 sustained falls on 1/30/2026, 2/19/2026, 3/1/2026, 3/23/2026, and 4/15/2026. During an interview and concurrent record review on 4/24/2026 at 2:24 PM with the Director of Nursing (DON), Resident 36's COC's indicating falls, dated 1/30/2026, 2/19/2026. 3/1/2026, 3/23/2026 and 4/15/2026 were reviewed, the DON stated post fall risk assessments were not completed after Resident 36's falls that occurred on 1/30/2026, 2/19/2026, 3/1/2026, 3/23/2026 and 4/15/2026. The DON stated it was important to complete fall risk assessments after every fall to find out the root cause of the fall, to prevent future falls, and to find out how to correct it [root cause]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated P&P titled Fall Risk Assessment, the P&P indicated the nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. The P&P indicated upon admission, the nursing staff and the physician will review a resident's record for a history of falls, especially falls in the last 90 days and recurrent or periodic bouts of falling over time. During a review of the facility's P&P titled Assessing Falls and Their Causes, dated 3/2018, the P&P's purpose indicated the procedure is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. The P&P's general guidelines indicated residents must be assessed upon admission and regularly afterward for potential risk of falls and relevant risk factors must be addressed promptly. The P&P indicated when a resident falls, the following information should be recorded in the resident medial record: completion of a falls risk assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure one bag of breaded fish, in one of one freezer (Freezer 1), was labeled and dated as indicated in the facility's policy and procedure (P&P) titled, Food Receiving and Storage.This deficient practice had the potential to result in foodborne illnesses (type of illness caused by consuming contaminated food or beverages) to the residents residing at the facility and consuming the food.Findings: During a concurrent observation and interview on 4/21/2026 at 9:07 AM during the kitchen tour with the Dietary Manager (DM), Freezer 1 had one bag of breaded fish with an undated label. The DM stated the bag of breaded fish did not contain a label that indicated a received, date and use by, date which was required for resident food safety.During a review of the facility's P&P titled, Food Receiving and Storage, dated 11/2022, the P&P's policy statement indicated foods shall be received and stored in a manner that complies with safe food handling practices. The P&P's refrigerated/frozen storage section indicated all foods stored in the refrigerator or freezer are covered, labeled, and dated (use by date).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection (the invasion and growth of germs in the body) prevention and control practices by failing to ensure:a.Personal care items found inside the [NAME] and [NAME] restroom (a shared restroom situated between two bedrooms, featuring direct access from both rooms) for 4 of 7 sampled residents (Resident 54, Resident 9, Resident 39, and Resident 45) were labeled and stored properly.b. The lint screen/trap for one of one sampled commercial laundry dryer (CLD) was free of accumulation of lint c. An Enhanced Barrier Precaution (EBP - an infection-control practice to prevent the spread of bacteria in nursing homes) sign was posted outside of 1 of 7 sampled residents (Resident 70).These deficient practices had the potential to result in cross contamination (the process by which microorganisms are unintentionally transferred from one area/object to another with a harmful effect) and/or the development and transmission of disease (an illness or sickness) and infections to the residents including Residents 54, 9, 39, 45, 70. Additionally, the deficient practice had the potential to result in a damp environment leading to mold and bacterial growth in the dryer and the spread of microorganisms throughout the facility.Findings: a. During a review of Resident 54's admission Record (AR), the AR indicated Resident 54 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including personal history of poliomyelitis (polio - a highly contagious virus [a very tiny germ] that spreads through contact with infected poop or contaminated food/water) and heart failure. During a review of Resident 54's History and Physical (H&P), dated 6/11/2025, the H&P indicated Resident 54 had the capacity to make medical decisions. During a review of Resident 54's Minimum Data Set (MDS - a resident assessment tool), dated 2/10/2026, the MDS indicated Resident 54's cognitive skills (ability to think and process information) for daily decision making were intact (decisions consistent/reasonable). The MDS indicated Resident 5 required partial/moderate assistance (helper does less than half the effort) with oral hygiene (the ability to use suitable items to clean teeth). During a review of Resident 9's AR, the AR indicated Resident 9 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus (DM II – adult-onset disorder characterized by difficulty in blood sugar control and poor wound healing) without complications, and pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) of sacral (a triangular bone at the base of the spine between the hip bones) region, unstageable. During a review of Resident 9's History of Present Illness (HPI), dated 3/27/2026, the HPI indicated Resident 9 had the capacity to understand and make decisions. During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9's cognitive skills for daily decision making were intact. The MDS indicated Resident 9 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. During a review of Resident 39's AR, the AR indicated Resident 39 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus with other simplified complication, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and essential (primary) hypertension (HTN – high blood pressure). During a review of Resident 39's H&P, dated 1/23/2026, the H&P indicated Resident 39 did not have the capacity to understand and make decisions. During a review of Resident 39's MDS, dated [DATE], the MDS indicated Resident 39 required substantial/maximal assistance (helper does more than half the effort) with oral hygiene. During a review of Resident 45's AR, the AR indicated Resident 45 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including COVID-19 (Coronavirus Disease of 2019 - a highly contagious respiratory illness caused by the SARS-CoV-2 virus), and urinary tract infection (UTI – an infection in the bladder/urinary tract), site not specified. During a review of Resident 45's H&P, dated 1/17/2026, the H&P indicated Resident 45 did not have the capacity to understand and make decisions. During a review of Resident 45's MDS, dated [DATE], the MDS indicated Resident 45's cognitive skills for daily decision making were intact. The MDS indicated Resident 45 required supervision or touching assistance with oral hygiene. During an observation on 4/21/2026 at 12:37 PM, Resident 54 and Resident 9's shared room had an EBP sign posted outside of the room and a wall mounted PPE (personal protective equipment – clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) holder was inside the room by the door. During a concurrent observation and interview on 4/21/2026 at 1:12 PM with Certified Nursing Assistant (CNA) 2, inside the [NAME] and [NAME] restroom of Residents 54, 9, 39, 45 there was an unlabeled gray colored emesis basin with a personal size toothpaste and two (2) toothbrushes stored on the sink counter. CNA 2 stated the emesis basin, toothpaste, and toothbrushes were personal care items and CNA 2 thought the personal care items belonged to Resident 45. CNA 2 stated personal care items should be labeled with the resident's (in general) name and probably placed inside a bag and stored at the resident's bedside for infection control. During an interview on 4/24/2026 at 9:40 AM with the Infection Preventionist (IP), the IP stated emesis basins, toothpaste, and toothbrushes were personal care items and should be labeled with the resident's room number, resident's initials, and stored at the resident's bedside. The IP stated the rooms of Residents 54, 9, 39, and 45 were on EBP and labeling and storing personal care items properly was important to avoid cross contamination and for infection control. During a review of the facility's policy and procedure (P&P) titled, Policies and Practices – Infection Control, revised April 2025, the P&P indicated the facility's infection control policies and practices were intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The P&P indicated one of the objectives of the facility's infection control and practices were to prevent, detect, investigate, and control infections in the facility. b. During a concurrent observation, interview, and record review on 4/24/2026 at 11:42 AM with the Housekeeping (HK) and the Maintenance Supervisor (MS), in the laundry room, the CLD had a thick (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accumulation of lint on the lint screen/trap and clumps of lint fell off and onto the floor of the CLD. The Daily Cleaning Lint Trap (DCLT), dated April 2026 was reviewed. The DCLT indicated the lint traps were cleaned every 2 hours on 4/24/2026 with 11 AM being the last time the lint trap was cleaned. The MS stated the lint trap was just cleaned about forty-five minutes ago. The HK stated the HK cleaned the CLD every 2 hours but only cleaned the floor of the CLD. The HK stated the HK did not know how to clean the lint screen/trap. The HK and the MS stated cleaning the lint screen/trap of the CLD was important to prevent fires in the facility. During a review of facility's P&P titled, Maintenance Service, date revised December 2009, the P&P indicated maintenance service should be provided at all areas of the building, grounds, and equipment. c. During a review of Resident 70's AR, the AR indicated Resident 70 was admitted to the facility on [DATE] with multiple diagnoses including bacteremia (condition in which bacteria are present in the bloodstream) and chronic (long standing) diastolic congestive heart failure (inability of the heart to efficiently pump blood through the body, causing buildup of blood in the veins and of other body fluids in tissue). During a review of Resident 70's H&P undated, the H&P indicated Resident 70 did not have capacity to understand and make decisions. The H&P indicated Resident 70 had a foley catheter (thin, flexible tube inserted through the urethra [tube that lets urine leave the body] into the bladder [hollow muscular balloon-like organ that stores urine] to continuously drain urine into a collection bag). During a review of Resident 70's Order Recap Report (ORR), dated 4/2026, the ORR indicated Resident 70 had a physician's order for EBP due to: indwelling medical device (foley catheter) with order date 4/21/2026. During a review of Resident 70's Care Plan (CP), initiated 4/21/2026, the CP's focus indicated Resident 70 required EBP related to indwelling urinary catheter. The CP's interventions indicated to place EBP signage at [Resident 70's] door entry. During a concurrent observation and interview on 4/21/2026 at 11:38 PM with the Director of Nursing (DON), the doorway to Resident 70's room was observed without EBP signage. The DON stated Resident 70 had a foley catheter and was on EBP. The DON stated the DON would place an EBP sign outside Resident 70's door. During an interview on 4/24/2026 at 9:43 AM with the IP, the IP stated a foley catheter was an indwelling medical device and anyone with an indwelling medical device required EBP. The IP stated if a resident was on EBP, a sign was posted near the door to indicate that any high contact care with the resident required the caregiver to wear at least a gown and gloves. The IP stated if there was no signage indicating EBP, the resident could be exposed to potential infections. During a review of the facility's P&P titled, Enhanced Barrier Precautions, dated 4/2024 the P&P indicated EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of multidrug resistant organisms' colonization.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 44) was treated with dignity when Certified Nursing Assistant (CNA) 1 failed to close the door of Resident 44's shared room and/or the door of the shared restroom while Resident 44 was using the toilet on 4/21/2026.This deficient practice could potentially result in Resident 44 feeling bothered, invaded, or humiliated, and the potential to negatively impact Resident 44's psychosocial (the emotional and social requirements that individuals must have to feel safe, supported, and capable of functioning well in their environment) well-being.Findings:During a review of Resident 44's admission Record (AR), the AR indicated Resident 44 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD - a long standing lung disease causing difficulty in breathing) with acute (sudden) exacerbation (worsening of a disease), and unspecified dementia(a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance, psychotic (relating to or affected with a psychosis - a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) disturbance, mood disturbance, and anxiety (intense, excessive, and persistent worry and fear about everyday situations).During a review of Resident 44's Minimum Data Set (MDS - a resident assessment tool), dated 3/18/2026, the MDS indicated Resident 44's cognitive skills (ability to think and process information) for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 44 required substantial/maximal assistance (helper does more than half the effort) to partial/moderate assistance (helper does less than half the effort) for activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 44 was frequently incontinent (lack of control) of urine (7 or more episodes) and bowel (2 or more episodes).During a concurrent observation and interview on 4/21/2026 at 1:25 PM with CNA 1, Resident 44 was using the toilet and occasionally groaned. CNA 1 was standing outside of the restroom. The doors to Resident 44's shared room and shared restroom were open. CNA 1 stated the doors were open because Resident 44's roommate (unnamed) was not in the room. CNA 1 stated CNA 1 should have closed Resident 44's door to the restroom for [Resident 44's] privacy.During an interview on 4/23/2026 at 1:44 PM with the Registered Nurse Supervisor (RNS), the RNS stated, when a resident (in general) used the toilet, the door to the restroom should be closed to give the resident privacy and for dignity.During a review of the facility's policy and procedure (P&P) titled, Dignity, date revised February 2021, the P&P indicated residents are treated with dignity and respect at all times. The P&P indicated staff promoted, maintained and protected resident privacy, including bodily privacy during assistance with personal care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to create a Baseline Care Plan (BCP, a form where one can summarize a person's health conditions, care needs, and current treatments) for one of one sampled resident (Resident 70) with 48 hours of admission.This deficient practice had the potential to result in unmet needs for Resident 70.Findings: During a review of Resident 70's admission Record (AR), the AR indicated Resident 70 was admitted to the facility on [DATE] with multiple diagnoses including bacteremia (a condition in which bacteria are present in the bloodstream) and chronic (long standing) diastolic congestive heart failure (inability of the heart to efficiently pump blood through the body, causing buildup of blood in the veins and of other body fluids in tissue).During a review of Resident 70's History and Physical (H&P), date of admission 4/17/2026, the H&P indicated Resident 70 did not have capacity to understand and make decisions.During an interview on 4/24/2026 at 3:15 PM with the Director of Nursing (DON), the DON stated Resident 70's BCP was created on 4/23/2026 and almost one week after Resident 70 was admitted on [DATE]. The DON stated Resident 70's BCP should have been created upon Resident 70's admission [to the facility]. During a concurrent interview and record review on 4/24/2026 at 3:21 PM with the Registered Nurse Supervisor (RNS), Resident 70's BCP dated 4/23/2026 was reviewed. The RNS stated Resident 70's BCP was created on 4/23/2026. The RNS stated the purpose of the BCP is to get to know Resident 70 better and let staff know the plans for care.During a review of the facility's policy and procedure (P&P) titled, Care Plans - Baseline, dated 3/2022, the P&P indicated a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement safety measures to ensure one of four sampled residents (Resident 36) who had a history of multiple falls and was at risk for falls. On 4/24/2026 Resident 36's bed was not in the lowest position and Resident 36's bilateral (two sides) floor mats were not on Resident 36's bedside.The deficient practice had the potential to result in falls, injury, and a physical decline to Resident 36.Cross Reference F684 and F656.Findings:During a review of Resident 36's admission Record (AR), the AR indicated Resident 36 was admitted to the facility on [DATE] with diagnoses that included intervertebral disc displacement (a spinal condition where the soft, gel-like center of a spinal disc pushes through its tough outer ring into the spinal canal) - lumbar region (lower part of the back), cerebellar ataxia (involuntary muscle coordination causing unsteady movements), repeated falls, and lack of coordination, abnormalities in gait and mobility (abnormal walking, characterized by unsteadiness, shuffling, limping, or stiffness).During a review of Resident 36's History and Physical (H&P), dated 10/26/2025, the H&P indicated Resident 36 did not have the capacity to understand and make decisions. During a review of Resident 36's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 1/22/2026, the MDS indicated Resident 36's cognition (the ability to think and process information) was moderately impaired (moderate problems with thinking and memory). The MDS indicated Resident 36 was dependent (helper does all of the effort) with toilet hygiene, lower body dressing and needed maximal assistance (helper does more than half the effort) with upper body dressing.During a review of Resident 36's care plan (CP), initiated 2/11/2026, the CP's goal indicated low bed in use. The CP's interventions indicated keep the bed in the lowest position at all times when resident is resting, unless care is being provided. During a review of Resident 36's Change in Condition Evaluations (COC), the COCs indicated Resident 36 sustained falls on 1/30/2026, 2/9/2026, 2/15/2026, 3/1/2026, and 3/23/2026.During a review of Resident 36's Fall Risk Assessment (FRA), dated 4/4/2026, the FRA indicated Resident 36 was at risk for falls.During a review of Resident 36's Order Summary Report (OSR), dated active as of 4/24/2026, the OSR indicated a physician's order (PO), dated 1/14/2026, the PO indicated to place bilateral floor mats at Resident 36's bedside.During an observation and concurrent interview on 4/24/2026 at 9:45 AM with the Director of Nursing (DON), inside Resident 36's room, Resident 36 was lying in bed alone in Resident 36's room. Resident 36's floor mats were folded up vertically and leaning up against the wall and Resident 36's bed was not in the lowest position. Upon entering Resident 36's room, the DON lowered Resident 36's bed to the lowest position then unfolded Resident 36's floor mats and laid them on the floor on each side of Resident 36's bed.During an interview on 4/24/2026 at 10:33 AM with the Director of Rehabilitation (DOR), the DOR stated for Resident 36, who was at high risk for falls, a low bed (lowest position) and floor mats [at the bedside] were important to [prevent] falls and ensure Resident 36 did get a fracture [if the fall occurred].During an interview with the DON on 4/24/2026 at 2:33 PM, the DON stated Resident 36 had already sustained many falls and had a history of jumping off Resident 36's bed. The DON stated Resident 36's bed should be at the lowest position to prevent injuries to Resident 36. The DON stated floor mats needed to be placed on the floor next to Resident 36's bed and not leaning on the wall for Resident 36's safety.During a review of the facility's policy and procedure (P&P), titled Safety and Supervision of Residents, revised 7/2017, the P&P's policy statement indicated the facility strives to make the environment as free from accident hazards as possible. The P&P indicated the care team shall target interventions to reduce accident risks.ensuring that interventions are implemented, evaluating the effectiveness of interventions, and modifying or replacing interventions as needed.During a review of the facility's P&P titled Falls and Fall Risk, Managing, revised 3/2018, the P&P indicated based on previous evaluations and current data, the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 32), who was receiving enteral feeding (tube feeding), was provided appropriate treatment and services to prevent complications to Resident 32's gastrostomy tube (GT, a surgical opening fitted with a device to allow feedings and/or medications to be administered directly to the stomach common for people with swallowing problems). On 4/23/2026, Resident 32 did not have an abdominal binder (a wide, compressive belt made of elastic or fabric that wraps around the stomach) wrapped around Resident 32's GT area, Resident 32's GT site had an undated soiled dressing (a piece of material such as a pad applied to a wound to promote healing and protect it from infection), and the GT site had redness, inflammation, and dried-up drainage around the GT site.This deficient practice had the potential to result in an infection (the invasion and growth of germs in the body) to Resident 32 and displacement (partial or complete unintended removal of a feeding tube) of Resident 32's GT.Findings:During a review of Resident 32's admission Record (AR), the AR indicated Resident 32 was originally admitted to the facility on [DATE] with multiple diagnoses including cerebral palsy (a group of permanent disorders affecting movement, posture, and muscle coordination caused by abnormal brain development or damage before, during, or shortly after birth), unspecified, displacement of other gastrointestinal prosthetic devices, implants and grafts, subsequent encounter, and encounter for attention to gastrostomy.During a review of Resident 32's History and Physical Examination (H&P), dated 2/22/2025, the H&P indicated Resident 32 did not have the capacity to understand and make decisions.During a review of Resident 32's Care Plan (CP), date revised 1/7/2026, the CP's focus indicated Resident 32 required tube feeding r/t (related to) dysphagia (difficulty swallowing). The CP's goal indicated Resident 32's insertion site (GT) would be free of s/sx (signs and symptoms) of infection. The CP's interventions indicated to provide local care to GT site as ordered and to monitor for s/sx of infection.During a review of Resident 32's CP, date revised 1/7/2026, the CP's focus indicated Resident 32 was at risk for Resident 32's GT getting pulled out by Resident 32. The CP's interventions indicated to apply/place abdominal binder at all times, inspect skin integrity inside and outside of the abdominal binder, and to monitor GT and the site Q (every) shift.During a review of Resident 32's Minimum Data Set (MDS - a resident assessment tool), dated 4/12/2026, the MDS indicated Resident 32's cognitive skills (ability to think and process information) for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 32 was dependent (helper does all the effort) for activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 32 had a feeding tube as a nutritional approach on admission and while a resident at the facility.During a review of Resident 32's Order Summary Report (OSR), dated active as of 4/23/2026, the OSR included a physician's orders, dated 4/6/2026, indicating,1.Cleanse the GT site with normal saline (NS, sterile mixture of salt and water designed to match the natural fluid balance of the human body), pat dry, apply dry dressing and secure with tape as needed for soiled or dislodged GT.2.May have abdominal binder wrapped around the GT area related to history of pulling out GT every shift.During a concurrent observation and interview on 4/23/2026 at 8:12 AM with Licensed Vocational Nurse (LVN) 1, Resident 32 did not have an abdominal binder wrapped around Resident 32's GT area. Resident 32's GT site had an undated soiled dressing. Resident 32's GT site had redness, inflammation, light brownish colored dried-up drainage, and crusty dried-up skin around the GT site. LVN 1 stated, staff (in general) checking the GT site, providing GT care, and reporting to the treatment nurse was important to prevent skin irritation, MASD [moisture associated skin damage caused from prolonged exposure to moisture], and infection. LVN 1 stated, having an abdominal binder on as ordered was important [to prevent] Resident 32 from (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pulling out Resident 32's GT and be sent back to the hospital, [Resident 32] had pulled it out before.During an interview on 4/23/2026 at 12:07 PM with the Treatment Nurse (TN), the TN stated resident's (in general) GT site care and dressing changes were done daily and prn [as needed]. The TN stated a date on the dressing [was important] so staff knew when the last time the dressing was changed. The TN stated Resident 32 had problems with the GT site leaking and Resident 32's GT site had redness, and it was important to monitor [Resident 32's GT site] to avoid infections the. The TN stated Resident 32's dressing should have been changed. The TN stated Resident 32 should have the abdominal binder on to prevent Resident 32 from pulling out the GT.During a concurrent interview and record review on 4/24/2026 at 12:35 PM with the Registered Nurse Supervisor (RNS), Resident 32's medical records were reviewed. The RNS stated Resident 32's skin assessment was done upon admission and weekly. Resident 32's Progress Note - Wound Care (PNW), by the Physician Assistant-Certified (PA-C), dated 2/25/2026 was reviewed, the note indicated Resident 32's GT wound site, peristoma (the area of skin around the stoma) dermatitis (inflammation of the skin) was healed. A review of Resident 32's Weekly Nursing Progress Note (WNPN), dated 3/23/2026 and 4/7/2026, the notes indicated Resident 32's GT was patent and intact. A review of Resident 32's Licensed Nurse Skin Assessment Form (LNSA), dated 3/27/2026 and 4/24/2026, the forms did not indicate any documentation about Resident 32's GT site. A review of Resident 32's Admission/readmission Date Tool (ARDT), dated 4/5/2026 and timed at 3:21 PM, the tool indicated redness around GT. The RNS stated Resident 32's GT site had redness with irritation, and the site should have been monitored, the dressing changed, and physician notified (unnamed). The RNS stated applying the abdominal binder on Resident 32 was important to prevent Resident 32 from pulling out Resident 32's GT which Resident 32 had done in the past.During a review of the facility's policy and procedure (P&P) titled, Gastrostomy/Jejunostomy Site Care, date revised October 2011, the P&P's purpose indicated to promote cleanliness and to protect the gastrostomy or jejunostomy site from irritation, breakdown, and infection. The P&P indicated to assess the stoma's (a surgically created small opening in the abdomen that leads directly into the stomach) site for signs of redness, pain or soreness, swelling, or drainage and report any of these signs of infection immediately to the supervisor and the resident's physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 14) received proper respiratory (relating to breathing) care such as oxygen (02 [a colorless, odorless, tasteless gas essential for living]) therapy in accordance with the physician's order.This deficient practice resulted in Resident 14's not receiving the correct dose of supplemental 02 and the potential to result in complications such as shortness of breath and respiratory failure. Findings:During a review of Resident 14's admission Record (AR), the AR indicated Resident 14 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including acute respiratory failure with hypoxia (a medical emergency where the lungs suddenly fail to get enough oxygen into the blood causing severe shortness of breath), and heart failure, unspecified.During a review of Resident 14's undated History and Physical Examination (H&P), the H&P indicated Resident 14's did not have the capacity to understand and make medical decisions.During a review of Resident 14's Minimum Data Set (MDS - a resident assessment tool), dated 3/5/2026, the MDS indicated Resident 14's cognitive skills (ability to think and process information) for daily decision making were moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 14 was dependent (helper does all of the effort) to requiring partial/moderate assistance (helper does less than half the effort) with activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 14 was receiving continuous 02 therapy.During a review of Resident 14's Order Summary Report (OSR), dated active as of 4/24/2026, the OSR indicated a physician's order, dated 2/26/2026, for 02 at three (3) liters per minute (LPM - the speed or volume of 02 a device delivers in one minute) via nasal cannula (N/C - a small plastic tube that fits into a person's nostrils for providing supplemental oxygen) continuously.During a concurrent observation and interview on 4/21/2026 at 9:50 AM with Resident 14, Resident 14 was sitting up in bed watching tv. Resident 14 was receiving two and half (2 1/2) LPM 02 via N/C. Resident 14 had one (1) nasal prong (the two smaller tubes that are parts of the N/C that deliver the 02 inserted directly one in each nostril) inside Resident 14's left nostril. Resident 14 stated, Resident 14 always used 02 and did not know who placed the 02 N/C on Resident 14.During a concurrent observation and interview on 4/21/2026 at 10:01 AM with the Treatment Nurse (TN), Resident 14 was sitting up in bed watching tv. Resident 14 was receiving 2 1/2 LPM 02 via N/C with 1 nasal prong inside Resident 14's left nostril. The TN stated Resident 14 only had 1 of nasal prong in Resident 14's nostril. The TN stated ensuring both nasal prongs were in Resident 14's nostrils was important for Resident 14 to receive the right dose of 02 since Resident 14 had chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing).During a concurrent interview and record review on 4/23/2026 at 1:44 PM with the Registered Nurse Supervisor (RNS), Resident 14's physician orders were reviewed. The RNS stated Resident 14 had an order for 02 at 3 LPM dated 2/26/2026 for respiratory failure. The RNS stated Resident 14 had the tendency of removing Resident 14's N/C and staff should be monitoring Resident 14. The RNS stated Resident 14 was not receiving the ordered dose of 02 when both nasal prongs were not in Resident 14's nostrils. The RNS stated Resident 14 not getting the correct 02 dose could lead to episodes of desaturation (a dangerous drop in blood oxygen levels) and respiratory failure. The RNS stated it was important for the nasal prongs to be in Resident 14's bilateral [both] nostrils, for the correct dose of 02 to be administered.During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, date, revised October 2010, the P&P indicated the purpose of the P&P was to provide guidelines for safe oxygen administration. The P&P indicated the nasal cannula was a tube that was placed approximately one-half inch into the resident's nose.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post nurse staffing information of actual hours worked by licensed and unlicensed nursing staff who were directly responsible for resident care, per shift daily, in a prominent location and make readily accessible to residents and visitors for viewing on 4/21/2026, 4/22/2026, 4/23/2026 and 4/24/2026. This deficient practice resulted in inaccurate nursing hours posted by the facility and had the potential to result in residents and family members obtaining misleading information posted.Findings:During an observation on 4/24/2026 at 12:35 PM, the facility's posted document titled Projected Census and Direct Service Hours Per Patient Day (DPHHD) on 4/21/2026, 4/22/2026, 4/23/2026, and 4/24/2026, the DPHHD indicated the projected hours for direct care staff for shifts 7 AM to 3 PM, 3 PM to 11 PM, and 11 PM to 7 AM. The DPHHD did not indicate the actual hours worked per shift.During an interview and concurrent record review with the Director of Staff Development (DSD), on 4/24/2026 at 12:41 PM, the facility's posted DHPPD dated 4/21/2026, 4/22/2026, 4/23/2026 and 4/24/2026 were reviewed, the DSD stated projected nursing hours were posted at the beginning of the day. The DSD stated actual worked direct care hours were not calculated/generated until the following day and were kept in a binder inside the front office. The DSD stated actual worked nursing hours were not posted for the public to view. DSD stated it was important for actual nursing hours to be posted to ensure we [the facility] tracked the actual nursing hours provided to the residents.During an interview and concurrent record review on 4/24/2026 at 2:35 PM with the Director of Nursing (DON), the DON stated actual nursing hours should be posted for patient care ratios and for the safety of the residents. During a review of the facility's policy and procedure (P&P) titled Staffing, Sufficient and Competent Nursing, revised on 8/2022, the P&P indicated direct care daily staffing numbers (the number of nursing personnel responsible for providing direct care to residents) are posted in the facility for every shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident's (Resident 48) had two home medication bottle contents verified by a licensed pharmacist as indicated by the facility's policy and procedure (P&P) titled, Medications Brought to the Facility by the Resident/Family.This deficient practice had the potential for Resident 48 to receive medication and/or tablets other than what was indicated on the medication bottle labels and the potential to affect Resident 48's physical well-being.Findings: During a review of Resident 48's admission Record (AR), the AR indicated Resident 48 was admitted to the facility on [DATE] with multiple diagnoses including Alzheimer's disease (a condition that occurs late in life and worsens with time in which brain cells degenerate; it is accompanied by memory loss, physical decline, and confusion) and generalized muscle weakness.During a review of Resident 48's Minimum Data Set (MDS- a resident assessment tool), dated 3/2/2026, the MDS indicated Resident 48's cognition (ability to understand and process information) was moderately impaired and Resident 48 was dependent (helper does all of the effort) for toileting and bathing.During a review of Resident 48's Order Summary Report (OSR), dated with active orders as of 4/24/2026, the OSR indicated the following physician orders:Glucosamine Hydrochloride tablet give 1500 milligrams (mg - unit of weight) by mouth one time a day for supplement two tablets per day.Mens 50+ Multivitamin Oral Tablet (Multiple Vitamins with Minerals) give one tablet by mouth one time a day for supplement.During an observation on 4/24/2026 at 11:52 AM with Licensed Vocational Nurse (LVN) 1, the following two medication bottles were observed in medication cart # 2:220 tablet bottle of Glucosamine Hydrochloric acid (HCl, a chemical substance) with Chrondoitin/methylsulfonylmethane (MSM) complex (dietary supplement).275 tablet bottle of Men's 50+ Multivitamin (dietary supplement).LVN 1 stated the medication bottles were not from the facility's pharmacy and had been brought into the facility by Resident 48's family. LVN 1 stated LVN 1 did not know if the pharmacist had checked Resident 48's medication bottles.During an interview on 4/24/2026 at 2:48 PM with the Director of Nursing (DON), the DON stated the contents of the medication bottles had not been verified by the facility's pharmacist. The DON stated it was important to verify the contents of home medication bottles for resident safety and to ensure that whatever is indicated on the label is [are the contents] inside the medication bottle.During a review of the facility's undated P&P titled, Medications Brought to the Facility by the Resident/Family, the P&P indicated if a medication is not otherwise available and/or it is determined to be essential to the resident's life, health, safety, or well-being to be able to take a medication brought in from outside, the director of nursing services and nursing staff, with support of the attending physician and consultant pharmacist, shall check to ensure that: d. the contents of each container have been verified by a licensed pharmacist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055817	A. Building B. Wing	04/24/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 4) had a consent (when a patient gives permission for something to happen) for the COVID-19 (Coronavirus Disease of 2019 - a highly contagious respiratory illness caused by the SARS-CoV-2 virus) vaccine (medications used to prevent diseases usually given by injection or by mouth) prior to being administered the vaccine and as indicated by the facility's policy and procedure (P&P) titled, Coronavirus Disease (COVID-19) - Vaccination of Residents.This deficient practice had the potential to result in Resident 4 not making informed decisions due to not being aware of the potential risks and benefits associated with the vaccine.Findings:During a review of Resident 4's admission Record (AR), the AR indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD - a long standing lung disease causing difficulty in breathing), unspecified and sepsis (a life-threatening blood infection [(the invasion and growth of germs in the body), unspecified organism.During a review of Resident 4's History and Physical Examination (H&P), dated 4/19/2026, the H&P indicated Resident 4 could make needs known but could not make medical decisions.During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 4/23/2026, the MDS indicated Resident 4's cognitive skills (ability to think and process information) for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 4 was dependent (helper does all of the effort) to requiring partial/moderate assistance (helper does less than half the effort) for activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated, Resident 4's COVID-19 vaccination was not up to date.During a concurrent interview and record review on 4/24/2026 at 9:40 AM with the Infection Preventionist (IP), the facility's Residents Immunization (RI), dated 4/23/2026 was reviewed. The RI indicated Resident 4 received the COVID-19 vaccine on 9/17/2025. The IP stated there was no record of a consent for Resident 4's COVID-19 vaccine. The IP stated the facility did not provide the COVID-19 vaccine to the residents (in general). The IP stated an outside contracted pharmacy (CP) came to the facility to administer the vaccine to the residents. During an interview on 4/24/2026 at 2:38 PM with the IP, the IP stated the CP did not have a COVID-19 consent for Resident 4. The IP stated a consent was when a resident gave the okay, the permission, to be administered medications. The IP stated, obtaining a consent was important to get the permission from Resident 4 to administer the COVID-19 vaccine.During a review of the facility's P&P titled, Coronavirus Disease (COVID-19) - Vaccination of Residents, date revised October 2025, the P&P indicated residents must sign a consent to vaccinate form prior to receiving the vaccine. The P&P indicated the resident's medical record included documentation that indicated, at a minimum, a signed consent.