STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055989	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor	610 North Garfield Avenue Monterey Park, CA 91754

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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a comprehensive resident centered care plan (a formal process that correctly identifies existing needs and recognizes a resident's potential needs or risks to achieve healthcare outcomes) in accordance with the facility's care plan policy for one of three sampled residents (Resident 1), by failing to ensure the diabetes mellitus care plan initiated on 7/15/2025 was appropriate. This deficient practice had the potential to result in delay or lack of delivery of care and services to Resident 1, which could affect the resident's overall wellbeing. Cross Reference to F684, F726, F756 Findings: During a review of Resident 1's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar), encounter for attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and dysphagia (difficulty swallowing). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 7/18/2025, the MDS indicated Resident 1's cognitive skills (ability to think and reason) for daily decision making was moderately impaired (some difficulty in situations only). The MDS indicated Resident 1 was dependent (helper does all the effort) with oral hygiene, toileting hygiene, shower, upper body dressing, lower body dressing and putting on/taking off footwear and personal hygiene. The MDS indicated Resident 1 had no orders of insulin and was not taking a hypoglycemic. During a review of Resident 1's care plan titled, The resident has diabetes mellitus, initiated on 7/15/2025, the care plan goals indicated the following: The resident will be free from signs and symptoms of hyperglycemia. The resident will be free from signs and symptoms of hypoglycemia (low blood sugar). The resident will have no complications related to diabetes. The care plan's interventions included the following: Diabetes medications as ordered by doctor. Monitor/document/report as needed for any signs and symptoms of hyperglycemia. Monitor/document/report as needed for any signs and symptoms of hypoglycemia. During a concurrent record review and interview on 8/15/2025 AM at 10:45 AM with MDS nurse 1 (MDSN 1), Resident 1's care plan was reviewed. MDSN 1 stated and verified she initiated Resident 1's care plan on 7/15/2025. MDSN 1 stated Resident 1 did not have a diabetes medication order or blood sugar monitoring on 7/15/2025. During a concurrent record review and interview on 8/15/2025 at 11:25 AM with Registered Nurse 1 (RN 1), Resident 1's care plan was reviewed. RN 1 stated Resident 1's care plan was inaccurate because Resident 1 did not have an order for diabetes medication and Accu-Chek (used by people with diabetes to manage their blood sugar levels) to monitor Resident 1's blood sugar on 7/15/2025. RN 1 stated the wrong care plan interventions might lead to confusion of care to Resident 1. During a concurrent record review and interview on 8/15/2025 at 12:26 PM with MDSN 2, Resident 1's care plan was reviewed. MDSN 2 stated the facility had 21 days to complete a care plan for a resident who was newly admitted to the facility. MDSN 2 stated the care plan was developed by the Interdisciplinary Team (IDT, a group of healthcare professionals who work together to provide comprehensive and coordinated care for residents) and was being discussed during IDT meetings or care conferences for the residents. MDSN 2 verified Resident 1's care plans were initiated on 7/15/2025, prior to having a care conference with the IDT members. MDSN 2 verified Resident 1's care plan for diabetes mellitus that was initiated on 7/15/2025 was inaccurate and should have been revised. MDSN 2 stated Resident 1 did not have an order of insulin or any diabetes medication on 7/15/2025. MDSN 2 stated the care plan interventions were not resident specific centered care and that it was important to reflect the current orders and appropriate interventions on the care plan for the entire team to know the specific care for Resident 1's diagnosis of diabetes mellitus. During a review of facility's policies and procedures (P&P) titled, Comprehensive Care Plans, revised on 12/9/2024, the P&P indicated to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.

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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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the necessary diabetic care and services for one of three sampled residents (Resident 1), who had a diagnosis of type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control), by failing to coordinate services for diabetic care and management for Resident 1 that included checking blood sugar with an accu-check machine (checking blood sugar level with the use of a machine, by pricking the finger and collecting a small blood sample on a test strip, which would be read by the machine) in accordance with Physician 1's H&P treatment plan. This deficient practice resulted in Resident 1 experiencing hyperglycemia (a condition where there's too much glucose in the blood) placing Resident 1 at risk for various serious complications, in ketoacidosis (DKA, a complication of diabetes in which acids build up in the blood to levels that can be life-threatening), dehydration (a condition occurs when the body loses more fluids than it takes in, leading to an insufficient amount of water for normal bodily functions), confusion (a state of reduced awareness and impaired thinking) and coma (a state of prolonged unconsciousness where a person is alive but unresponsive to their surroundings). Cross reference to F656, F726, F756.Findings: During a review of Resident 1's GACH 1's Lab (prior to admission to the facility), dated 7/10/2025, the Lab report indicated Resident 1's hemoglobin A1C (HA1C, a blood test that reflects average blood sugar levels over the past two to three months) was 7.1, which was higher than the normal range. During a review of Resident 1's GACH 1's Nursing Narrative Note, dated 7/10/2025, the Note indicated the nurse notified Physician 1 the result of HA1C and Physician 1 ordered metformin (a medication used to treat Type 2 DM) 500 milligrams (MG, a unit of measurement) twice a day. During a review of Resident 1's GACH 1's Orders, dated 7/10/2025, the Orders indicated Physician 1 ordered metformin 500 MG one table orally twice per day before meals on 7/10/2025. During a review of Resident 1's General Acute Care Hospital (GACH) 1's Medication Tasks-Scheduled (MT), dated 7/11/2025 to 7/14/2025, the MT indicated Resident 1 received metformin 500 MG one table orally twice per day before meals from 7/11/2025 and 7/14/2025. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE], with diagnosis of type 2 diabetes with hyperglycemia. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 7/18/2025, indicated Resident 1 had severely impaired cognitive (ability to think and reason) skills for daily decision making was moderately impaired memory and cognition (ability to think and reasonably). During a review of Resident 1's H&P, dated 7/15/2025 indicated Physician 1's plan was for Accu-check daily, continue DM meds. During a review of Resident 1's care plan titled, The resident has diabetes mellitus, initiated on 7/15/2025, the care plan goals indicated the following: The resident will be free from signs and symptoms of hyperglycemia. The resident will be free from signs and symptoms of hypoglycemia (low blood sugar). The resident will have no complications related to diabetes. The care plan's interventions included the following: Diabetes medications as ordered by doctor. Monitor/document/report as needed for any signs and symptoms of hyperglycemia. Monitor/document/report as needed for any signs and symptoms of hypoglycemia. During a review of Resident 1's Medication Administration Record (MAR), from July 2025-August 2025, indicated Resident 1 did not get daily accu-check and did not receive any diabetes medication from 7/14/2025 to 8/8/2025. During a review of Resident's SBAR, dated 7/22/2025 at 2:52 PM, the SBAR indicated Resident 1 had weight loss of six pounds per week related to edema decreased and the physician recommended Complete Blood Count (CBC, a common blood test that analyzes the three main types of blood cells), Comprehensive Metabolic Panel (CMP, a blood test that measures 14 different substances in the blood that includes blood sugar level), lipid panel (a blood test that measures different types of fats in the blood), and thyroid-stimulating hormone (TSH, a blood test to check thyroid [a gland that regulating energy, growth and organ function] function) During a review of Resident 1's laboratory CMP result dated collection date dated 7/23/2025 indicated Resident 1's blood sugar level was 289 milligram per deciliter (MG/DL, a unit of measurement) which was high according to reference range (70-110 MG/DL). During a review of Resident 1's Situation, Background, Appearance, Review and Notify Communication Form (SBAR, a form to communicate about a resident's change of condition), dated 8/9/2025 at 9:50 AM, the SBAR indicated Resident 1 complained about weakness and not feeling well. The SBAR indicated the resident's blood sugar was at 557 milligram per deciliter (MG/DL, a unit of measurement). The SBAR indicated the physician ordered regular insulin with sliding scale and metformin. During a review of Resident 1's MAR, dated

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the Minimum Data Set Nurse (MDSN, a licensed nurse who specializes in the assessment and documentation of patient health data in long-term care) 1 completed the annual licensed nurse competency for 2023 and 2024. This deficient practice caused an increased risk for improper resident assessments, inadequate documentation, and could negatively impact the quality of care to the residents which could lead to hospitalization or death. Cross Referenced to F656, F684, F756 Findings: During an interview on 8/14/2025 at 10:30 AM, MDSN 1 stated she did not know the facility's policy and procedure for comprehensive care plans (a detailed, individualized document that outlines all aspects of a patient's medical, emotional, and daily living needs). During an interview on 8/14/2025 at 12:30 PM, MDSN 2 stated developing residents' comprehensive care plans is one of the tasks of the MDS nurses. MDSN 2 stated MDS nurses should know the facility's policy for developing comprehensive care plans, as the facility has up to 21 days upon resident's admission to develop a comprehensive care plan. MDSN 2 stated this included reviewing all the pertinent records (hospital records, active orders, Doctor's History and Physical notes). MDSN 2 stated the facility conducted yearly competency to licensed nurses to ensure staff were updated and provided reminders of the standard of practice. During an interview on 8/14/2025 at 4:52 PM, the Director of Nursing (DON) stated and verified that MDSN 1 did not complete the annual licensed nurse competency (a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual need to perform work roles or occupational functions successfully) and should have completed it for the year 2023 and 2024. During a concurrent record review and interview on 8/14/2025 at 4:57 PM, the facility's Licensed Nurse Competency checklist was reviewed. The DON verified that the care plan was one of the skills that was checked off on the list. The DON stated completing the annual licensed competency was important to ensure the licensed nurses were up to date with knowledge, skills, and abilities to perform their roles for the residents. The DON stated it would help the licensed nurses to effectively and safely conduct their tasks for the residents. During a review of the facility's P&P titled, Training Requirement, revised on 12/19/2022, the P&P indicated the facility developed, implemented, and maintained an effective training program for all new and existing staff, consistent with their expected roles. During a review of facility's P&P titled, Competency Evaluation, revised on 12/19/2022, the P&P indicated annual competency was evaluated at a frequency determined by the facility assessment, evaluation of the training program, and/or job performance evaluations. During a review of facility's assessment dated [DATE], the facility assessment indicated in the staff training / education and competencies section, that Person-centered care was one of the topics in this section and should include but not be limited to person-centered care planning, education of resident and family /resident representative about treatments and medications, documentation of resident treatment references, end-of-life care, and advance care planning.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to perform a comprehensive medication regimen review (MRR, a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) in accordance with the facility's policies and procedures (P&P) for one of three sampled residents (Resident 1). This deficient practice resulted in Resident 1 not having medication for the diagnosis of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control) since admission on [DATE], which lead to Resident 1's hyperglycemia (high blood sugar) on 8/9/2025. Cross Referenced to F656, F684, F726 Findings: During a review of Resident 1's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control) with hyperglycemia (high blood sugar), encounter for attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and dysphagia (difficulty swallowing). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 7/18/2025, the MDS indicated Resident 1 had moderately impaired cognitive skills (problems with the ability to think and reason) for daily decision making. The MDS indicated Resident 1 was dependent (helper does all the effort) with oral hygiene, toileting hygiene, shower, upper body dressing, lower body dressing and putting on/taking off footwear and personal hygiene. The MDS indicated Resident 1 had no physician's orders for insulin and was not taking hypoglycemic medication. During a review of Resident 1's MRR dated 7/1 - 7/28/2025, the MRR indicated a recommendation for Resident 1's gabapentin (medication to treat epilepsy [a brain disease] and nerve pain) and clarification of the medication route. There were no other recommendations for July 2025 for Resident 1. During a telephone interview on 8/14/2025 at 2:46 PM, the Consultant Pharmacist (CP) stated Resident 1's medications were reviewed in July, and there was no recommendation regarding any diabetes medication (metformin nor insulin). The CP stated Resident 1's diagnosis of diabetes mellitus was not included in the list of diagnoses that was reviewed for Resident 1. The CP verified Resident 1 received insulin medication from the previous admission to the facility and that he did not review Resident 1's hospital records when the MRR was conducted last month. The CP stated he did not review Resident 1's laboratory results and also stated, I would only review hospital records, laboratory results, and doctor's notes if there's something that I would clarify, so it's only sometimes, not all the time. During a follow up telephone interview on 8/14/2025 at 3:48 PM, the CP stated he did not have access to Resident 1's full diagnoses list. The CP stated a recommendation for Resident 1's diagnosis of DM without medication or treatment would have been documented in July's MRR report if he knew that Resident 1 had a diagnosis of DM. The CP stated he would have reviewed Resident 1's laboratory results if he knew that Resident 1 had diagnosis of DM. During an interview on 8/14/2025 at 4:55 PM, the Director of Nursing (DON) stated the CP did not do a comprehensive MRR for Resident 1 in July because the CP claimed he did not see the diagnosis of DM. The DON stated that the CP should have reviewed Resident 1's previous medication orders from the last admission to the facility and the CP should have reviewed Resident 1's hospital records for the new admission this July. The DON stated the CP should have reviewed Resident 1's H&P and the medications of Resident 1, which was also not reviewed by licensed nurses upon Resident 1's admission to the facility on 7/14/2025. During a review of facility's P&P titled, Medication Regimen Review, dated June 2021, the P&P indicated the consultant pharmacist performs a comprehensive MRR at least monthly and the facility assured the consultant pharmacist had access to residents and the residents' medical records.