STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555055	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baldwin Gardens Nursing Center	10786 Live Oak Avenue Temple City, CA 91780

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement an individualized care plan (a document that outlines a person's health needs and the care they require) for one out of three sampled residents (Resident 1) when: 1. Facility did not ensure a care plan was developed for Resident 1's diagnosis of rhabdomyolysis ([rhabdo] a life-threatening medical condition involving the rapid breakdown of damaged skeletal muscle). This deficient practice negatively affected Resident 1's care and created an immediate risk to Resident 1's health, safety, and quality of life. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included rhabdomyolysis and encephalopathy (brain disease that alters brain function or structure causing a declining ability to reason and concentrate, memory loss, personality change, seizures, and twitching). During a review of Resident 1's History and Physical Examination (H&P, physician clinical evaluation and examination of the resident), dated 4/24/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/27/2026, the MDS indicated Resident 1's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was intact. The MDS indicated Resident required set up assistance for eating. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) for oral hygiene, toileting hygiene, shower/bathing, upper body dressing, and personal hygiene. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) for lower body dressing and putting on/taking off footwear. During a review of Resident 1's electronic medical record, unable to locate Resident 1's care plan for Resident 1's diagnosis of rhabdomyolysis. During an interview on 6/23/2026 at 1:10 p.m. with Resident 1, Resident 1 stated Resident 1 was upset with the care that Resident 1 had received at the facility. Resident 1 stated Resident 1 suffered from muscle spasms due to Resident 1's diagnosis of rhabdomyolysis. Resident 1 stated the muscle spasm caused pain on Resident 1's bilateral lower extremities. Resident 1 stated nursing staff did not know how to care for a resident with Resident 1's diagnosis and felt that instead of getting better Resident 1 was getting worse. Resident 1 stated nursing staff should receive training on how to care for residents with a diagnosis of rhabdomyolysis. During an interview on 6/24/2026 at 1:18 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 was in constant pain due to muscles spams on bilateral lower extremities. LVN 1 stated Resident 1 had a diagnosis that caused Resident 1 to have muscle spasms. LVN 1 stated LVN 1 was not familiar with Resident 1's diagnosis. LVN 1 stated LVN 1 had to research Resident 1's disease to know what it was. LVN 1 stated a care plan offered a plan of care for resident diagnoses and licensed nurses must practice the interventions in the care plan. During a concurrent interview and record review on 6/24/2026 at 1:26 p.m. with LVN 1, Resident 1's care plans were reviewed. The care plans indicated no care plan for the diagnosis of rhabdomyolysis was developed. LVN 1 stated LVN 1 was not aware that a care plan was not developed for rhabdomyolysis because LVN 1 did not check the care plans. LVN 1 stated Resident 1 required a care plan for the diagnosis of (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	rhabdomyolysis because it would guide nurses to provide the best care for Resident 1 and specifically because the diagnosis was not a common diagnosis. LVN 1 stated without a care plan Resident 1 would not receive the proper care and treatment for the diagnosis of rhabdomyolysis. During an interview on 6/24/2026 at 1:40 pm with Minimum Data Set (MDS) Nurse (clinical leader who manages comprehensive patient assessments), MDS Nurse stated a care plan was a problem-solving interventions and goal setting to address residents' problems or conditions. MDS Nurse stated residents' diagnoses must be part of resident's care plans. MDS Nurse stated MDS Nurse did develop a care plan for Resident 1's diagnosis of rhabdomyolysis. During a concurrent interview and record review on 6/24/2026 at 1:50 p.m. with MDS Nurse, Resident 1's care plan was reviewed. The care plans indicated no care plan was developed for the diagnosis of rhabdomyolysis. MDS Nurse stated it was important to develop a care plan to monitor Resident 1's condition and to set new interventions as needed. MDS Nurse stated no care plan had the risk of Resident 1 not being properly monitored for the effect of interventions in place. During an interview on 6/24/2026 at 3:35 p.m. with Director of Nursing (DON), the DON stated a care plan was a plan of care for residents' problems, set of goals, and interventions for residents' problem or concerns. The DON stated residents' diagnoses were implemented in the care plan. The DON stated a care plan was specific to a diagnosis and not a list of diagnoses because interventions would be different according to residents' problem. The DON stated the risk of not having a care plan was a resident would not receive the proper intervention or receive the proper assessment that they require for their condition. During a review of facility's Policy and Procedure (P&P) titled Care Plans, Comprehensive Person-Centered, dated 11/2025, the P&P indicated a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychological and functional needs would be developed and implemented for each resident. The P&P indicated the comprehensive, person-centered care plan would:Include measurable objectives and timeframes.Incorporate identified problems areas.Incorporate risk factors associated with identified problems.Aid in preventing or reducing decline in the resident's functional status and/or functional levels.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure food was prepared and served to meet individualized needs for one of three sampled residents (Resident 3) when: 1. Dietary cook (DC) failed to honor Residents 3's food dislikes and served Resident 3 turkey for lunch. 2. Licensed nurses did not verify Resident 3's food was correct prior to serving food to Resident 3. These deficient practices did not meet Residents 3's individual needs. It had the potential to impact Resident 3's nutritional intake. It made Resident 3 feel unsatisfied with the meal and caused Resident 3 not to want to eat the meal. During an observation on 6/23/2026 at 12:38 p.m., in Resident 3's room, Resident 3 was sitting at bedside staring at food tray. Food was untouched. During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included bipolar disorder (a mental illness that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks) and left artificial knee joint (a prosthetic knee joint (or artificial knee) replaces a missing or damaged natural joint). During a review of Resident 3's History and Physical Examination (H&P, physician clinical evaluation and examination of the resident), dated 6/2/2026, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 6/5/2026, the MDS indicated Resident 3's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was intact. The MDS indicated Resident 3 required set up assistance for eating. The MDS indicated Resident 3 required moderate assistance (helper does less than half the effort) for oral hygiene, toileting hygiene, shower/bathing, dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 3's Nutritional Screen, dated 6/2/2026, the Nutritional Screen indicated under food preferences, no chicken, turkey, eggs, and fish. During a review of Resident 3's dietary slip, dated 6/23/2026, the dietary slip indicated Resident 3's food dislikes were fish, chicken, eggs, and turkey. During a review of facility's menu, dated 6/23/2026, the menu indicated lunch meal was roast turkey, bread dressing, and broccoli with garlic. During a concurrent observation and interview on 6/23/2026 at 12:40 p.m. with Resident 3 in Resident 3's room, Resident 3 pushed away food tray. Resident 3 stated Resident 3 was not eating lunch today because Resident 3 did not like fish. Resident 3 stated this had happened before where Resident 3 received fish and Resident 3 did not like fish. Resident 3 stated Resident 3 would not eat the meal. Resident 3 took a bite out of the food and stated it was not fish it was chicken but Resident 3 was not going to eat it because Resident 3 did not like chicken. Resident 3 stated the chicken did not taste good. Resident 3 stated Resident 3 had told dietary staff Resident 3 did not like chicken, fish, and turkey and did not know why they continued to serve food Resident 3 did not like. Resident 3 stated he would prefer to eat something else or not eat at all. Resident 3 stated when this happened before, staff removed the meal tray and did not offer a food substitution. During an interview on 6/23/2026 at 12:46 p.m. with Director of Staff Development (DSD), DSD stated DSD provided Resident 3 with meal tray. DSD stated DSD did not check Resident 3's food dislikes before providing Resident 3 meal. DSD stated DSD was supposed to check food for the correct diet, texture and food dislikes. DSD stated Resident 3 did not receive fish, it was chicken and that was ok. During a concurrent observation and interview on 6/23/2026 at 12:48 p.m., in Resident 3's room, Resident 3 told DSD Resident 3 did not like chicken and would prefer a substitution meal. Resident 3 stated Resident 3 tasted the food and it did not taste good. DSD stated DSD checked the menu and it was not chicken and that it was turkey. DSD stated Resident 3 could eat the food because it was not fish or chicken. Resident 3 stated turkey was also one of Resident 3's disliked food choice. During an interview on 6/24/2026 at 2:12 p.m. with Dietary Supervisor (DS), DS stated on 6/23/2026 residents received turkey, bread stuffing and some (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vegetables for lunch. DS stated nursing staff notified DS Resident 3 received turkey for lunch and that was one of Resident 3's food dislikes. DS stated the dietary cook (DC) was responsible to check residents' dietary slip and to serve food according to residents' dietary slip. DS stated DC must check residents' diet, food texture, and honor food dislikes. DS stated DC was responsible to serve food to all residents according to their dietary slip and DC did not do it for Resident 3 because Resident 3 received turkey for lunch. DS stated all meals should be checked for accuracy and for residents' safety. DS stated when residents received food they do not like there was a risk for residents not to eat and could potentially cause weight loss. DS stated nursing staff was also responsible to check residents' food before delivering food trays to residents. During an interview on 6/24/2026 at 2:56 p.m. with DSD, DSD stated before passing food tray to a resident, staff must check if food diet, food consistency, and food allergy was correct. DSD stated licensed nurses and certified Nursing Assistants (CNA) were responsible to check residents' food tray before delivering to residents. DSD stated it was important to check food before delivering it to a resident because nursing staff must ensure food was safe to eat and to make sure the food was something a resident liked and would want to eat. DSD stated on 6/23/2026 resident received chicken and Resident 3 did not like chicken. DSD stated DSD should have checked the food served to Resident 3 and changed the meal before it was delivered to Resident 3 but DSD did not do that. During an interview on 6/24/2026 at 3:40 p.m. with the Director of Nursing (DON), the DON stated dietary staff were responsible to serve the correct meal to all residents. The DON stated licensed nursing staff and CNAs were responsible to check the food prior to delivering it to the residents. The DON stated licensed nurses and CNAs must check if residents receive the correct diet, the correct food consistency, and the correct diet likes and dislikes. The DON stated licensed nurses must check diet list and residents dietary slip and compare it to the food that was served to the resident. DON stated if there was an issue with the food it must be sent back to the kitchen to get it fixed. The DON stated it was important to serve residents the correct food so they can eat it. The DON stated if residents did not receive the correct food, residents would not eat it and would not receive the proper nutrition. During a review of facility's Policy and Procedure (P&P) titled, Nutrition Care, dated 2018, the P&P indicated all residents must be ordered a substitute food item when an item they dislike is on the menu. The P&P indicated substitutes must be foods of similar nutrition value.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not provide a working call light to one of four sampled residents (Resident 3). This deficient practice had the potential to cause a delay or the inability in obtaining necessary care and services for Resident 3. During an observation on 6/23/2026 at 12:42 p.m., in Resident 3's room, Resident 3 pushed call light and call light outside of room did not light up and there was no audible sound. During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included bipolar disorder (a mental illness that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks) and left artificial knee joint (replaces a missing or damaged natural joint). During a review of Resident 3's History and Physical Examination (H&P, physician clinical evaluation and examination of the resident), dated 6/2/2026, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 6/5/2026, the MDS indicated Resident 3's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was intact. The MDS indicated Resident required set up assistance for eating. The MDS indicated Resident 3 required moderate assistance (helper does less than half the effort) for oral hygiene, toileting hygiene, shower/bathing, dressing, putting on/taking off footwear, and personal hygiene During an interview on 6/23/2026 at 12:40 p.m. with Resident 3, Resident 3 stated Resident 3 needed assistance with the meal that was served. Resident 3 stated Resident 3 pushed call light to get assistance but no one showed up to help. Resident 3 stated this was not the first time Resident 3's call light was not answered. Resident 3 stated using a call light was the only way to ask for assistance if Resident 3 needed something and staff should check if they worked. Resident 3 stated it was important for Resident 3 to be able to receive the assistance Resident 3 required especially during an emergency. During an interview on 6/23/2026 at 12:53 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated CNAs were responsible to check residents call lights to see if they were working. CNA 1 stated CNAs must push call lights and make sure the call lights outside of residents' room lit up and that it made a noise. CNA 1 stated CNA 1 did not check if Resident 3's call light was working today because CNA 1 forgot but everyone that entered Resident 3's room was responsible to check call lights too. CNA 1 stated it was important for residents to have a working call light so they could use it in case of an emergency. During a concurrent observation and interview on 6/23/2026 at 12:57 p.m. with CNA 1 in Resident 3's room, CNA 1 pushed on call light and the call light outside of Resident 3's room did not light up and there was no audible sound. CNA 1 stated Resident 3's call light was not working and needed to be reported. CNA 1 stated not having a working call light put Resident 3 at risk of not receiving the attention and care that Resident 3 required. During an interview on 6/24/2026 at 2:56 p.m. with Director of Staff Development (DSD), DSD stated a call light was used by residents to request assistance. DSD stated when a call light was pushed it caused a light outside of resident room and at nurse's station to turn on and it caused an audible sound to go off. DSD stated it was important for all residents to have a working call light to use during an emergency because that would be the fastest way for a resident to get help. DSD stated maintenance was responsible to check residents call lights to make sure they were in working condition. DSD stated maintenance checked call lights once a week. DSD stated nursing staff was responsible to check if call lights were nearby and assessable to residents. During an interview on 6/24/2026 at 3:28 p.m. with Director of Nursing (DON), the DON stated a call light was a system used by residents to ask for assistance. The DON stated maintenance and nursing staff were responsible to check if call lights were working. The DON stated the DON expected staff to make sure call lights were connected correctly and in working condition by pushing the call light and making sure it turned on. The DON stated DON expected CNAs to check call lights on every shift and maintenance to check weekly. The DON stated it was important (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to make sure all call lights worked to keep residents safe. The DON stated it was important for residents to have a working call light to prevent falls or to assist residents if they are not feeling good. During a review of facility's Policy and Procedure (P&P) titled, Call Light, undated, the P&P indicated the purpose was to ensure timely response to the resident's request and needs. The P&P indicated staff would make sure call light was plugged in and functioning at all times.